PROFESSIONAL DOCTORATES

Supporting Foster Carers Through Training

Exploration of foster and kinship carer training needs and attendance on a behaviourally based training programme.

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Supporting Foster Carers Through Training: Exploration of foster and kinship carer training needs and attendance on a behaviourally based training programme.

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Ymddiriodolaeth Ymyrraeth Cynnar Plant

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Declaration

Yr wyf drwy hyn yn datgan mai canlyniad fy ymchwil fy hun yw'r thesis hwn, ac eithrio lle nodir yn wahanol. Caiff ffynonellau eraill eu cydnabod gan droednodiadau yn rhoi cyfeiriadau eglur. Nid yw sylwedd y gwaith hwn wedi cael ei dderbyn o'r blaen ar gyfer unrhyw radd, ac nid yw'n cael ei gyflwyno ar yr un pryd mewn ymgeisiaeth am unrhyw radd oni bai ei fod, fel y cytunwyd gan y Brifysgol, am gymwysterau deuol cymeradwy.

I hereby declare that this thesis is the results of my own investigations, except where otherwise stated. All other sources are acknowledged by bibliographic references. This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree unless, as agreed by the University, for approved dual awards.

Acknowledgements

This work has only been possible as a result of the opportunity offered to me by my supervisor Professor Judy Hutchings, her ongoing support and that of my second supervisor Dr Maggie Hoerger has been invaluable. Thank you both for your patience, feedback, optimism and kindness, I would never have completed without you.

Thank you to the people involved in this research, who have given their time so freely and been so supportive of the project. To the child we fostered through much of this time, I hope you have benefited from my learning as much as I have learned from you, during our time together.

The team at the Centre for Evidence Based Early Intervention have been there for me throughout this journey and a special thanks to Dilys for the administrative support. Thank you to Margiad, who has patiently trained me in observational coding, helped with all my data and statistical questions and generally been a fount of all knowledge.

Thank you to my family, who have faithfully asked if I am finished yet, for a long time now, to Roly who has done everything I have not done and that needed doing, over the last four years and who has been a daily rock of support and source of laughter and love. Finally, to the constant and faithful patience of the three dogs who have spent most of their time curled up at my feet.

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Background to the Thesis

In 2009 whilst working in Information Technology with individuals resistant to engaging with systemic change, I decided to revisit my early interest in Psychology and enrolled with the Open University to undertake a Graduate Conversion Diploma in Psychology. During this time, we applied and were approved as foster carers and were offered our first long-term looked after child placed in 2013. Shortly after this, after an application for a PhD post at Bangor University, I was offered a Masters by Research Knowledge Economy Skills Scholarship (KESS). KESS is a collaboration between a university and a local business, in this case Bangor University with Professor Judy Hutchings at the Centre for Evidence Based Early Intervention. We designed a project using Judy's book, the Little Parent Handbook that took some of the chapters and made them available to foster carers in an online format. During the course of the Masters, an organisation in South Wales approached Judy interested in evaluating a home delivery of the Incredible Years© (IY) programme with foster carers and parents of children being rehabilitated home. An application for a KESS funded PhD was made and accepted based on the IY rehabilitation project and I started in December 2015.

Difficulties in recruiting sufficient participants in a timely manner arose early in the project and so a second option with a different local authority was explored. The local authority were keen to evaluate the training that they were offering to foster and kinship foster carers and to better understand the difficulties experienced by both carers and the children they looked after. A survey of carers identified a high level of carer reported child behavioural difficulties. It also became apparent that carers were not being routinely offered the parenting interventions recommended for children with behavioural difficulties. During this time, the Confidence in Care parenting skills programme was being offered to foster and kinship foster carers in Wales as part of a Cardiff University evaluation. The authority was not scheduled to be offered the Confidence in Care programme for a further 18 months, so agreed to offer the Incredible Years© parenting intervention to interested foster and kinship foster carers in the meantime. Two groups were run during 2017, one for foster carers and one for kinship foster carers. Personal circumstances led to a six month extension to the completion date for the PhD.

Recognition of the limitations of group based programmes in being effective and accessible for all participants, led to the final study that explored the utility of the Enhancing Parenting Skills (EPaS) programme with carers. The programme, developed by Judy, is a one to one intervention for individual parents to address difficult child behaviour. Local

authorities were approached to gauge interest in the training programme for social workers. After some introductory meetings, one authority agreed to send supervising social workers on an EPaS training programme, so that they could deliver EPaS to carers they supervised, with the intervention being evaluated as part of the PhD. Ethical approval was written and obtained and the EPaS training programme undertaken during the autumn of 2018. The social workers had been unable to deliver the intervention to any carers to fit within the timescale of the PhD, so the project was amended to evaluate the training and explore its perceived relevance and the difficulties experienced by social workers in delivering it. An amendment was obtained to the ethical approval and the interviews undertaken.

The PhD as a whole has been a challenging project to manage, requiring several changes in direction and modification of plans. Flexibility and adaptability have been crucial and the difficulties reflect some of the challenges of undertaking pragmatic research outside of the laboratory. When thinking about what sort of research I would like to do at the start of this project, I was very clear that my wish was to undertake research that was likely to be found helpful to the participants. Many of the challenges were associated with undertaking pragmatic research, and I have experienced a fairly steep learning curve in my entry into real world research. However, I have received some feedback from participants in the IY intervention:

> "*It is unusual for me to mention training in my magazine write-ups, but some of us participated in the "Incredible Years" course this year which ran in conjunction with Sue Layland's Bangor University project. It is only a couple of hours per week for 12 weeks but is fun as well as informative. One of the best courses I have been on and well-delivered by the leaders, who I suggest you contact if you would like to participate or find out if there is another one planned*."

Whilst collecting the follow up measures for the IY intervention I also received comments from participants as to how attending the programme had benefitted them and the children they cared for. As a foster carer all too aware of the challenges faced by carers of looked after children on a daily basis, this feedback has made the hard work of the last four years worthwhile.

Summary

This thesis explores characteristics of foster carers and children/young persons placed with them, carer training needs, response to training and contributes to a discussion on ways to improve outcomes for children looked after. There are two types of local authority approved foster carers who participated in the studies reported. Traditional foster carers are unrelated and usually strangers to the children they foster and are recruited specifically for a fostering role. Kinship foster carers are known to the children they care for and are identified and approved as part of the process of a child entering the care system.

The thesis reports on three investigations, study one and two were undertaken with the same local authority, study three was undertaken with a different local authority. Both local authorities were in Wales Studies one and three are reported in single chapters, Chapter 4 and Chapter 7. Study two is reported in two chapters, Chapter 3 and 4.

In study one, a survey of a local authority training programme for foster and kinship foster carers identified that the majority of carers reported clinical levels of child behavioural problems, however carers were not routinely offered the parent management training recommended for problem behaviours.

These findings led to the Authority offering carers an Incredible Years© behavioural parenting intervention, reported in study two. Eleven foster and eleven kinship foster carers were recruited. A comparison of characteristics at baseline found that foster carers reported higher levels of stress $t(36)=2.49$ $p<.05$ and more behavioural problems $t(18)=3.22$ $p<.001$ than kinship foster carers, with 70% of foster and 30% of kinship foster carers reporting abnormal levels of child behavioural difficulties. Both types of carers reported similar attachment relationships with the children they cared for.

Eight foster carers and six kinship foster carers completed the IY programme. Separate groups were run for foster and kinship foster carers and follow-up measures were collected six months post-baseline. Children placed with kinship foster carers had been in care for a shorter period (1 year) than those in foster care (5.5 years) and foster carers had been approved as carers for longer (12 years) than kinship foster carers (0.8 years). There was a significant improvement in carer reported child behaviour for the whole sample on the total score from the Child Behaviour Check List $t(13)=2.67$, $p<.05$; $d=.41$. Whole sample results for carer stress also showed a significant improvement on the Parenting Stress Index (Short-Form) $t(13)=3.47$ $p<.01$; $d=.45$. There was no significant whole sample change in the Quality of Attachment Relationships Questionnaire. Between group comparisons showed

that foster carers reported a significant improvement in child internalising behaviour t(8)=2.74 $p<.05$, improvements in levels of stress t(8)3.49, $p<.01$ and improvements in carer-child attachment relationships t(8)=2.35, $p<.05$. There were no significant improvements reported by kinship foster carers on any measures. There was a high level of satisfaction with the programme with 98.5% of kinship and foster carers responses rating the programme as helpful or very helpful.

High levels of within group variation across the measures indicated differences in the needs of individual carers. In order to better support foster and kinship foster carers through an individualised intervention tailored to their specific needs, five supervising social workers were recruited and trained to deliver a one to one behavioural intervention, the Enhancing Parenting Skills programme (EPaS) and is reported as study three. At follow up two social workers had left the service and the remaining three social workers had failed to recruit participants. A semi-structured interview with the three social workers indicated a lack of confidence in their ability to deliver the intervention. Lack of familiarity with the structured assessment measures used to build the individual case study, combined with unfamiliarity with the behavioural knowledge required to develop a case analysis and intervention, and a perception of anticipated difficulties in establishing a collaborative working relationship with carers were seen as barriers to implementing the programme. Organisational barriers included work pressures and role conflicts between the role of supporting carers and a safeguarding supervisory role. Despite these challenges, social workers recognised the benefits of the EPaS programme for carers and found the training useful. They suggested that an alternative team would be more suited to deliver the programme and indicated the need for ongoing support after training and during implementation.

The thesis concludes with a discussion on the implications of the findings and recommendations for future research, policy and practice in the field.

Aims and Objectives of the Thesis

The main objective of the thesis was to explore ways of supporting foster and kinship foster carers through training, in order to benefit the children they look after. Five different themes were explored during this process;

1. The evidence base supporting training available to foster and kinship foster carers
2. The main challenges and difficulties in relation to children looked after, experienced by carers
3. The similarities and differences between kinship and foster carers
4. The potential for parenting interventions to address attachment relationships and behavioural problems
5. The challenges in delivering training to foster and kinship foster carers.

Structure of the Thesis

The thesis consists of eight chapters, structured as follows:

Chapter 1.	An overview of the history, present day situation and challenges experienced by children looked after, primarily in England and Wales.
Chapter 2.	The challenges experienced by foster carers, including statistics on numbers of carers and issues around retention and the psychological theories that underpin child behaviour, including attachment theory and behavioural-learning theories. The final section explores how training and support could help both foster carers and children looked after.
Chapter 3.	A scoping review of the literature to establish the extent and nature of evidence based training available to foster and kinship foster carers.
Chapter 4.	Study one is a survey of training provision for foster and kinship foster carers in a local authority, identifying carer characteristics and carer reported child characteristics.
Chapter 5.	Study two is a comparison of the baseline characteristics of carers and children they look after, from a sample of foster and kinship foster carers recruited to attend one of two behaviourally based parenting groups.
Chapter 6.	Pre and post-intervention results for the whole study two sample and the two groups attending an Incredible Years© parenting intervention, one for foster carers and one for kinship foster carers.

Chapter 7. Study three evaluates findings from a training course for social workers working with foster and kinship foster carers, exploring the challenges to delivery of training to carers.

Chapter 8. Discussion of the findings of the thesis as a whole, the implications, limitations and recommendations for future research, policy and practice in the field.

Table of abbreviations used in the thesis

Abbreviation	
ACE	Averse childhood experience
BASC	Behavioural Assessment System for Children
BDI	Beck Depression Inventory
CAMHS	Child and Adolescent Mental Health Service
CBCL	Child Behaviour Check List
CD	Conduct disorder
CLA	Child looked after
DAWBA	Development and wellbeing assessment
DPICS	Dyadic Parent-Child Interaction Coding System
DSM-5 / DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, version 5
ECBI	Eyberg Child Behaviour Inventory
EPaS	Enhancing Parenting Skills programme
IFA	Independent foster agency
IQ	Intelligence Quotient
LA	Local authority
NEET	Not in education, employment or training
ODD	Oppositional defiant disorder
PDR	Parental Daily Report
PMT	Parent Management Training
PSI, PSI-SF	Parent Stress Index and Short Form
PTSD	Post-traumatic stress disorder
QUARQ	Quality of Attachment Relationships Questionnaire
RCT	Randomised control trial
SDQ	Strengths and difficulties questionnaire
SDQ	Strengths and Difficulties Questionnaire
SEN	Statement of special educational needs
SES	Socio-economic status
SESBI-R	Stutter-Eyberg Student Behaviour Inventory - Revised
SS	Strange Situation
TFR	Teacher Report Form
UK	United Kingdom
USA	United States of America

CHAPTER 1

An Overview of the History, Present Day Situation and Challenges Experienced by Children Looked After, Primarily in England and Wales

General Introduction

This chapter explores the history of foster care and the current situation and concludes with the challenges experienced by present day looked after children. It is structured in three sections;

Section 1 briefly describes the legislative history for child protection in England and Wales and how it evolved in relation to changing perceptions of child need, and relates this to how foster care has evolved over time.

Section 2 describes the current situation in the UK, the safeguarding process in Wales and focuses primarily on England and Wales in terms of the numbers of children in the care system, at what age they came into care and what is known about why they came into care.

Section 3 explores the challenges experienced by children looked after (CLA) in the care system.

Section 1: History and Background of the UK and Wales Looked After Child Legislation and System

Children looked after (CLA) are children for whom it has been decided that being taken into the care of the state is in their best interests, usually due to risk of serious harm if they remain where they are. The process of entering care is a legal process during which parental authority is passed to the local authority applying for the care order. Every local authority recruits, approves and trains people who care for children looked after. Traditionally these carers would be strangers to the child and are known as foster carers or foster parents. More recently, there has been a rise in relatives or friends of the child being identified as suitable to care for the child and these carers are approved by the local authority as kinship foster carers. Sometimes children stop living with parents and live with friends or relatives as part of a private arrangement between the child's parents and the kinship carer concerned. These arrangements have to be notified to the local authority, however parental authority remains with the parent and the kinship carer is not required to be approved as a kinship foster carer by the local authority.

An understanding of some of the history of social care in the UK helps to put the current legislation for children looked after into a context. The UK care system has evolved over four-hundred years with early social legislation focused on provision of basic care and protection, including regulating child labour and the compulsory provision of education (Appendix A). The increase in children needing care following the first and second world

wars, along with growing awareness of the association between early child experience and development of anti-social behaviour, marked a shift towards concern for child welfare as well as protection (Bowlby, 1950; Metcalf, 2010). The children's homes abuse scandals of the seventies and eighties marked another turning point and recognition that children not only do best in family environments, but also require protection from institutional abuse of power and abdication of responsibilities (Utting, 1991, 1997). The United Nations Convention on the Rights of the Child, as deserving of life, survival and development, protection, education, a relationship with their parents and to have their opinion listened to, enshrined principles of childhood as a defined experience and gave children fundamental rights (figure 1.1). Subsequent focus on the needs of children highlighted shortfalls in the abilities of children to overcome early adversity and achieve their potential. This led to a focus on improving outcomes for children looked after, particularly in relation to education. Recent legislation has coalesced around a move to place the child's voice at the heart of decision-making processes relating to themselves (Welsh Assembly Government, 2014).

Figure 1.1 – UK social care legislation and key reports timeline

Legislation	Significant Reports or Events
Poor Law **160**1	**1793** Foundling hospitals
Poor Law (amendment) **1834**	NSPCC formed
Prevention of Cruelty to, and protection of, children act **1889**	
Prevention of Cruelty to, and protection of, children act (amendment) **1894**	
Children act **1908**	
Children and Young Persons Act **1933**	
	1945 Monkton Report into death of 13yr old boy in foster care
	1946 Curtis report – care system reform
Children Act **1948**	
	1951 WHO report *Maternal care and Mental Health,* Bowlby.
European Convention on Human Rights **1953**	
Children and Young Persons Act **1963**	
	1968 Seebohm report care system amalgamation
Local Authority Services Act **1970**	
	1974 Field-Fisher report into the death of Maria Colwell at the hands of her stepfather. Child protection committees set up
Abortion Act **1967**	
	1973 Rowe & Lambert, *Children who wait*, promotion of permanency
Children Act **1975**	
Adoption Act **1976**	
Children Act **1989**	

1991 Utting *Children in the public care – a review of residential child care.* Report into residential homes child abuse.

United Nations Convention of the Rights of the Child adopted in the UK. **1992**

1997 Utting *People Like Us: The Report of the Review of the Safeguards for Children Living Away From Home.*

1998 HM Gov. *Children Looked After By Local Authorities* identified poor outcomes for LAC.

1998 Quality Protects DofH

Government of Wales Act **1998**

Protection of Children Act **1999**

1999 Criminal Records Checks compulsory

Children Leaving Care Act **2000**

2003 Lord Laming Inquiry into the death of Victoria Climbié at the hands of her carers

2003 HM Gov. Every Child Matters

2003 National Minimum Standards for Fostering Services (CIW monitors)

The Fostering Services (Wales) **2003**

2004 Welsh Assembly, Children First Strategic Framework for placement choice and stability

Children Act **2004**

2006 Welsh Devolution

2007 HM Gov, Care Matters: Time for Change

2007 SSIA. What works in promoting good outcomes for LACYP?

Placement of Children (Wales) Regulations **2007**

2007 Welsh Assembly. *Towards a stable life and brighter future.*

2011 Welsh Assembly. *Delegated Authority for Foster Carers*

2012 Wales Audit office. *The educational attainment of looked after children and young people*

2014 – Care Council for Wales. Induction framework for foster carers.

Children and Adoption Act **2014**

Social Services and Well-being (Wales) Act **2014**

Well-being of Future Generations (Wales) Act **2015**

Care Planning, Placement and Case Review (Wales) Regulations **2015**

Regulation and Inspection of Social Care (Wales) Act **2016**

Local Authority Fostering Services (Wales) Regulations **2018**

The Regulated Fostering Services (Service Providers and Responsible Individuals) (Wales) Regulations **2019**

Statutory Guidance Fostering Services **2019**

The rationale of how and why children are 'looked after' by the state has evolved along with changes in cultural and social values. Recognition of childhood as a unique period of development is a relatively recent phenomenon, within the last couple of centuries. With the decline in the influence of religion and the Church in society, responsibility for the destitute moved from the Church to philanthropic individuals and then to society as represented by the state. In parallel with this process was a move from regarding destitute children as a charitable burden, to their deserving of care in the same way any good parent would care for a child. Awareness that children needed food and shelter, evolved into recognition of the need for protection from abuse, including from people designated to care for them, to a deeper understanding of vulnerability and the lasting effects of maltreatment (Laming, 2016; Risley-Curtiss & Kronenfeld, 2001). Decision-making power for children has moved from the parent, to the state, shifted back in favour of the parent after institutional abuse and currently, more towards the child. The role and importance of the family has likewise varied, with several shifts in focus towards preventative support given to the family, rather than removal of the child. Recent awareness that despite provision of protection and welfare, children within the care system are not achieving in the same way that children in either secure or disadvantaged families achieve, has led to a focus on improving outcomes for children in care (Luke, Sinclair, & Sebba, 2014; SCIA, 2011). See Appendix A for an expanded discussion on the historical situation of children looked after.

UK legislation relating to children in care has often been reactive in response to public pressure in relation to socially unacceptable treatment of children, or failures in corporate parenting by local authorities. However, addressing previous failures misses the complexity of the underlying problems that lead to low achievement. Much of the legislation has focused on the systems and processes of taking children into care, legal responsibilities and inter-agency communication and collaboration. Measuring and reporting along with good intention have been shown not to be enough, to make the necessary changes to allow children in the care system to achieve their potential (Department of Health, 1998). Safeguarding legislation and the processes involved in placing children are quite detailed, however, there is little reference within the legislation to the role that carers of children looked after play in meeting the child's developmental needs, in order to achieve the duty of care placed on the local authorities. The recently published national fostering framework (AFA, 2019) is intended to address shortcomings in foster carers training and skills development. However, it is not clear what the incentives will be to adopt the framework across all fostering services within the sector. The experiences of children looked after both prior to, and post entry to care can mean many need sensitive and considerable ongoing support to achieve their potential. How well their carers are supported to provide this, will be

explored as part of this thesis. First, reported statistics for children looked after in England and Wales will be explored to better understand the current situation.

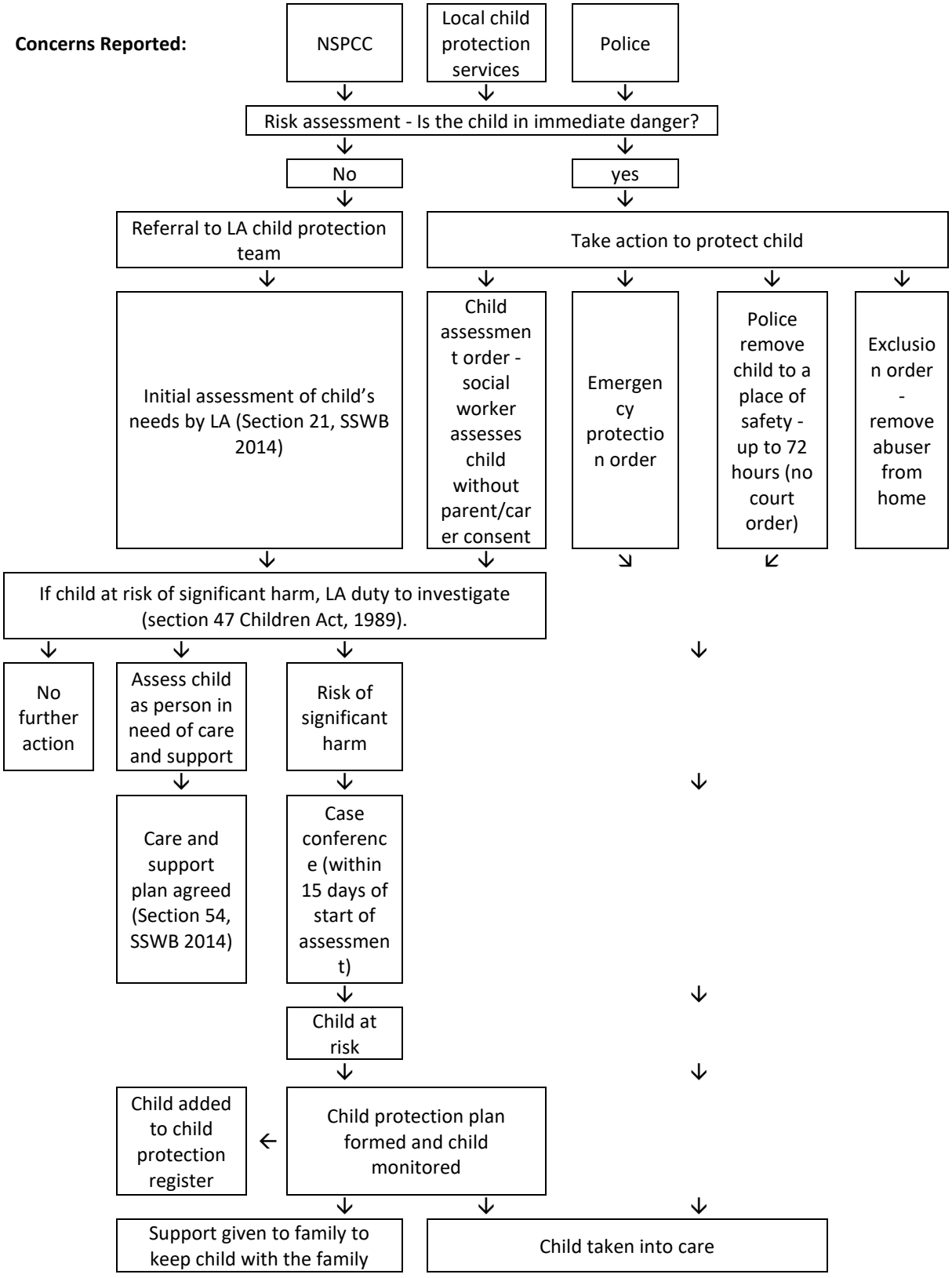
Section 2: The Present Situation in England and Wales

The care system.

The process of how and when children are taken into care is enshrined in legislation. In all four regions of the UK, children are taken into the care of the local authority if there is an immediate or future risk of significant risk of harm to the child if they remain where they are. In Wales, the legal framework for social service provision now comes under the Social Services and Well-being Act, 2014, (Welsh Assembly Government, 2014) which came into force in April 2016. The act is supported regionally by safeguarding boards which co-ordinate and ensure the effectiveness of work to protect children. When a concern is reported to the Police or local authority, the child protection team has a legal duty to investigate (figure 1.2).

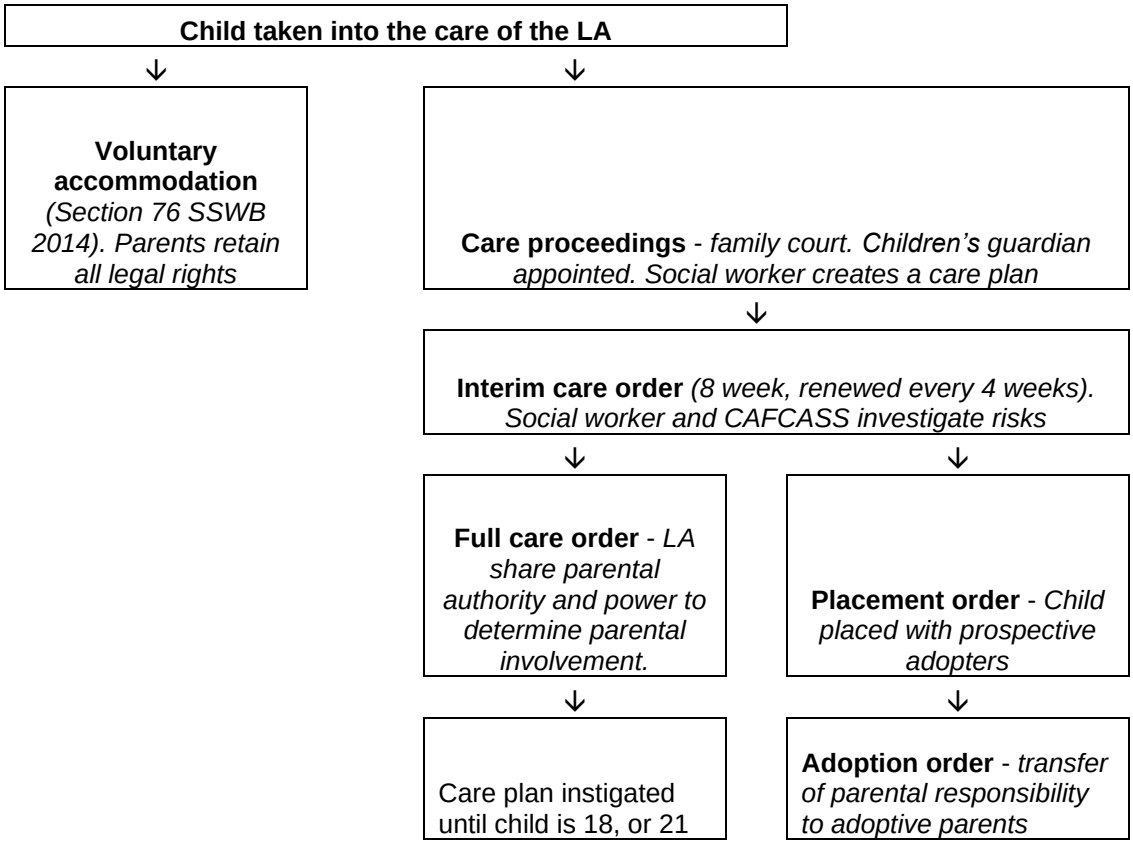
Children can be removed from the care of their parent/s by the Police, for a period of up to 72 hours, or by an authorised person such as a local authority by application to the family court for an emergency protection order (table 1.3). Where possible, initial investigations are undertaken whilst the child remains at home, with an exclusion order obtained to remove an alleged abuser from the family home obtained if necessary. If the child is determined to be in need of support in addition to that already provided by the family, an assessment of child needs will be undertaken by the local authority where the child is living. If it is decided the child is in need of care and support, a plan will be agreed, between the local authority, the child (where it is age appropriate) and the parents. If the child is thought to be at risk of significant harm, a case conference will be held within 15 days of the start of the assessment of the child. A child determined by a case conference to be at risk of significant harm will be added to the child protection register and have a child protection plan drawn up. The child and family will be monitored until the child is no longer considered to be at significant risk or they are taken into care.

Figure 1.2. The care process flow chart



(Information from : NSPCC, 2019)

Figure 1.3. Legislative process for entry to care flow chart



Children can be taken into care on a voluntary care order through agreement with parents and the local authority, parents retain all legal rights and can require the child's return at any stage. Alternatively, an application is made to the family court for an interim care order that gives the local authority shared parental responsibility and the ability to make decisions on behalf of the child. Interim care orders are for an initial eight weeks and may be renewed every four weeks after this period. They allow time for further investigation and a care plan to be made for the child. The results of investigations, assessments on suitable carers and the proposed care plan is then submitted to the family court for approval within 26 weeks of care proceedings starting. If agreed, the care plan for the child is then carried out and reviewed through the looked after children review process every six months. Changes to the care plan can be made at children's reviews and reviews can be held more frequently if necessary.

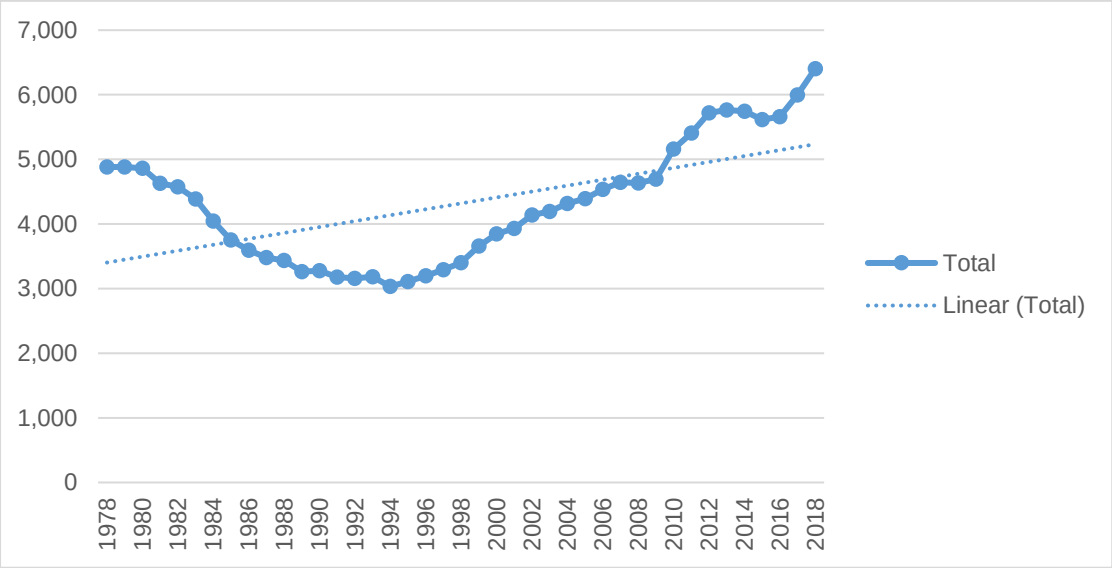
Entry to care – numbers and trends.

The demographics of children within the care system are explored in this section, including the numbers of children entering care, the demographics of those in the system and the primary reasons for entry to the care system in England and Wales. Reasons for placement moves are explored, with both planned moves, linked to care planning processes, and unplanned moves, where placements breakdown and the child is moved on,

investigated. Finally, statistics in relation to looked after child mental health will be reported. Statistics are provided from Wales where they are available and from England where data is relevant, but not reported within Wales.

The number of children in care in England and Wales is around 60 per 10,000 of the population, with 70,440 children in care in England and 6,405 in Wales in 2018. Proportionally per head of population, twice as many children are in the care system in Wales as in England, with 1% (70,440) of the child population in England in the care system, compared to 2% (6,405) in Wales (Department for Education, 2018; Welsh Government, 2019). The numbers of children and young people looked after in Wales are the highest they have been in the last forty years. Numbers declined between 1977 and 1996 (4,922 to 3,161 children respectively) but have since risen to 5,995 children in 2017, representing a 90% increase from the lowest point in 1994 (3,033 children). As a percentage of the total child population within Wales, this is an increase from 0.6% (64 per 10,000) in 2003, to 1% (95 per 10,000) in 2017 (Welsh Government, 2019) (Figure 1.4.).

Figure 1.4. Numbers of children in care per year, in Wales (1977-2018).



(Data from: Welsh Government, 2019)

Entry to care.

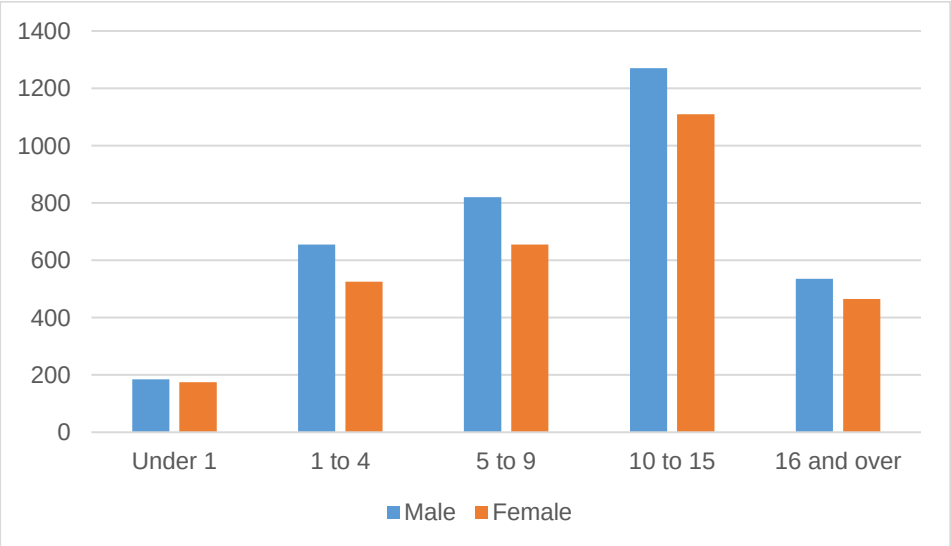
The main reason given for entry to care for children in Wales is abuse and neglect. The numbers of children entering care for this reason has risen by 16% over fifteen years, (48% in 2003, to 64% in 2018) (Welsh Government, 2019) with numbers entering care for other categories remaining largely stable over the same period (Appendix A; Figure A.1). Evaluation of the ages of children taken into care between 2006-2018 in England (Appendix

A; Figure A.2), shows a trend towards similar numbers of children of all ages being taken into care. In 2018, babies under one made up 19% of children taken into care, children aged 1-4 made up 18%, 5-9 years 18%, 10-15 years 28% and 16 and over, 18% (Department for Education, 2018). Age on entry to care was not available from Welsh Government data.

Demographics of children looked after.

There are more boys (54% in Wales, 56% in England) in care than girls (46% in Wales, 44% in England) with biggest proportion of looked after children and young people (CLA) aged between 10-15 years (36% in Wales, 39% in England). There are some differences in the ages of children and young people in care between England and Wales (Figure 1.5), with relatively more children under ten in care in Wales (47%), than in England (37%) and relatively more children over ten in care in England (62%), than in Wales (53%) (Department for Education, 2018; Welsh Government, 2019) (Appendix 2: Figure 1.2). Ford, Vostanis, Meltzer, & Goodman, (2007) used data from a UK wide survey of (*n* = 11,881) children aged 5-17 in 2000 to investigate (*n* = 839) children looked after by local authorities in England, Scotland and Wales. They noted gender differences in where children looked after were accommodated, with residential care having the highest percentage (65.9%) of males, and kinship care having the highest percentage (54.2%) of females. (Ford, Vostanis, et al., 2007) also found children living with kinship carers tended to be younger (10.5 years), whilst those living with foster carers were older (11.8 years). The study also found 90.7% of the sample were ethnically white, the same as the proportion of ethnically white children looked after in Wales in 2018.

Figure 1.5. Numbers of children looked after by age and gender, in Wales (2018)



(Data from: Welsh Government, 2019)

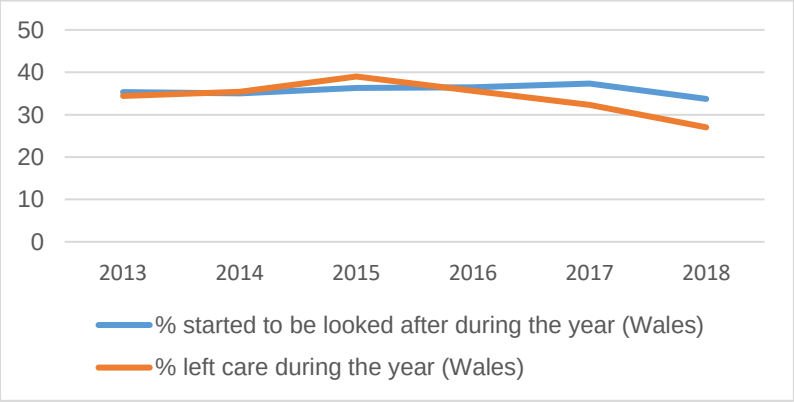
Placing trends whilst in care.

Children in care in England and Wales are primarily placed with non-relative foster carers (74% in Wales, 61% in England). Children looked after can also be placed at home with parents, or with friends and family (kinship) (13% in Wales, 18% in England), in residential accommodation (5% in Wales, 13% in England) or may live independently (2% in Wales, 4% in England) (Appendix A: Figure A.3). The percentages of children placed in the different types of care in Wales has remained relatively stable over the last fifteen years. There has been a small increase (2%) in children placed with friends and family carers or in residential care (1%), and a corresponding decrease (3%) in children placed with foster carers since 2012 (Department for Education, 2018; Welsh Government, 2019). For children in Wales reported as being in foster placements (n = 4,715) in 2018, the majority are placed with traditional foster carers, of which 47% (*n* = 2,200) are with local authority approved foster carers, 28% (*n* = 1,320) with foster carers approved by independent fostering agencies (IFA) and 25% (*n* = 1,200) placed with friends and family (kinship) carers.(Appendix A: Figure A.4).

Numbers entering and leaving care and trends.

Numbers entering care as a percentage of all children in care have been relatively stable in Wales over the last five years, at around 35%. This rose to a high in 2017 of 37% dropping in 2018 to 34% (Figure 1.6). There has been more fluctuation in percentage numbers leaving care over the same period, with numbers exiting care peaking in 2015 at 39% dropping to 27% in 2018 (Welsh Government, 2019). This period coincides with the change in legislation allowing children still in care aged 18, to choose to stay on with their carers until they are 21 years old, under the 'when I am ready' agreement.

Figure 1.6. Percentages of CLA entering and leaving care, in Wales (2013-2018).



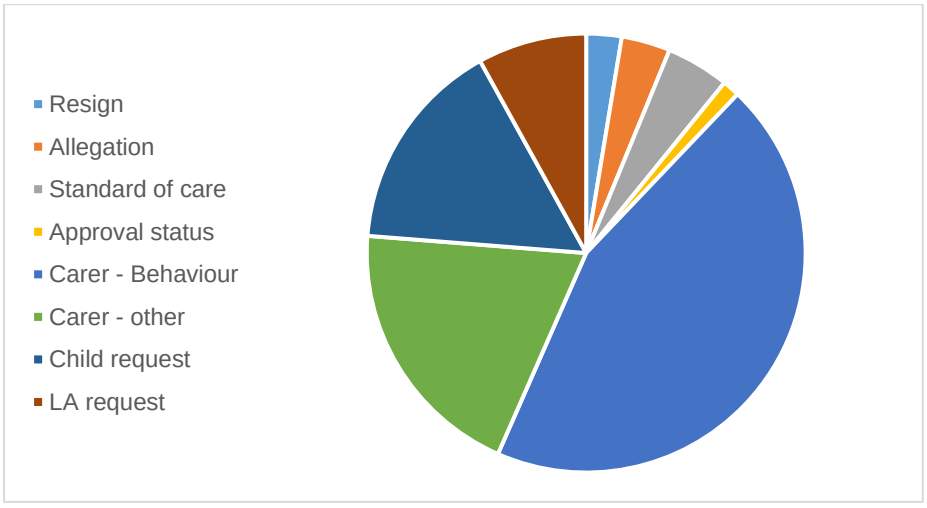
(Data from: Welsh Government, 2019)

In Wales, exits from care that do not include a new care episode starting on the same day make up 36% of care exits. The remaining 64% relate to placement moves, where the child leaves one placement to start a new placement in a new location. Investigation of the 36% of CLA who exited care in 2018, shows that the highest percentage left to return home to parents (40%), with 11% moving into independent living, 3% transferring to adult social care, 9% opting to remaining with foster carers post 18, under the 'when I am ready' option and 2% in custody. A further 21% were adopted, with 0.3% moving to a different LA and 14% had special guardianship orders made for them (Welsh Government, 2019) (Appendix A: Figure A.5). Special guardianship provides a legally secure placement for a child who cannot live with parents, carers obtain parental responsibility and the right to use it to the exclusion of all others, such as parents or the local authority. There has been some variability in reasons for exits from care over the last five years (Appendix A: figure A.6). There has been a 19.6% reduction in the numbers of CLA returning home and a -17.7% reduction in moves to independent living. In contrast, the numbers transitioning to adult care have increased (20%) as have those entering into special guardianship arrangements with carers (10.3%). There is also an increase in numbers incarcerated in the justice system (15.4%). Some of overall reduction in exits from care has been due to new legislation allowing care leavers over 18 to be able to choose to stay on until they are 21, under Welsh when I am ready, legislation that came into force in 2016. Approx. 9% of exits from care in 2018 were due to this category (Welsh Government, 2019).

Exits from care - Reasons for change in placement.

Reasons for changes in placement are not available from Welsh assembly statistics, so information collected and published by the UK government for English local authorities are used instead (Figure 1.7).

Figure 1.7. Reasons for unplanned placement moves, England (2018).



(Data from: Department for Education, 2018)

In England, 64% of placement endings in 2018 were planned and due to care planning, for example children moving from short to long-term placements, to home or due to a placement status change such as where short-term carers become long-term carers. For the remaining 36%, the biggest percentage of moves came at the request of the carer, with 44.5% (of 36%) requesting moves as a result of child behaviour and a further 19.7% requesting moves for non-specified reasons. A further 15.7% of moves were at the request of the child and 8% at the request of the local authority. The remaining 12% were as a result of carer resignations (2.6%), allegations (3.6%), concerns regarding standards of care (4.7%) and due to changes in carer approval status (1.3%) (Department for Education, 2018).

Placement moves and duration.

In Wales, 72% of children looked after remained in one placement during the reporting year of 2017-2018, 18% had two placements and 10% experienced three or more placements (Appendix A: Figure A.7). There were no statistics for the total numbers of moves experienced per child during their time in care (Welsh Government, 2019). Placement duration data was not available from Welsh assembly statistics, so information collected and published by the UK government for English local authorities has been used (Appendix A: figure A.8). In England, in 2018 the average length of a placement was just over 2 years (772 days). The majority, (78%) of placements were of one year or less in duration, with 13% being between one and two years, 7% between three and five years and 3% of five years or more (Department for Education, 2018).

Summary of section two.

This section has looked at the process of entry to care, indicating that it is only children who are at risk of serious harm who are removed from birth families and placed in out of home care. Exploration of the statistics available for children looked after indicate some trends. About 2% (5,995) of the child population in Wales are in the care system. Just over half are boys (54%) and the average length of stay is 2 years, with 78% in care for a year or less and 10% in care for 3 years or more. Children enter care primarily for reasons of abuse and neglect (64%) with an increase of 16% of children entering care for this reason over the last five years. Numbers entering care as a percentage of number in care has remained stable at around 35%; however, numbers leaving care are lower with 27% leaving care in 2018. Children primarily leave care to return home (40%), although this percentage has fallen by 19.6% over the last five years. There are indications that children are staying in

care for longer, with a 20% increase in transitions to adult services and a 10.3% increase in children staying with carers who are not parents under special guardianship arrangements.

The age at which children enter care has changed, moving towards a more even spread between all age ranges, with the biggest proportion (28%) entering care aged between 10-15 years. Once in care, children are mainly placed in foster care (74%), with 13% in friends and family or kinship foster care, 5% in residential placements and 2% living independently. Children placed in foster care are primarily placed with local authority approved carers (47% foster carers, 25% kinship carers), with the remainder with independent fostering agency carers (28%). Numbers of children in the care system are at the highest levels for forty years, the majority in care are aged between 10-15 years (36%). Most remain in placement for less than a year, with 10% having three or more moves during 2018. Figures from England indicate that 36% of placement endings in 2018 were unplanned, mainly due to foster carers ending placements (64%), with 44.5% of these placement moves being due to child behavioural problems (Department for Education, 2018; Welsh Government, 2019).

Children enter care after all other options have been explored and due to concerns they are at risk of serious harm should they remain at home. As the majority enter care for reasons of abuse and neglect, it could be expected that once removed from an environment deemed to be harmful, they will subsequently thrive despite early adversity. The next section will explore outcomes for children in the care system, in relation to mental health, education and long-term outcomes.

Section 3: Children Looked After Outcomes

Links between early life adversity and long-term health and social well-being are reported from the literature on the impact of aversive childhood experiences (ACE). Educational performance is a key indicator in government strategy in recognition of the key role it plays in individual success. The performance of children in care in education is reported and compared with children who are not looked after. The mental health of children looked after in Wales is not routinely measured, so mental health outcomes are explored through research from the last national survey of public health, which included children and children looked after. Factors that influence child development trajectories and experience of maltreatment are explored. These include maternal health and well-being, socio-economic status, substance abuse and parenting skills. Finally, the effects of maltreatment on brain development are discussed in relation to how it may contribute to developmental difficulties and behavioural challenges.

Links between early adversity and long-term health.

Research undertaken by Felitti et al., (1998) in America found a relationship between childhood abuse, household dysfunction and long-term physical and mental health problems. A UK sample with a Welsh cohort, reported that averse childhood experiences (ACE) are strongly linked to a range of later behavioural and psychiatric health problems (Bellis et al., 2017; Bellis et al., 2015). Using a validated ACE questionnaire (Anda et al., 2006) 7,414 participants aged between 18-69 years were interviewed, 2,002 from Wales and 5,412 from three English counties, In the Welsh sample, 47% had experienced at least one ACE, with 14% of people experiencing four or more (Bellis et al., 2017). Experiences defined as averse include maltreatment, abuse and environmental stressors, with varying percentages of exposure. Participants reported experiences of verbal (23%), physical (17%) and sexual abuse (10%), and experience of environmental stressors that included parental separation (20%), exposure to domestic violence (16%), parental mental illness (14%), parental alcohol abuse (14%), drug use (5%), and incarceration of a family member (5%).

Participants who as children experienced four or more adverse experiences, were significantly more likely to engage in health harming behaviours as adults, including increased rates of alcoholism and abuse of alcohol. They were more likely to develop mental health problems such as depression, and physical health problems including heart or liver disease over a lifetime. Compared to those with no ACEs, people with four or more ACEs, over the previous twelve months had an increased risk of becoming a victim of violence (x14), committing violence against another person (x15) and to have been incarcerated over their lifetime (x20) (Bellis et al., 2015). Increasing ACE counts also correlated with higher rates of absenteeism or other employment issues and with serious financial problems. (Bellis et al., 2017; Hughes et al., 2017).

Maltreatment of children, through physical, sexual or emotional abuse, neglect or exposure to domestic violence, is associated with long-term negative consequences. A review of the literature concluded that child maltreatment has short and long lasting effects on mental health, drug and alcohol problems, risky sexual behaviour, obesity and criminal behaviour (Gilbert et al., 2009; Erskine et al., 2016). Longer-term outcomes include reduced educational achievement and economic consequences that include lower rates of employment overall, with a greater proportion of employment in menial or semi-skilled roles. A longitudinal twin study in the UK assessed participants between the ages of 5-18 years (*n*=2232) and found the probability of low education, or of not being in education, employment or training (NEET) aged 18, was two times greater for young people with a history of child maltreatment (Jaffee et al, 2018). They determined that gender, socio-economic status (SES) and childhood IQ accounted for about 30% of the effect of

maltreatment on education and NEET status, with childhood psychopathology accounting for a further 7-9%, indicating that maltreatment may be a contributing factor for up to 60% of the difference in outcomes. With 64% of children entering care due to abuse and neglect (Welsh Government, 2019) and 39% in care experiencing mental health difficulties (Ford, Vostanis, et al., 2007), it is unsurprising children looked after are disadvantaged compared to peers.

Children looked after and education.

Statistically, children looked after underperform academically at all stages of the education system despite findings by Jackson & Sachdev, (2001) that the vast majority of looked after children are of normal intelligence. In Wales, 23% of children looked after achieve the benchmark five GSCE's grade A* to C, compared to 67% of all children. Aged sixteen, 29% of children looked after leave school with no qualifications at all, compared to 1% of children not in state care. In 2011, 48% of Welsh care leavers aged 19 were not in employment, education or training (NEET), compared to 12% of children not in the care system (Fletcher, Strand, & Thomas, 2015; Welsh Government, 2019). Children looked after were more likely to attend school, but also more likely to move school than the general population and there were gender differences within all sub-groups, with girls out-performing boys. Children in care were more likely to have a statement of special educational needs (SEN), with the SEN categorisation more likely to be for behavioural, social and emotional needs (Fletcher et al., 2015). High scores on a behavioural problems measure, the strengths and difficulties questionnaire also predicted poorer Key Stage four (14-16 years) academic attainment scores, as did placement and school instability (Luke, Sinclair, & O'Higgins, 2015). Large numbers (70%) of children in care experience at least one placement move (Harker, Dobel-Ober, Lawrence, Berridge, & Sinclair, 2003). Placement moves are detrimental to educational achievement, with higher numbers of moves linked to lower educational performance. However, children placed with foster or kinship foster carers experienced lower levels of placement changes than those accommodated in residential care (Luke et al., 2015).

In depth analysis of educational data indicates that children in care largely perform at the same level as their peers, with the exception of a minority who perform very poorly and depress average scores (Luke et al., 2015). Analysis of the English national pupil database for 2013, selecting for schoolchildren aged fifteen and then cross-referenced with the children looked after dataset, revealed within group differences in performance for looked after children and children in need who are not in care (Fletcher, Strand, & Thomas, 2015; Luke et al., 2015). The longer children are in care the better their educational performance, with those entering care at Key Stage 2 (before the age of ten) and remaining in care to Key Stage 4 (age 14-16) doing best. Children in care for more than a year at Key Stage 4, do

better than both children who are in need (but not in care) and children who have been in care for less than twelve months. This improvement in educational performance for children looked after contrasted with children in need, but not in care, who showed an overall decline in educational performance over time, indicating that being in care had a protective effect on education. (Luke et al., 2015). These findings indicate that for children looked after, placement stability promotes educational outcomes, whilst instability and behavioural difficulties have a negative impact on educational achievements.

Children looked after and mental health.

Mental health disorders are categorised according to the Diagnostic and Statistical Manual of Mental Disorders (DSM). The latest revision in 2013 (DSM-5) provides the criteria for the diagnosis of different types of psychiatric mental health disorders. The manual provides a benchmark for mental health disorder categorisation that is widely used within mental health diagnosis. A UK study (*n* = 10,438) found that children with parents who experienced psychiatric problems, were twice as likely as the general population to have mental health issues and were more likely to experience multiple problems (Meltzer, Gatward, Goodman, & Ford, 2000). Research indicates that children entering care have significantly higher mental health needs compared to the general population (Blower, Addo, Hodgson, Lamington, & Towlson, 2004; Dimigen et al., 1999). However, although there is a requirement to assess children looked after health and education on entry to care, health assessments in Wales generally do not include a routine assessment of mental health.

A screening measure of socio-emotional and behavioural health, the strengths and difficulties questionnaire (SDQ; Goodman, 1997) has been used to collect mental health data annually for children looked after in England since 2015. Results from 2018 indicate that 78% of 39,590 children had results reported, with the SDQ average score at 14.1, in the borderline range between normal and cause for concern. In total, 49% of children were in the normal range, 12% were in the borderline range and 39% in the cause for concern range (Appendix A: figure A.9) (Department for Education, 2018). This corresponds with findings by Ford et al., (2007) who used a subsample of data (*n* = 1,543) from a 1999 UK wide study to investigate the mental health of looked after children within the care system. This Office for National Statistics study included the use of the development and wellbeing assessment (DAWBA), a package of interviews designed to assess mental health and includes a clinical assessment with DSM IV or 5 diagnoses. Findings showed that 45.3% of the sampled children looked after had a psychiatric disorder, with 38.6% of children in foster care and 31.5% of children in kinship care displaying mental health problems (Ford, Vostanis, et al., 2007). Within the looked after population, children assessed with psychiatric disorders experienced statistically more changes (1.4 compared to 1) in placement in the previous

twelve months. Time in placement was likely to be shorter (2.4 years rather than 3) and they entered care later (mean age 7.7 rather than 7) than children within the normal ranges (Ford et al., 2007).

Comparisons of children in care with children in private households showed large differences between the two populations. Higher numbers (49%) of children looked after aged 5-10 years were assessed with a mental health disorder, compared to 6% of children from private households, whilst for 11-15 year olds, 40% of children looked after were assessed as having a mental health disorder compared with 12% of children from private households (Ford, Vostanis, et al., 2007). Further comparisons using the SDQ with children who remained at home but living in disadvantaged or private households showed that 9% of children looked after were within the normal range, compared to 40% children in disadvantaged households and 53% in private households (Ford, Vostanis, et al., 2007). These findings suggest that some children looked after experience significant problems in relation to mental health in comparison to children who are not looked after. These difficulties can continue after children have left care, with care leavers also experiencing higher levels of mental health disorders than the general population. A survey of people (*n* = 479) aged 20-33 years who had been in foster care, showed significantly higher rates of Post-Traumatic Stress Disorder (PTSD) and Depression, with mental health diagnoses three to five times higher than for youth still in care (Kessler et al., 2008). The most prevalent mental health problem experienced by children looked after in the UK are behavioural problems including conduct disorder (CD) and oppositional defiant disorder (ODD) (Ford et al., 2007). This is consistent with findings the USA where, within a sample of 188 adolescents in care, 20.7% had a DSM-IV diagnosis of conduct disorder and 29.3% of oppositional defiant disorder (Pecora, Jensen, Romanelli, Jackson, & Ortiz, 2009).

Developmental pathways for behavioural disorders are associated with family dysfunction, instability and socio-economic deprivation, combined with child temperament, gender and cognitive problems (Buitelaar et al., 2013; Farmer et al., 2001; Ford, Vostanis, et al., 2007; Silberg et al., 2015). Morgan et al., (2015) found that poor educational performance in kindergarten, combined with low socio-economic status households with parents who used physical punishment or experienced emotional problems or substance abuse, were significant predictors of the development of conduct disorders by early adolescence. Links between early onset conduct problems and increased likelihood of later delinquency, violence and drug use have been identified in the literature (Erskine et al., 2016; Patterson, DeGarmo, & Knutson, 2000), with research on ACE confirming the detrimental impact of negative early experiences on later life outcomes for education, health and social mobility. There are two important findings indicated here, firstly that the most

prevalent mental health issue for children looked after are behavioural problems. Secondly, that placement instability is linked with behavioural difficulties, with children experiencing more moves having higher risk of behavioural problems. These findings indicate that supporting stable placements for children looked after, may be a key factor in promoting long-term outcomes for children.

Parental influences on child development.

On entry to care, large numbers of children looked after have experienced multiple or repeated instances of maltreatment. There is a bi-directional relationship between maltreatment, educational difficulties and emotional and behavioural problems (Romano, Babchishin, Marquis, & Fréchette, 2015). Factors associated with child maltreatment include parental factors of poverty, low educational achievement, mental ill health and parental exposure to childhood maltreatment (Gilbert et al., 2009; Silberg et al., 2015). In addition, pre-natal influences such as maternal use of alcohol or tobacco have been associated with the development of child behavioural problems (Britto et al, 2017) and maternal nutrition is also associated with child health (Britto et al., 2017). The relationship between parent behaviour and development of childhood difficulties can in part be explained through the impact on child neurobiological development. Children raised in low-income families had a smaller brain surface area, with regions supporting language, reading, executive functions and spatial skills most affected (Noble et al., 2015). The link between household income and brain development could be partially explained in relation to levels of parental education, since lower parental educational attainment also predicts children's brain development in areas critical for language, memory and executive functions (Bradley & Corwyn, 2002; Noble et al., 2015).

Post-natal risks to child development include parental ability to sooth, respond appropriately and provide adequate stimulation, which facilitate the development of sensory pathways, language and cognitive functions within the brain during the first two years of life (Zeanah et al., 2003). Experience of abuse or neglect within this developmental period may profoundly and negatively impact brain development (Nelson et al., 2007; Teicher & Samson, 2016). In an extreme example of parental or carer unavailability, children placed in orphanages in Bucharest experienced early deprivation with very little human interaction. These institutionalised children displayed a range of maladaptive developmental problems including restricted physical and brain growth, cognitive problems, speech and language delays, sensory integration difficulties and social and behavioural abnormalities (Zeanah et al., 2003). However, despite this early adversity, children improved both cognitively and socio-emotionally when they moved to an enriching foster environment, with children under

two years making the most progress. Additional support for foster carers included emphasis on language stimulation and play, with gains maintained whilst the child remained in a stable and enriched environment (Nelson et al., 2007).

Experience of childhood maltreatment including verbal abuse, witnessing domestic violence or experience of sexual abuse can result in neurological changes in brain functionality. Functional alterations can lead to behavioural adaptations that include heightened responses to facial emotions and reduced responses to anticipated rewards. Brain changes show differing effects of neglect (increased amygdala volume) and maltreatment (smaller hippocampi volume) (Teicher & Samson, 2016). The amygdala regulates emotional reactivity and anxiety, whilst the hippocampus processes short-term memories (Siegel, 2014), suggesting that behavioural maladaptation's in children who have experienced abuse or parental depression have a biological link (Teicher & Samson, 2016). When children are exposed to high levels of physical trauma, the stress-response system remains in an over active state for long periods, leading to the brain becoming organised in a dysfunctional manner. This can manifest in physical and mental health problems, including maladaptive internalising and externalising behaviours such as aggression, substance abuse, antisocial behaviour and mood disorders. Maltreatment experienced early in life is more likely to result in increased risk of internalising and withdrawn behaviours, difficulties in self-regulation and inappropriate responses compared to other maltreated children (Leeb, Lewis, & Zolotor, 2011). Children looked after exposed to early experiences that trigger neurological adaptations are likely to have increased risk of displaying maladaptive internalising and externalising behaviours, as a result of early experience.

Parenting skills and impact on child development.

Individual parenting experience, relational skills, levels of stress, support and the temperament and cognitive abilities of the child all influence parenting efficacy. Parental socio-emotional skills influence the choice and effectiveness of parenting strategies, including using praise to build positive relationships and the consistent use of non-punitive and effective discipline (Patterson, Forgatch, Yoerger, & Stoolmiller, 1998; Reid, 1993; Webster-Stratton, Hollinsworth, & Kolpacoff, 1989). Conversely, parents with low confidence in their ability to successfully parent are more likely to use strategies not conducive to compliance and cooperation, including either harsh or lax methods of discipline (Sanders & Woolley, 2005). Inconsistent and harsh discipline methods (Arnold, O'Leary, Wolff, & Acker, 1993), along with lack of emotional warmth have been identified as being linked to the development and maintenance of child behavioural problems (Lengua, Wolchik, Sandler, & West, 2000).

The onset of conduct problems before the age of ten is associated with longer-term persistence (Silberg et al., 2015) and behaviours that are more problematic (Morgan et al., 2015). Developmental pathways for behavioural disorders are associated with family dysfunction and instability, combined with child temperament and cognitive problems (Buitelaar et al., 2013; Silberg et al., 2015). Morgan et al., (2015) found poor educational performance in kindergarten, combined with low socio-economic status households with parents who used physical punishment or experienced emotional problems or substance abuse, were significant indicators for development of conduct disorders by early adolescence. Late onset conduct disorder, which appears during adolescence, may have differing triggers to early onset conduct disorder with greater social influence from peers (Buitelaar et al., 2013).

Effects of maltreatment on children.

Removal of children from the birth family is to ensure safety and to give opportunities for them to develop and reach their potential. For some children, changing the family environment seems sufficient to enable them to achieve this task, particularly for younger children, (Nelson et al., 2007; Zeanah et al., 2003), but for others this is not the case and existing problems continue (Ford et al., 2007). Exposure to early maltreatment increases risk of poor longer-term outcomes, in part by raising the risk for behavioural and psychological problems during adolescence, which impact negatively on education (Landsford, Dodge, Petit, Bates, Crozier, & Kaplow, 2002). In turn, parental poverty, low educational achievement, mental ill health and exposure to childhood maltreatment are associated with maltreatment of children (Gilbert et al., 2009), highlighting the risk of inter-generational transmission of the negative effects of maltreatment. Child maltreatment is strongly associated with parents, with around 80% perpetrated by parents or parental guardians. However large differences in maltreatment rates are reported by victims and parents and rates substantiated by child-protection investigations indicate that only a small number of children exposed to maltreatment (1:250) are monitored through a child-protection plan (Gilbert et al., 2008), indicating those entering care are likely to be children exposed to most serious forms of maltreatment.

The effect of exposure to both multiple types and repeated occurrences of maltreatment is regarded as more harmful than exposure to one type or lower levels or repeated instances of abuse. Some children are exposed to more than one type of maltreatment (MacMillan, Tanaka, Duku, Vaillancourt, & Boyle, 2013) and this is more harmful than exposure to a single type, or instance of harm (Leeb et al., 2011). However, child-protection agencies can be discouraged from reporting multiple types of abuse (Gilbert

et al., 2008), indicating that children taken into care are likely to have experienced significant levels of maltreatment (Afifi et al., 2015). Children in care in the UK have significant problems on entry to care, with 72.3% of a sample of children (*n* = 453) aged 5-15 years showing indications of emotional problems, half (50.2%) of the sample showed indications of conduct problems and 22.9% emotional or conduct problems (Blower et al., 2004; Simkiss, Stallard, & Thorogood, 2013). Whilst in care, many children looked after experience mental health problems (Ford et al., 2004) educational difficulties (Berridge, Bell, Sebba, & Luke, 2015) and are at increased risk of having contact with, or being incarcerated by the justice system (Laming, 2016).

Early life experiences may have significant impacts on child development that may endure and be ongoing even after entry to care. There are indications that these early experiences may mean children who experience maltreatment or neglect are more likely to develop the behavioural problems that are linked with placement instability, lowered educational and subsequent life outcomes.

Summary of section three.

Early childhood experiences appear to impact long-term developmental trajectories, with problematic early experiences implicated in later social dysfunction and health-harming behaviours. Very early childhood experience is dependent on both the environment provided by and the skill of, the parent or carer. Good developmental experiences typically include a stable, enriching environment where the carer is responsive, sensitive and emotionally warm towards the child and the child receives appropriate developmental stimulation (Britto et al., 2017). These early experiences form a solid foundation for cognitive and socio-emotional developmental progress (Walker et al., 2007). Problems arise when shortcomings in this early environment or early relationship are significant enough to impede or alter developmental trajectories. Factors that may influence trajectories in a negative way can be inter-related and include parental physical or mental health, socio-emotional skills, educational ability and employment. These combine with child temperament and cognitive ability and interact with environmental influences including peer associations and family support providing a complex mix of variables. Factors can directly influence physical or emotional development through abusive relationships or malnutrition, or may combine and become cumulative, for example early adversity contributing to development of behavioural problems that impact on academic achievements. There are links between early experiences and later health and social problems, with childhood adversity associated with 45% of childhood-onset mental health disorders (Green et al., 2014). In turn, childhood exposure to physical abuse, emotional abuse and neglect has been significantly associated with

subsequent depressive disorders, drug use, suicide attempts and risky sexual behaviour (Norman, Byambaa, De, Butchart, Scott & Vos, 2012). These cumulative and diverse outcomes of early maltreatment have led to some researchers concluding that prevention is the most effective solution (Leeb et al., 2011).

Summary of Chapter One

The history of social care in the UK shows how the focus has evolved from protecting children from harm to promoting their welfare and adoption of the aim that all children have the right to fulfil their potential. It is clear from the statistics relating to children in the social care system that this goal is not being achieved for many children who are looked after. There are increasing numbers of children within the care system, yet despite decades of reports and legislation attempting to improve outcomes for children and young people who are looked after, as a group their mental and physical health, educational achievements and job prospects are still very different from children not looked after. For many, parental behaviour or neglect in the early years of life appears to contribute to a pattern of underachievement that is not addressed within the current system of care. Outcomes can be improved if children are provided with enriching and stable care. The difficulties experienced by those that care for children looked after and the theoretical approaches used to underpin interventions to support children and those that care for them, will be addressed in the next chapter.

CHAPTER 2

Foster Carer Challenges and Psychological Theories.

This chapter has two sections, the first looks at the challenges experienced by caregivers of looked after children and the second, explores how psychological theories can help with understanding looked after child behaviours. Much of the literature referred to in this chapter is based on research on traditional and stranger foster carers. Where literature includes kinship foster carers, or kinship carers who are not approved by the local authority, the terms kinship foster carers and kinship carers are used in addition to foster carer for clarification.

Introduction

Traditional foster carers experience multiple challenges in relation to their role of caring for children who are looked after, including behavioural challenges, difficulties in managing relationships with the team of professionals and family involved with the child in addition to any stress external to fostering they may experience (Farmer, Lipscombe, & Moyers, 2005; Morgan & Baron, 2011). These multiple stressors mean that some carers are no longer able to cope and may choose to cease fostering and be lost as carers for future children in need (Hannah & Woolgar, 2018). An overall and increasing shortage of carers means retention and recruitment of carers is crucial, with local authorities in particular finding it difficult to recruit and retain adequate carers (OFSTED, 2019). Independent fostering agencies (IFA) are recruiting a larger percentage of foster carers than local authorities, and carers recruited by agencies help to fill some of the shortage of available local authority carers (OFSTED, 2019). Indications are that carers leave due to lack of support to face the many challenges they experience (Hannah & Woolgar, 2018). The ways that carers are supported, including training and relationships with professionals in relation to the issues that carers feel are important to them are addressed in the last section.

Section 1: Foster Carer Challenges to Caring for Children Looked After (CLA)

It can be inferred from the previous chapter, that carers of children who are looked after are likely to experience a range of challenging behaviours and issues related to the diverse needs presented by the children for whom they care. In this section these challenges and issues associated with caring for these children are explored, including sources of support, contact with birth family and complications related to making decisions for a child for whom they do not have parental authority. The impact that these multiple stressors can have on carers and the indirect impact on recruitment and retention of carers are investigated, along with a description of the different types of carers, demographics and numbers. The section concludes with a brief look at the sources of support available to carers to help them in a role that can be challenging.

Challenges faced by foster carers.

Challenges experienced by carers of looked after children are multiple, and include looked after child needs and behaviour, relationships with social workers, difficulties associated with child and family contact, levels of support available to the carer, and experience of life stressors. The maltreatment, trauma and loss experienced by the majority of children looked after prior to entry to care can lead to persistent and ongoing behaviours that are challenging to manage (Tarren-Sweeney, 2008). Child behaviour can be both problematic for carers inside the home and in the community, with 38% of carers of adolescents (*n* = 68) experiencing hostility or criticism related to fostering, with the largest percentage from neighbours (Farmer et al., 2005). Within the home, children who were violent to others, hyperactive or had contact difficulties caused most strain on carers, with higher frequency of challenging and uncooperative behaviour having most impact on family life (Farmer et al., 2005; Harding, Murray, Shakespeare-Finch, & Frey, 2018).

In addition to difficulties in child behaviour, foster and kinship foster carers are subject to a high level of supervision with regular visits from both their supervising social worker and the child's social worker (Cosis Brown, Sebba, & Luke, 2014), and regular interactions with health care workers, education and other professionals. Foster carers and kinship foster carers do not have parental authority for the child and without written delegated authority are unable to make some day-to-day decisions on matters such as sleepovers, haircuts and attendance on school trips without consultation with, and approval from, the local authority. Adherence to the child's care plan, normally includes promoting contact between the child and their birth family. However, visits can act as triggers for problematic child behaviours both prior to, and after birth family contact (Triseliotis, 2011), in addition to the practicalities of transporting them to, and in some cases supervising, visits. Kinship foster carers have to balance existing and often close, relationships with the child's birth parents with the contact arrangements detailed in the care plan, with the family relationships meaning this can be challenging to manage.

Relationships with social workers can both add to and alleviate strain for caregivers. Good relationships, where social workers are contactable, able to make decisions promptly and visit regularly are associated with lower levels of strain experienced by foster carers. Social workers who are difficult to contact, visit infrequently, or fail to consider the views or needs of carers when making decisions add to the burden of experienced strain (Farmer et al., 2005). High levels of mobility in the social care workforce means children and carers can have multiple social workers over relatively short time-frames, making relationship building and case familiarity more challenging (Blackburn, 2016). Farmer et al., (2005) investigated

levels of strain on carers in relation to previous experiences and stressors associated with fostering, using a combination of measures to record previous and current experience. Changes in social worker, carer views not being taken seriously and experience of high impact previous stressors, including relationship breakdown, illness or placements starting or ending, were all associated with carers reporting higher levels of day to day strain. Carers are vulnerable to secondary trauma and burnout, related to the high demands of their role. A study of UK foster carers (*n* = 131) showed that 19.8% of participants had clinical levels of secondary trauma and 30.5% were at high risk of burnout (Hannah & Woolgar, 2018).

Strain can negatively impact carers parenting ability by reducing sensitive and empathic interactions and availability. Carers under stress were less likely to provide nurturing and play opportunities appropriate to a young person's emotional age, as well as having lower levels of engagement and long term commitment to the placement (Farmer et al., 2005). Compassion fatigue experienced by foster carers was linked to lower job satisfaction and intent to continue to foster, indicating carers under strain may be more likely to cease fostering (Hannah & Woolgar, 2018). Negative relationships with social workers and lack of respect and recognition have also been cited as reasons why foster carers consider leaving fostering, (Hudson & Levasseur, 2002; Rodger, Cummings, & Leschied, 2006). Carers who felt supported and adequately trained were more likely to continue to foster, with training and support associated with placement stability and improved looked after child outcomes (Berridge, 2017; Rhodes, Orme, & Buehler, 2001). Research into placement disruptions indicates that by the time the placement reaches breaking point carers need urgent and practical support. Measures that included having their views heard, having one child only in a family placement, or twenty-four hour support, were more important to carers in crisis than pre-placement preparation or training (Gilbertson, 2003). Carers who experience multiple stressors may choose to cease fostering children, potentially exacerbating systemic difficulties that include shortages of available or experienced carers. An understanding of available capacity within the fostering system will be explored next, along with an understanding of available support and what carers ask for to support them in their role.

Recruitment and retention of foster carers.

The numbers of approved foster carers is not rising as fast as numbers of children coming into care (Rodger et al., 2006), with fostering being described as 'bursting at the seams' (Harber & Oakley, 2012). Kinship foster carers are not recruited, but designated suitable to care for the child by local authorities and the statistics reported here refer to traditional foster carers, unless specified otherwise. The fostering network estimates the

number of foster carers in Wales to be 3,700 families at 31 March, 2018 with a shortfall of around 550 placements for children looked after (The Fostering Network, 2019). In England, Ofsted collects annual statistics on foster carers, in Wales, statistics directly relating to foster carers are not currently collected. Findings for England show that the overall number of households approved to foster has reduced by 1% since 2017, although the number of approved fostering places available for children looked after has increased. Despite this increase, there are 5% fewer vacant places within those households for children to be accommodated than in 2017, in part due to the increase in the number of children in care during the year (OFSTED, 2018, 2019). The number of places offered by carers approved by independent fostering agencies increased by 8%, whilst carers approved by the local authorities decreased by 2%, with independent agencies offering 39% of the total number of approved places in the 2018 reporting year.

An independent fostering approval panel agrees the type of placement that foster carers can accept when carers are approved to foster. In England 89% of the placements offered by foster carers were made up of short-term foster placements (44%), long-term foster placements (31%) and kinship or friends and family fostering placements (14%) with the remaining 11% being specialist placements (OFSTED, 2019). Compared to the previous year, the numbers of households approved by independent agencies and offering short-term placements increased by 6%, whilst short-term local authority fostering households decreased by 1% and kinship foster placements decreased by 5%. Long-term fostering placements reduced by 9% across both local authority and independent services. For the remaining types of fostering placements, notable changes included a doubling of independent agency households taking emergency placements, and an increase in the number of fostering to adopt households, by a quarter. Historically, emergency placements have been with local authority carers, with independent agencies taking long-term or harder to place children. In Wales, fostering to adopt households differ from those in England, in that foster carers are unable to access statutory adoption leave from employment until there is a placement to adopt order for the child made by the family court. Consequently, numbers of foster to adopt families in Wales may differ proportionally to England.

The numbers of placements offered in England showed a trend towards households taking increasing numbers of children. In England, 36% households were approved for two placements, with an increase from 28% to 33% in households approved for three children. Carers approved with an independent fostering agency were more likely (42%) to be approved for three children than carers approved by an local authority (22%) (OFSTED, 2019). There have been long-term difficulties in recruiting adequate numbers of foster carers (Luke & Sebba, 2013; Nutt, 2006), although it is not clear whether the numbers are

insufficient, or whether there are inadequate numbers of carers where they are needed (Narey & Owers, 2018). In England, over the year there was a 3% increase in enquiries about fostering and an 11% increase in applications, with a 5% increase in independent fostering agency enquiries compared to a 3% reduction in local authority enquiries (OFSTED, 2019). Recruitment of foster carers to independent agencies would seem to be keeping pace with annual loss of carers. Local authorities appear to be finding both recruitment and retention of foster carers difficult, a problem compounded by the rising numbers of children entering the system that results in an overall deficit in places available for children looked after. Carers under strain, or considering leaving indicate that levels of support are important for them to feel able to cope with the challenges they face (Rhodes et al., 2001). Support can include social support available from friends, family or professionals within the team who surround the child, or it can mean feeling competent in the level of skills or experience to manage challenges. The next section looks at training as a form of support available to carers, what legislation indicates that they need, what training they receive and what carers feel they need.

Foster Carer Training.

Requirement for training.

Information about the training offered to foster and kinship foster carers is limited, with only general guidance and recommendations contained within legislature. Ogilvie, Kirton, & Beecham, (2006) identified a lack of clear training strategies within local authorities and noted that where training frameworks did exist they were often linked to payment schemes, rather than being focused on development of skills necessary to the fostering role. In England and Wales there is little reference to, or requirement for, training of foster carers within legislation. The 1998 Quality Protects UK strategy included targets for residential workers to complete the post qualifying child care award and encouraged foster carers to complete a relevant national vocational qualification, but there were no statutory requirements to do so. Social Care Wales issued a framework on induction and continued professional development for foster and short break carers in 2001. However the induction framework is optional and not adopted by all local authorities or fostering agencies within Wales (Lawson & Cann, 2017). The Fostering Services (Wales) act, 2003 and the National Minimum Standards for Fostering Services (2003), have been replaced by the Regulated Fostering Services (Wales) Regulations 2019 and the Statutory Guidance for Fostering Services, 2019 that combined make up the legislative framework for fostering providers in Wales. Whilst the regulations are mandatory, the standards are guidance, although compliance is assessed during Care Inspectorate Wales regulatory inspections.

Guidelines within the legislation and standards in relation to training recommends general topic outlines that should be covered, including safety, managing behaviour and administrative skills, but is non-specific in terms of content. The National Fostering Framework, produced in collaboration with the Welsh Government, is about to be launched and aims to address training shortcomings. Whilst the scope of the training recommended for foster carers is more comprehensive than that within the 2003 regulations and standards, there is still no indication of any need for training to demonstrate that it is effective, delivered to any minimum standard, or be progressive in terms of skills development. Training is offered to all foster carers as part of their approval process to be a foster or kinship foster carer, with attendance on the pre-approval course providing evidence for some of the competencies carers are required prior to approval by fostering panel. There is some consistency regarding pre-approval training with most agencies providing the 'Skills to Foster' course from the Fostering Network. This course contains a range of generic information in relation to fostering including topics relating to the role of the carers, child identity, working collaboratively, the impact of abusive or neglectful parenting, safe caring guidance and children moving on. This is a three-day course, with interactive sessions and provides opportunities for discussions, role-plays and meeting existing carers and children who have been looked after. Sellick & Connolly, (2002) found that 100% of independent fostering agencies were providing pre-approval training to new carers. Post-approval training requirements vary across the regions with mandatory induction standards in England but no ongoing training guidelines, optional induction standards in Wales and no induction or post-approval standards in Scotland or Northern Ireland (Lawson & Cann, 2017). The National Fostering Framework will address some of the gaps in post-approval training, however it is not yet clear how well it will be adopted across all fostering service providers in Wales.

Training being delivered.

Training given to foster carers has been researched by the Fostering Network State of the Nation Survey (Lawson & Cann, 2017) which surveyed 2,130 predominantly traditional foster carers across the UK. They found that 82% of carers who had received training had found it helpful however, 6% of carers had received no training in the previous twelve months. In addition, 49% of carers said that they did not have a training plan, despite the recommendation in the National Minimum Standards for Foster Care (2003). Research on training delivered to foster carers generally finds that carers like the training they have received (Lawson & Cann, 2017). However, studies have also found that carers request more or different training than they are being given, with foster carers in New Zealand, Canada and the USA indicating their needs are not being met through existing training programmes (MacGregor, Rodger, Cummings, & Leschied, 2006; Murray, Tarren-Sweeney,

& France, 2011; Rhodes et al., 2001). There are also indications that foster carers may be reluctant to acknowledge any skills gaps. Cooley & Petren, (2011) used qualitative and quantitative measures to evaluate foster carer self-perceived competence, finding that quantitative questions elicited confident responses, but qualitative questions produced answers indicating a lack of confidence for the same domains. It has been suggested foster carers may be reluctant to acknowledge lack of skills due to an expectation that they are competent within a professional role (McDaniel, Braiden, Onyekwelu, Murphy, & Regan, 2011; Pithouse, 2004) with an expectation placed on them to manage, or appear competent within their role.

Need for training.

The importance of training for foster carers is widely acknowledged (Department of Health, 1998; Luke, Sinclair, Woolgar, & Sebba, 2014) given the impact that it can have on looked after child outcomes (Sinclair, Wilson, & Gibbs, 2000). However, recommendations on appropriate content or format of training is sparse. Reviews of training delivered to foster carers highlights that research studies tend to focus on group based multi-session interventions, delivered over 13-16 weeks (Benesh & Cui, 2017; Uretsky & Hoffman, 2017), whereas the training that is being delivered to foster carers by fostering services tends to be single session (Dorsey et al., 2008; Festinger & Baker, 2013). The implication is that the training offered and delivered to foster carers may not have an evidence base that demonstrates that it is effective, a view supported by Landsverk, Burns, Stambaugh, & Rolls Reutz, (2009) who found that evidence based practices are not routinely used in foster care. The multi-session training researched with foster carers is largely skills based training, often adaptations of parent management training, teaching strategies to help with challenging and problem behaviours (Dorsey et al., 2008; Festinger & Baker, 2013). In general it is not clear what training is offered to fostering caregivers, if kinship foster carers are offered the same training as traditional foster carers, whether the training is evidence based, or whether it delivers the skills based training needed to help carers within their role.

Conduct and behavioural disorders are the largest child mental health disorders among looked after children (Ford, Vostanis, et al., 2007), with the associated negative impact on educational outcomes and they are a major factor cited by foster carers in placement breakdowns (Department for Education, 2018). In the UK, the National Institute for Health and Clinical Excellence (NICE) recommends social learning theory based parenting interventions for behavioural problems in children, as being demonstrably effective for both parents and foster carers (NICE, 2013). Consequently, it would seem appropriate for foster and kinship foster carers to receive training that supports the development of skills to

help them manage behavioural issues. Parenting interventions can reduce carer stress and behavioural problems and increase the use of positive parenting strategies and prosocial behaviours in children (Bywater et al., 2011; Roberts, Glynn, & Waterman, 2016). Furthermore the changes are mediated by increases in positive parenting practices including praise, positive attention and clear instructions, demonstrating that changes in caregiver behaviours positively affects the children they care for (Hutchings & Bywater, 2011; Uretsky & Hoffman, 2017).

Summary of Section One

Foster carers manage a range of challenges, both relating to the child and to the care system, in addition to any personal life stressors. The challenges for kinship foster carers are likely to be similar in some respects, but different in others and this information is not readily available or differentiated within the literature. Children looked after can bring diverse issues, making them challenging to care for. In addition, children placed with traditional foster carers are strangers to the carers, necessitating a period of relationship building prior to the carer being able to effectively address behavioural challenges. Relationships with professionals supporting the child and actual or perceived support from them can be a key factor in how well carers cope. Unsurprisingly, there is evidence that carers can experience high levels of strain, particularly in relation to difficult child behaviours, with some carers unable to cope and requesting a child be removed (Hannah & Woolgar, 2018).

Independent fostering agencies appear to be more successful in recruiting new carers than local authorities. However, the overall number of carers is falling at a time when there are increasing numbers of children entering care. In this situation the retention of existing carers is key to maintaining enough carers to provide homes for the children who need them. It is important to establish what could make a difference and foster carers indicate that good levels of support is one of the more important factors that help them to cope. There is no mandatory training pathway for foster or kinship foster carers, with fostering agencies left to decide what training is offered. The recommended intervention to support caregivers of children with challenging behaviour is parent management training. The following section will explore how psychological theories explain problematic child development and which theoretical approaches have interventions that aim to address these difficulties.

Section 2: Psychological Theories

Theoretical explanations for the difficulties experienced by children looked after have coalesced around two areas, a child development theory of attachment relationships, originally proposed by John Bowlby and behaviourally based theories, that focus on behavioural learning and change.

This section focuses on the theory of attachment and the behavioural and learning theories that underpin explanations for problematic child behaviour, exploring how they explain the influence of early adversity on long-term life outcomes. An exploration of the principles of each theory is followed by a discussion on interventions associated with each approach. The section will conclude by exploring the links between unmet attachment needs, coercive behaviours, behavioural psychopathologies and early looked after child experiences, with indications that social learning interventions may help with behavioural problems and also support attachment needs.

Child development theory – Attachment

Attachment theory (Bowlby, 1969) arose from a combination of observations of adolescent and infant behaviour made by Ainsworth and Bowlby (Ainsworth, 1964; Ainsworth, 1978; Bowlby, 1950). It is based on a broad theoretical base that includes ethology, systems theory, developmental theory and underpinning clinic based psychotherapeutic interventions for children and families (Bretherton, 1992). Bowlby developed the concept that child behaviour was influenced by early relationships with primary carers and proposed that infants were intrinsically motivated to maintain close proximity and therefore safety, to a primary caregiver. This evolutionary behavioural adaptation ensured survival of the infant in hostile environments where human hunter-gatherers moved around in social groups. Proximity is instigated by the child through attachment behaviours including crying, following, calling, clinging and smiling and is maintained by carer positive response and feedback. This behavioural cycle of learning leads to the development of goal directed behaviours in the infant through interaction with the caregiver. Infants aged between six months and three years use their primary carer as a safe base, content to explore and interact when the primary carer is within proximity, whilst becoming distressed or anxious when frightened, hurt, or alone. Infants respond to and are soothed by social interaction or attention and display attachment behaviours towards anyone, infant or adult they have frequent interaction with (Bowlby, 1969).

Patterns of attachment.

Organised forms of behaviour exhibited by infants during the strange situation test, a procedure where observation of infant reaction to carer reunion after being parted from them and left with a stranger, determined attachment style (Ainsworth, 1964; Ainsworth, 1978), led to three attachment styles being identified; secure attachment, insecure avoidant and insecure ambivalent (or resistant). Infants who were distressed but allowed themselves to be soothed were determined to be securely attached. Infants who avoided the carer on their return, even if distressed were found to be avoidant and infants who were distressed, but difficult to soothe, were classed avoidant. The strange situation has become the primary form of determination of attachment style in infants and toddlers up to age four years. There is support for its use to determine attachment style, however there are also concerns relating to the consistency of methods and terminology used by researches in the strange situation (Wright et al., 2015). In addition, the criteria used to determine attachment style have been applied to children over the age of four, without the use of the strange situation, with limited evidence to support the validity of the criteria with older age groups (Madigan, Brumariu, Villani, Atkinson, & Lyons-Ruth, 2016).

Various theorists and researchers have postulated associations between caregiver behaviours, attachment styles and development of particular child behaviours. Carer ability and availability to appropriately respond and soothe distress is associated with securely attached (Type B) infants. Children who experience dismissive, angry or no response to attachment signals are likely to escalate attachment behaviours and adopt a strategy of avoiding showing emotional distress. These children, classified as insecure-avoidant (Type A), may develop future difficulties by avoiding or failing to recognise emotions, being at risk of relational conflict and having difficulties in trusting others (Crittenden, 2005; Wright et al., 2015) Insecure-ambivalent (Type C) children experience the carer as inconsistent and unpredictable and are likely to show escape and avoidant responses, distress and fear, clinging to the caregiver but not allowing themselves to be soothed. These children may develop a high need for approval, overreliance on feelings, be oversensitive to rejection yet be less likely to ask for help. Feelings of powerlessness may increase future risk of self-harming behaviours or substance abuse (Coman & Devaney, 2011; Crittenden, 2006; Wright et al., 2015). Children who experience emotional or physical abuse or neglect, with frightening or fearful caregivers may fail to develop an attachment strategy and be classified as disorganised (Type D) (Wright et al, 2015). These children may display the insecure attachment characteristics and conflict behaviours indicated as a clinical disturbance of attachment (Boris & Zeanah, 1999) and are at highest risk of developing behavioural problems.

Attachment disorder.

Attachment patterns or styles are associated with the work by Bowlby and Ainsworth and are determined in infants by the strange situation test. The DSM-5 (American Psychiactric Association, 2013) defines severe attachment problems as Reactive Attachment Disorder (RAD) with two sub-classifications. Inhibited RAD is typified as an emotionally withdrawn child, where there is a lack of reciprocity, failure to seek or respond to comfort and difficulties with emotional regulation. In disinhibited RAD, the child displays an indiscriminate social response that is non-selective in seeking comfort from adults, fails to seek reassurance from familiar caregivers and exhibits no fear in approaching strangers. Both types occur in children under five years and are linked to pathological or neglectful caregiving (Smyke, Dumitrescu, & Zeanah, 2002).The relationship between attachment patterns and attachment disorders is not clear and they may be different constructs (Wright et al., 2015).

Development of attachment patterns.

Factors influential in the development of secure attachment (Type B) include the harmonious timing of carer response, or sensitive attunement to infant attachment signals, that help the infant to learn self-regulation skills and that actions have predictable consequences. The frequency and nature of carer-infant interaction facilitate the infant learning social reciprocity (Bowlby, 1969), with infants slow to show person-differentiated attachment behaviours noted to have experienced less social stimulation (Bowlby, 1969). Variations in attachment styles may result from intrinsic child factors; for example, infrequent smiling may initiate lower rates of carer interaction whilst infants who are fussy may elicit frustration and slower responses from carers. Caregivers who are emotionally aware, able to reflect and are skilled in verbalising infant emotions, are associated with the development of a secure infant attachment style. Key caregiving factors in addition to maternal sensitivity, include mutuality and synchrony, levels of stimulation, a positive attitude and levels of emotional support (van Ijzendoorn, M. H. vanM. De Wolff, 1997). Unmet attachment needs in infancy are associated with difficulties in social relationships and in emotional regulation in later life (Schore, 1997). Once established, carer-infant attachment style can persist into childhood and beyond. Wright et al., (2015) identify a link between disorganised patterns in infancy and coercive controlling behaviours in middle childhood. Later publications have linked infant attachment with longer-term behavioural traits in children, adolescents and adults, with suggestions that adult attachment style influences caregiving, that in turn predicts infant attachment (Madigan et al., 2006).

Internal working model development.

The evidence for Bowlby's theory for types of attachment was observations of mother-infant dyads aged up to four (Ainsworth, 1964; Ainsworth & Bell, 1966). The theory proposed that early attachment styles influenced later childhood and adult behaviour through the development of cognitively based internal working models, or maps of the abilities of the self in interaction with the environment. These cognitive models are stable, sequentially organised, and composed of instinctive and learnt behaviours. Activation or inhibition of behavioural systems results in experienced behaviour that is initially survival orientated. Multi-system activation and inhibition informs why behaviour and internal motivation do not always correspond, explaining behaviours that may not make logical sense. Internal models are updated throughout life, with major changes becoming increasingly harder to achieve over time. Bowlby proposed that psychopathology was due to inadequate or ineffective working models, with one mode of regulation dominating in behavioural system activation conflicts.

Attachment and interventions.

Attachment is a child developmental theory originally informing one to one psychotherapeutic interventions (Bowlby, 1969). It has evolved into a theory related to an understanding of a range of developmental problems, which include difficulties with social interaction or emotional regulation, behavioural disorders and problems with self-esteem that result from unmet attachment needs (Collis, 2008). Support has been found for identification of different patterns of infant attachment, using the strange situation test (Wright et al., 2015). However, there are range of concerns with both definition of categories of attachment and the measures used to identify them. Attachment interventions, commonly focus on adult sensitivity including constructs such as warmth and acceptance which are difficult to measure consistently and reliably (Madigan et al., 2016). There is wide variation in the types of measures used to identify attachment post-infancy, including behavioural, representational and questionnaire measures (Madigan et al., 2016), with no certainty they measure the same attachment constructs. In addition, few attachment measures have demonstrated scientific validity and reliability (Madigan et al., 2016). There is a diverse range of descriptions and terminology defining attachment criteria, with even the strange situation test being subject to variations in criteria in different research studies (Wright et al., 2015). The most commonly cited criteria used to determine attachment style is maternal sensitivity and a meta-analysis by (Wright et al., 2015), indicates that interventions with 5-16 sessions that support maternal sensitivity and attunement with infants, are effective in promoting attachment security. Securely attached infants have lower risk for developing behavioural

difficulties, show better social relationships and abilities to regulate emotions. Interventions for older children with evidence for improving attachment are based on a behavioural approach (Wright et al., 2015), and these will be explored next.

Behavioural Learning Theories

Behavioural theory.

Behavioural explanations are primarily based on measurable and observable behaviour and focus on the premise that behaviour is learned and so can be changed. Behaviour is modifiable by altering influencing variables to reduce undesirable and promote desired behaviours. Skinner, (1938) used rats and pigeons in single subject experiments in laboratory settings to identify reliable functional relations between environmental events and behavioural learning (Cooper, Heron, Heward, 2014), developing his theory of behaviour based on an experimental analysis of behaviour. Operant conditioning is the modification of future behaviour as a result of a consequence that reliably followed and was a result of the same behaviour in the past. Skinner argued that internal or cognitive processes were governed by the same kinds of variables as observable behaviours, differing only in that they were not observable. Rather than seeing behaviour as an outcome of what we think, feel or want, behaviour became a process in its own right, with a set of determining variables that are a result of previous learning experiences. As the factors influencing a learning history are environmental, it was therefore be possible to re-arrange the environment to make desirable behaviours more likely and undesirable behaviours less likely. For Skinner, remodelling the environment to facilitate change was simpler and more reliable than modifying the internal processes of the self (Skinner., 1961, 1965).

The effectiveness of stimuli can be altered by environmental variables called motivating operations, acting to increase or decrease the frequency of behaviours reinforced by the stimulus. For example, hunger will influence the effectiveness of food as a reinforcer for a behaviour. Effective behavioural modification is dependent on accurate identification of the function of the behaviour, or why the behaviour is occurring in order to determine an effective plan for behavioural change. Identification of both antecedent and consequent stimuli, preceding and following behaviour along with the function of the behaviour, enables a plan for behavioural change to be constructed. Alternative behaviours can be encouraged through the use of effective reinforcement to replace the problem behaviour, fulfilling the function of the behaviour in a more effective or socially acceptable way.

Applied behavioural theory is used to understand behaviour by focusing on how learning takes place and how behaviours change, according to environmental influences. A

set of behavioural principles enable behaviours determined to be problematic to be understood and if necessary, a plan for effective behavioural change to be formulated.

Social construction theory.

Goldiamond, (1974; 1975) used applied behavioural analysis to develop a model for behavioural change that is constructional, within the operant-behaviourist tradition. Goldiamond recognised that behaviour is not only shaped by the consequence of a previous action, but also by any consequences for the actions opposite, i.e., what happens when you do something and what happens when you don't do something. In order for behaviour to change, the costs and benefits of a behaviour need to be made explicit by the individual. He suggested that behaviours society find disruptive, or pathological are actually highly successful actions and deliver effective (logical but costly) outcomes for the individual. The contingencies inherent in institutional and social systems lead to social constructs and control through power imbalances, which in turn shaped individual behaviours in highly functional, if not always socially acceptable ways. Goldiamond pointed out the lack of an explicit contract for change within the behavioural approach, where typically one person modified the behaviour of the other without their explicit consent (Goldiamond, 1974). The predominant focus in the medical and many therapeutic processes was on the pathological approach, establishing the problem or what was wrong, in order to find a solution and repair or fix the damage. This approach disempowered individuals and ignored their strengths and ways in which the individual was functioning in an effective, if sometimes adaptive way. By identifying what maintained existing behaviours, focusing on strengths and then building on them, Goldiamond proposed a new constructional way of working, a functional analytic approach to psychotherapy, which was highly collaborative. Using a constructional questionnaire, the start point for working with an individual identified what was happening now through a functional analysis of the behaviour the individual wanted to change. Following this, Goldiamond and the individual identified alternative replacement goals to attain reinforcement through socially acceptable functional behaviours, and formulated a step by step sequence of change, using effective reinforcers from the individuals' environment. Finally, ongoing maintenance and support for the behavioural change is addressed. This process occurred through negotiation of a contract for change with the individual, with all the steps made explicit. The therapists role is to assist in sensitising the individual to emotions and cognitions which facilitate identification of the contingencies linked to a consequence, these may then be altered (Layng, 2009). The approach proved effective in addressing adult mental health problems, teaching stutters to speak fluently (Goldiamond, 1965; 1978), the reinstatement of speech in psychotics who were mute (Isaccs, Thomas, &

Goldiamond, 1960) and in facilitating family to support change by working with an individual's strengths (Layng & Andronis, 1984; Goldiamond, 1974; 1975).

Social Learning Theory.

Social learning theory (Bandura, 1977) evolved from the idea that learning happens as a result of modelled behaviour by more competent peers or elders (Vygotsky, 1934). The concept of scaffolding represents a process where more advanced mentors support learning through demonstration, encouraging the learner to access higher levels of thinking. Bandura, (1977) combined behavioural ideas of classical and operant conditioning, cognitive ideas of memory, attention and motivation with ideas of learning through observation, to develop a new theory of social learning. Working with adolescents, Bandura found the behavioural premise of the environment being causal to behaviour to be too simplistic and proposed mediating processes between stimuli and response. These mediating processes of cognitive thought help determine whether behaviour is repeated in the future, proposing cognition as a moderator of behaviour. The Bobo doll experiment (Bandura, Ross, & Ross, 1961) where children observed adults modelling aggressive behaviour towards a doll, demonstrated the ability of children to learn through modelling, when they encoded and then reproduced the aggressive behaviour. However, children shown adults experiencing negative consequences for aggression resulted in a reduction in child-modelled aggression, indicating a process that had influenced the modelling of previously displayed behaviour (Bandura et al., 1961).

For Bandura, this vicarious learning was most effective when experienced within the child's immediate social group, with observation of either reinforcement or punishment for imitated behaviour influencing future repetition. Reinforcement is obtained through external experiences such as praise from another person, or via internal feelings of happiness when experiencing approval. The motivation to adopt observed behaviours arises from a desire to identify with the other, to obtain a desirable quality the other possesses. Models of behaviour vary widely and can include adults, peers, teachers or TV characters, with information gained actively processed to determine if future behaviour will be modified. Bandura proposed four cognitive mediational processes which influenced likelihood of behavioural imitation; attention to the behaviour, retention of the behaviour, the ability to reproduce the behaviour and motivation to reproduce the behaviour. Adoption of a behaviour required all four processes to be engaged, with attention, retention and ability to perform the behaviour dependant on the motivation to repeat the behaviour in the future. The motivation to repeat the behaviour is dependent on effective reinforcement at the time. This interaction between an individual and environment is a form of reciprocal determinism where individual processes and environmental experience combine to determine future behaviours.

Social learning principles are used in parent training programmes by programme leaders to model relational skills and coach parents to learn new ways of managing child behaviours. These programmes have been found to be highly effective in altering parenting style, which have in turn, led to improvements in child behaviours. The concept that parent behaviour is highly influential in the development of problematic child behaviours was promoted in a theory developed by Gerald Patterson, this will be explored next.

Coercion theory.

Coercion theory, developed by Patterson and colleagues, (Patterson, 1975; Patterson, 1982; Patterson & Yoerger, 2002) is based on operant conditioning principles of negative reinforcement or escape conditioning and describes a process of mutual reinforcement that underpins the development of antisocial behaviours. The theory evolved from observations of aggressive behaviour, initially at school and later in the home, to establish how children learn to behave in an aggressive way (Patterson, 1982). Aggressive patterns observed in school were a result of parents 'training' children to behave in an antisocial way. Toddlers displaying behaviour problems had parents who made repeated minor intrusions to the child, typically with either indirect demands or to request compliance. The frustrated toddler would respond coercively (whining, tantrums) and in turn, the parent becomes frustrated and gives in to the child's behaviour by withdrawing the request and negatively reinforcing the child. In turn, the child stops being coercive, negatively reinforcing the parents behaviour by providing the parent with some peace. This cycle of negative reinforcement where the parent and child act to reinforce each other's behaviour, means the behaviour is more likely to occur again in the future and can lead to escalating levels of aggression, as demand and avoidance behaviours become more entrenched (Granic & Patterson, 2006). Behaviours are typically intermittently reinforced, with parents sometimes successful in terminating the behaviour. Behaviours reinforced on an intermittent schedule of reinforcement are more persistent and harder to extinguish.

Patterson identified specific parenting behaviours as contributory to development of problematic child behaviours, including reinforcing coercive behaviour, using harsh or punitive punishments and giving inconsistent responses (Patterson, 1982). Coercive cycles based on behavioural contingencies in childhood have been shown to predict clinical behavioural problems (Capaldi, DeGarmo, Patterson, & Forgatch, 2004; Granic & Patterson, 2006), providing a pathway for early onset behavioural disorders. Late onset behavioural disorders are thought to be influenced by peer reinforcement of feelings of power or being in control, for example engaging in talking about anti-social behaviours including stealing, lying

or taking drugs (Dishion, Spracklen, Andrews, & Patterson, 1996; Granic, Dishion, & Hollenstein, 2008).

Coercive interactions have been described as higher order patterns of behaviour, underpinned by cognitive and emotional processes that maintain coercive behaviour in a form of circular causality (Granic & Patterson, 2006). Patterns of coercive behaviour may originate in deficits in social and emotional skills, indicated by a limited or inflexible range of affective states. Parents who remain in the same affective mode for extended periods expose the child to a limited range of experiences or affective states (Hollenstein, Granic, Stoolmiller, & Snyder, 2004). This lack of internalised dyadic regulation means children fail to learn sensitivity to contextual demands and find it difficult to transition to and from different emotional states. On the other hand, children who learn to express a range of emotions tend to become adept at regulating their physiological arousal and emotional expression (Granic & Patterson, 2006). There are strong similarities within this explanation with the relational consequences of insecure or disorganised attachment. Insecure attachment patterns are associated with problems in identifying and regulating emotions, overactive physiological arousal and social interaction difficulties. In addition, disorganised attachment patterns include aggressive and controlling behaviours, hypervigilance and underlying negative beliefs about the self and others leading to avoidance of, or the need to control relationships (Collis, 2008).

Interventions Associated with Behavioural and Social Learning Theories

The behavioural and social learning theories explored above provide insights into how early life experience can shape the behaviour of children, through modelling behaviour, social interactions and the behavioural principles of reinforcement and punishment of actions. The common theme with all of these theories is the use of behavioural principles to explain how individuals learn, with social, environmental and caregivers influencing the process. These theories all focus on how a relationship influences behaviour and how learning occurs in conjunction with another, and are backed up with evidence supporting effectiveness. For children, the primary influencing person will be the caregiver, commonly parents. Many interventions that target problematic child behaviours are aimed at parents and a range of parenting programmes have been developed. These incorporate the behavioural and social learning principles of identification of behavioural function, with the social and environmental contingencies that maintain the behaviour and identifying the desired alternative outcome. Most parent management training (PMT) programmes use collaborative coaching approaches, along with interactive learning including rehearsal and home practice to empower parents to identify and resolve relational difficulties. Hanf, (1969)

developed a two-stage operant model for children with difficult behaviours where parents were first taught to give attention to positive child behaviours and ignore negative behaviours, and secondly to give clear directions whilst rewarding compliance and punishing non-compliance. Forehand & McMahon, (1981) developed this model further, incorporating coaching of parents using video footage of parent-child interactions, they identified five key skills for effective parenting;

1. Rewarding appropriate behaviour using immediate and effective praise.
2. Relationship building through play and joint activities.
3. Giving clear, simple instructions, focusing on what the child is to do (rather than not do).
4. Ignoring minor problems maintained by attention.
5. Using non-aversive consequences such as privilege removal to manage problems not maintained by attention.

These key principles underpin a range of effective parenting programmes that have since been developed (Eyberg, 1988; Patterson, Chamberlain, & Reid, 1982; Sanders, 1999; Webster-Stratton, 1982). Parent training programmes use behavioural strategies to teach new behaviours, including gaining attention, modelling and shaping new behaviours using reinforcement schedules (Hutchings & Bywater, 2013). Programme leaders effectively model the principles and techniques taught on parent training, using collaboration, praise and problem solving to encourage and support parents to make effective changes (Eames et al., 2009).

Interaction and Crossover between Attachment and Behavioural Theories

Attachment theory originally provided an understanding of the importance of early relationships in child socio-emotional development. Disruptions in early relationships leading to organised attachment strategies with unmet attachment needs, or experience of abusive or harmful early relationships leading to disorganised attachment patterns, are associated with the development of psychopathologies, including behavioural disorders. From a behavioural perspective, behavioural problems are associated with an individual's learning history, with current behaviour influenced by social and environmental factors and reinforced by consequences that have followed previous actions. Parents may contribute to the development of child behavioural problems through use of ineffective strategies, such as non-specific communications or difficulties in emotional self-regulation, inconsistency and coercive or negative interactions. Childhood insecure or disorganised attachment patterns may be a contributing factor limiting social and relational skills and predicting the subsequent development of an adult parenting style that is predisposed to difficult parent-child

interactions. Additional factors that contribute to the development of problem child behaviours include child temperament, parental socio-economic status, mental and physical health and social support (Gardner, Hutchings, Bywater, & Whitaker, 2010; Morgan et al., 2015; Tichovolsky, Arnold, & Baker, 2013). The development of problematic child behaviour as a logical consequence of previously reinforced actions, previously modelled behaviour, or coercive interactions has strong research evidence (Patterson et al., 2000; Scott & Dadds, 2009).

Attachment disorders in looked after children have been defined as 'a child who, as the result of unmet attachment needs, has one or more diagnosable medical or behavioural disorders' (Collis, 2008. p. 29). This definition indicates a focus on the behavioural outcomes of unmet early attachment needs that may be helpful in determining ways to promote secure attachment and associated positive outcomes. Interventions recommended for children with behavioural disorders focus on parent training programmes, designed to teach parenting skills (Furlong et al., 2010; NICE, 2013, 2015). Parenting interventions are effective in improving child behaviour, by training parents in relationship building and positive behavioural strategies (Gardner et al., 2010; Webster-Stratton & Hammond, 1997). There is research evidence that the same approach may be helpful with behavioural problems associated with unmet attachment needs, with studies investigating changes in both child behaviour and attachment that follow caregivers attending a parenting intervention. A randomised control trial of four to six year olds (n = 174) in the UK, examined the effect that a social learning theory based intervention had on both child behaviour and parent-child attachment quality. Children were assessed using teacher and parent SDQ prior to trial entry, with a SDQ scoring, indicating behavioural difficulties randomised on a 2:1 ratio to intervention /control, whilst those with lower SDQ scores were randomised on 1:2 ratio for intervention / control, to facilitate attendance of parents with children showing behavioural difficulties. Two observational measures were used, the Coding of Attachment Related Parenting was a global measure of parent-child interaction quality, based on attachment theory, measuring sensitive responding and mutuality. The Parent Behaviour Coding Scheme was used to code the number of parent-child interaction events based on social learning theory, such as praising, attending, encouragement, commands, prohibitions and criticisms. The Manchester Attachment Story Task was also administered to each child to elicit attachment representations.

Parents attending the intervention showed increases in observed positive behaviour and in sensitive responding to their children, with increases in sensitive responding independent of behavioural outcomes (Matias, O'Connor, Futh, & Scott, 2014; O'Connor, Matias, Futh, Tantam, & Scott, 2013).

The effect that parenting interventions may have, on both attachment relationships and child behaviour was noted by Ijzendoorn, (1997) observing that the focus on maternal sensitivity as the main determinant of attachment security meant that researchers missed the role that parental management and control may contribute to attachment development. Investigation of attachment in adolescents (*n* = 248), showed that secure attachment relationships were associated with parental monitoring and supervision as well as parental warmth (Scott, Briskman, Woolgar, Humayun, & O'Connor, 2011). The National Institute for Health and Care Excellence (NICE, 2013) in the UK recommends evidence based parenting interventions based on social learning theory and using modelling, rehearsal and feedback to improve parenting skills, for both parents and carers of children with challenging behaviours. For children in care with attachment difficulties, NICE, (2015) recommend video feedback training targeting sensitivity and behaviour training for pre-school children, training which includes positive behavioural management for school age children, and group-based training that includes a behavioural reinforcement system for older children. In their meta-analysis of interventions for disorganised attachment, (Wright et al., 2015) report most effective interventions for disorganised attachment used a behavioural approach to increase parental sensitivity, that is particularly effective when video feedback is used. This attachment intervention focused review included interventions more usually associated with delivery to parents of children with behavioural problems, for example the Incredible Years (O'Connor et al., 2013), Fostering Changes (Briskman et al., 2010) and Multidimensional Treatment Foster Care Programme for Pre-schoolers (Fisher & Kim, 2007).

Summary of Section Two

Abuse and neglect are the primary reasons children looked after enter care. It is highly likely that children with experience of early adversity have learning histories that include both unmet social and emotional needs and experience of maladaptive modelled behaviours, resulting in the development of maladaptive or inappropriate behaviours. Behaviour may be highly functional within the environment where it is learned, but may not be adaptive for different social environments such as school or foster care. Behaviours determined as socially problematic are associated with negative life outcomes for the individuals concerned. There is an underlying assumption within social care that removal to a place of safety will result in an improvement in short- and longer-term outcomes for a child. However, this does not hold true for all children and it is reasonable to expect that children who have experienced high levels of adversity, will need considerable support to facilitate the changes that will enable them to achieve their potential. For children in care, pre-placement

experiences can influence levels of child disorganisation and attachment security (Bovenschen et al., 2016). However, children can develop secure attachment relationships with foster carers, despite having insecure attachments with birth parents (Bovenschen et al., 2016). Reviews have demonstrated links between disorganised attachment style and conduct disorders (Madigan et al., 2016; Wright et al., 2015), but have also pointed out that the association between attachment style and behavioural problems could be explained by associated experiences of abuse and neglect (Wright et al., 2015). Disorganised attachment patterns within the looked after child population may be as high as 50% (Prior & Glaser, 2006), compared to 5-10% for children not looked after (Howe, 2005) and disorganised attachment is both associated with poor outcomes and is the most resistant to change (Collis, 2008). Behavioural persistence is associated with the attachment constructs of internal working models, which are updated incrementally and slowly over time. Behaviourally, persistence is associated with irregular schedules of reinforcement, through for example, inconsistent use of consequences following previous behaviour. Both describe a situation where a child continues to use limited coping strategies in different and usually inappropriate situations (Granic & Patterson, 2006). It is clear that caregivers of children taken into care are likely to experience a wide range of challenging problems relating to the previous experiences of the children they look after and that appropriate training would be required to help them to manage these behaviours.

Introductory Chapters Summary

The two introductory chapters have outlined the history of social care in England and Wales, the difficulties experienced by children who enter out of home care and the challenges faced by those who care for them. The legislative system for social care initially focused on protection of children, with the aim of improving outcomes for children who have a right to be able to fulfil their potential. However, data from England and Wales indicates that a large proportion of children in the care system are failing to achieve this outcome. An explanation for how difficulties experienced by children looked after arise and are maintained was explored in terms of the psychological theories of attachment and behavioural learning. Attachment theory explains how early relational difficulties impact on child development and later behaviour, whilst behavioural and learning theories underpin the process of learning and provide strategies for teaching new, alternative behaviours.

Research suggests a cycle of early aversive experiences resulting in poor mental health and behavioural problems, which can lead to increased risk of placement breakdown that further exacerbates mental health and behavioural problems. Scott & Dadds, (2009)

suggest children with insecure attachments can elicit cycles of negative attachment behaviours to gain caregiver attention in a similar process to the coercive cycle, one of the challenges faced by caregivers of children who have problematic learning histories related to experience of neglect and maltreatment. One recurring problem is placement instability, with children who experience repeated placement moves being particularly vulnerable. Indications are that children who experience frequent moves have particularly challenging behaviours. Caregivers of children with challenging behaviours are recommended to access skills taught on parent training courses. These programmes have extensive evidence to support their effectiveness in helping parents and carers to address behavioural difficulties through promoting positive interactions that encouraging alternative, socially acceptable behaviours. It would seem appropriate that foster and kinship foster carers have a thorough understanding of both attachment needs and behavioural skills to enable them to effectively care for, and support, the children placed with them. It would seem equally important that training offered to all foster carers has evidence that the skills taught are effective. In the next chapter, the literature of evidence-based interventions for foster carers is reviewed, to establish what training programmes with evidence of efficacy could be helpful to carers.

CHAPTER 3

Literature Review

Introduction

This chapter undertakes a scoping review of the literature on evidence-based training undertaken with foster or kinship foster carers. Evidence based training is defined as training programmes for which a randomised control trial has been undertaken, demonstrating change in at least one outcome measure associated with the aims of the training programme. A search of literature published since 2000 identified relevant training programmes for this review. Twenty-four peer-reviewed papers reported on 15 different research studies, evaluating eight different training interventions with foster or kinship foster carers. The eight programmes all targeted carer or parent skills, in order to change child behaviours. There is considerable evidence to support the effective use of social learning and behavioural theories to change child behaviour, by teaching parents or carers new skills through parent training programmes (Barth et al., 2005; Leathers, Spielfogel, Gleeson, & Rolock, 2012; Patterson et al., 1982). The majority of the identified training programmes are parenting programmes and use a social learning and behavioural theoretical approach, with one programme based on attachment theory principles. Organisations in the USA created six of the programmes, with one developed in England and one in Israel. The majority of the research studies (10) were undertaken in the USA. Female foster carers made up the majority of participants with kinship foster carers identified as participating in four studies. The age of the children targeted by the intervention, ranged from infants to adolescents. Outcome measures included carer reports of child behaviours, carer stress and parenting skills.

Reason for this Review

Looked after children can have multiple and complex issues originating in early life histories, including unmet attachment needs and behavioural challenges (Tarren-Sweeney, 2008). Caregivers find caring for children looked after with multiple and complex problems, difficult and stressful (Farmer et al., 2005), with caregivers under strain being more likely to stop fostering, or ask for the placement to be ended and the child moved (Hannah & Woolgar, 2018). In turn, placement instability is associated with child behavioural problems, with children who have experienced multiple placements and changes of carer displaying higher rates of difficulties (Morgan & Baron, 2011). Increasing numbers of children entering care means there are there are placement shortages, with fewer available households to accommodate children looked after (OFSTED, 2019). Carers indicate that support and appropriate training are essential to help them undertake a challenging and complex role (Murray et al., 2011).

Recommended Interventions for Behavioural Problems

One of the most significant challenges foster carers face relates to child behaviour, with behavioural challenges cited as the reason for 44.5% of placements ending at the request of the foster carer (Department for Education, 2018). Social and behavioural psychologists explain the development of child behaviour problems in terms of exposure to a learning environment that reinforces difficult behaviour and leads to escalating coercive interactions (Granic & Patterson, 2006). Child development psychologists explain difficult behaviours through insufficient early nurture leading to disrupted attachment relationships and later socio-relational difficulties (Bowlby, 1969). Interventions recommended for children with difficult behaviours are parent management training courses, based on a social learning model using modelling, rehearsal and feedback to improve parenting skills (NICE, 2013). Parent training has been shown to be effective at improving child behaviours by coaching parents and foster carers in problem solving, relationship building and behavioural management strategies (Leve & Chamberlain, 2004; Webster-Stratton et al., 2004). Programmes are typically group based, delivered in 1-2 hour sessions, weekly over 10-16 weeks (Uretsky & Hoffman, 2017). Recommended interventions for unmet child attachment needs also suggest behaviourally based interventions for children over five, with video-coaching strategies advised for infants and toddlers (NICE, 2015). Video coaching targets caregiver-child interactions, with recorded clips used to coach and support caregivers in correctly interpreting child needs or behaviours (Bernard et al., 2012; Sprang, 2009).

The Importance of Efficacy and Fidelity

Evidence based practice provides assurance that interventions, when delivered with fidelity, are effective in achieving their aims (Hutchings, Gardner, & Lane, 2004). Programme developers establish intervention efficacy by rigorous research methodologies such as randomised control trials (RCT), with adequate participants to be confident findings are unlikely to be due to chance. Establishment of programme efficacy, is followed by trials to demonstrate programme effectiveness in pragmatic real world trials, delivering the intervention to participants in situations away from direct input from the programme developer. In this way, programmes demonstrate they are effective in achieving intervention goals in different situations and with alternative populations. Effective implementation of evidence-based programmes is reliant on both leader skills, adherence to programme content and delivery, and sufficient attendance by participants (Durlak & DuPre, 2008). NICE guidance on behavioural disorders indicates that appropriate intervention programmes will have both a developers manual and employ all materials to ensure consistent implementation of the programme (NICE, 2013). Programme leaders deliver parent-training

interventions to participants, with effective programmes ensuring that leaders are adequately skilled and trained in programme delivery. Programme leaders model the skills they coach participants in developing, with positive leader behaviours shown to predict changes in parenting skills (Eames et al., 2008). Active participation in learning is a highly effective method of learning new skills, and parent-training programmes incorporate strategies that include modelling, role-playing and feedback (Durlak & DuPre, 2008).

Gaps in Review of the Literature

In the ten years between 2007 and 2017 there have been nine reviews of training programmes for foster carers. These reviews have focussed on methodological approaches including intervention efficacy (Kinsey & Schlösser, 2013), study design (Rork & McNeil, 2011), intervention quality (Festinger & Baker, 2013) and programme content (Benesh & Cui, 2017). Reviews have established that training carers can positively impact outcomes for children looked after, with one review evaluating the effectiveness of training protocols (Dorsey et al., 2008). A later review evaluated the effect of carer training on the physical, emotional and wellbeing of children looked after (Everson-Hock et al., 2012). Three reviews have evaluated behaviourally based interventions, delivered to carers; a Cochrane review of Cognitive Behavioural Training (Turner, Macdonald, & Dennis, 2007), and two meta-analyses focusing on child behavioural outcomes (Solomon, Niec, & Schoonover, 2017; Uretsky, Lee, Greeno, & Barth, 2017).

Reviews recommend the use of evidence-based training for foster carers (Benesh & Cui, 2017; Dorsey et al., 2008; Rork & McNeil, 2011; Turner et al., 2007), with Dorsey et al., (2008) evaluating 30 studies and concluding that foster carer training should focus on skills based training aimed at managing problematic child behaviours. Issues with the quality of research were highlighted, with methodological improvements suggested including; the use of control groups, larger sampling sizes, descriptions of programme fidelity, the use of observational measures and provision of more detailed information on participants (Festinger & Baker, 2013; Rork & McNeil, 2011; Solomon, et al, 2017; Turner et al., 2007; Uretsky & Hoffman, 2017). Two meta-analysis evaluated training for foster carers aimed at improving child behaviours (Solomon et al., 2017; Uretsky et al., 2017). Uretsky et al., (2017) evaluated 11 research studies undertaken since Dorsey et al., 2007, finding group based parenting interventions were effective in reducing child problem behaviour when delivered to foster carers. Solomon et al., (2017) reviewed the impact of foster carer training on parenting skills and child disruptive behaviour in 16 studies published prior to 2014, concluding that training improved parenting skills and child behaviour. These reviews excluded studies without a control group (Solomon et al., 2017) or programmes prior to 2007 and those that

were not parent training programmes (Uretsky et al., 2017). These limitations mean that a review of all evidence-based training delivered to foster carers, has yet to be undertaken.

Review Type

To establish the extent and nature of evidence based training available to foster and kinship foster carers, this scoping review is based on criteria outlined by Arksey & O'Malley, (2005) and aims to gain a comprehensive understanding of the existing literature, with limited exclusion criteria. Arksey & O'Malley, (2005) identify four reasons why a scoping study may be undertaken:

1. To examine the extent, range and nature of research activity.
2. To determine the value of undertaking a full systematic review.
3. To summarize and disseminate research findings.
4. To identify gaps in the existing literature.

The first and fourth reasons have been identified as relevant for this review. Arksey and O'Malley (2005) list six stages in their framework for a scoping review, with the sixth stage being optional. The six stages are: 1) identification of a broad research question, 2) identify relevant studies, 3) select studies based on inclusion / exclusion criteria, 4) collate and sort the information according to key issues and themes, 5) summarise and report results and 6) consult with stakeholders to validate findings. In this review, stage six is excluded.

Aims of this Literature Review

This review undertakes an evaluation of all training delivered to foster or kinship carers, where the programme has evidence of efficacy through a published RCT. The review aims to determine which evidence based interventions have been shown to be effective with foster or kinship carers and to identify any gaps in the literature.

Methods

Inclusion / Exclusion Criteria

Studies were included in this review if they evaluated a training programme delivered to foster or kinship carers, where the programme had undergone at least one randomised controlled trial with the same or similar population (for example parents). Studies were included if they were the first RCT for the programme to demonstrate efficacy. Studies were included irrespective of design, so service evaluations and pilot studies were also included Outcomes for the study had to include an effect, or intended effect on children looked after,

such as a behavioural, socio-emotional or attachment related outcome. Intended effects also included development of carer parenting skills, or reductions in carer stress. Single subject studies were excluded, as were papers published prior to 2000.

With the exception of Dorsey et al., (2008), Multidimensional Treatment Foster Care (MTFC; now called Treatment Foster Care Oregon) either did not meet the inclusion criteria, or was specifically excluded from reviews. MTFC is a multi-treatment intensive approach to supporting fostered children and adolescents involved with the youth justice system and displaying severe emotional and behavioural problems. The approach has been shown to be effective in improving positive outcomes, including reduced re-offending rates and successful return home (Chamberlain, Price, Leve, et al., 2008; Chamberlain & Reid, 1994; Leve & Chamberlain, 2004). However, the approach is more than a training programme and includes as an essential part of the treatment, extensive support around the carers and child. For these reasons, MTFC is excluded from this review.

Study Identification

A search of literature for peer reviewed articles was undertaken in April 2018 in two databases, PsycINFO and Web of Science, using the search terms ‘foster care training’ or foster parent training’. The initial searches returned 2,548 articles. The titles were examined and duplicates removed leaving 153 articles. Papers published prior to the year 2000 were removed, leaving 82 articles. Abstracts for these papers were read and 62 relevant papers were identified. These papers were then read to identify training programmes with evidence of efficacy resulting in 24 papers, reporting on seven different training programmes and 15 different research studies.

Information Extraction

The information collected about each study included; study aims, outcomes, measures used and results found. Additional information extracted from each study included: year of publication, authors, country, design, programme, participant and child demographics, recruitment and participant numbers, programme format, number of sessions and length. Fidelity information extracted included leader training, supervision, use of a manual and delivery methods.

Results

Intervention Overview

All of the programmes had been evaluated with foster or kinship carers and could be classed as parent training programmes. No other types of training that met inclusion criteria had been evaluated with foster or kinship carers. All of the programmes worked with caregivers to change behavioural outcomes for the children that they care for, through changing parenting behaviours or teaching new skills to carers. Seven different programmes meet the criteria for this review. Three programmes are primarily focused on parent training and utilise behavioural and social learning theory (SLT), these are: Incredible Years (IY), Keeping Foster and Kinship Carers Supported (KEEP) and Parent Management Training Oregon (PMTO). Two programmes, Parent-Child Interaction Therapy (PCIT) and Fostering Changes (FC), combine attachment theory with aspects of behavioural/social learning theory. One programme is primarily based on attachment theory, Attachment and Bio-behavioural Catch-up (ABC). The final programme, Non Violent Resistance (NVR) combines principles of nonviolent resistance with systemic or family therapy to address aggressive or violent behaviours. Details of the programmes, studies and research papers are in table 3.1.

Location.

Five of the programmes originated in the USA, Attachment and Bio-behavioural Catch-up (ABC; Dozier et al., 2006), Parent-Child Interaction Therapy (PCIT; Eyberg, 1988), Incredible Years © (IY; Webster-Stratton, 1982), Keeping Foster and Kinship Carers Supported and Trained (KEEP; Chamberlain, Moreland, & Reid, 1992) and Parent Management Training Oregon (PMTO; Forgatch & DeGarmo, 1999). One programme, Fostering Changes originated in the Institute of Psychiatry, Kings College, London, (FC; Pallett, Scott, Blackeby, Yule, & Weissman, 2002) and one programme, Non-Violent Resistance, originated in the University of Tel Aviv, Israel (NVR; Omer, 2001).

Two programmes originating in the USA have been evaluated in the UK, Incredible Years © and Keeping Foster and Kinship Carers Supported and Trained. Parent Management Training Oregon has been evaluated in Holland, whilst Non-Violent Resistance has been evaluated in Belgium. The remaining eight studies were all undertaken in the USA.

Participants.

Most training was reported as being delivered to foster carers, with two programmes (KEEP, NVR) identifying that they include kinship carers. The eight studies that specified foster carers, did not clarify whether kinship carers were included and, where kinship carers were included, results were generally reported jointly (Chamberlain, Price, Leve, et al., 2008;

Degarmo, Leve, & Price, 2009; Greeno, Lee, et al., 2016; Price et al., 2008; Price, Roesch, & Walsh, 2012; Uretsky et al., 2017; Van Holen, Vanderfaeillie, & Omer, 2016) with one study reporting them separately (Roberts et al., 2016). One study (IY+CoP) was an adapted IY plus co-parenting intervention aimed at foster carers and biological parents (Linares, Montalto, Li, & Oza, 2006).

Table 3.1. Training programme, study and research papers

Prog	Theory	Study	Research Paper	Location	Participants	Trial type
ABC	Attachment	ABC-1	(Dozier et al., 2006) (Dozier, Peloso, Lewis, Laurenceau, & Levine, 2008) (Dozier et al., 2009)	USA	Foster	RCT
		ABC-2	(Sprang, 2009)	USA	Foster	RCT
FC	SLT and Attachment	FC-1	(Briskman et al., 2010)	UK	Foster	RCT
IY+CoP	SLT and Co-Parenting	IY+CoP	(Oriana, Linares et al., 2006)	USA	Foster / Biological	RCT
IY	SLT	IY-1	(Nilsen, 2007)	USA	Foster	Pre-Post
		IY-2	(McDaniel et al., 2011)	UK	Foster	Pre-Post
		IY-3	(Bywater et al., 2011)	UK	Foster	TAU control
KEEP	SLT	KEEP-1	(Chamberlain, Price, Reid, & Landsverk, 2008) (Price et al., 2008) (Degarmo et al., 2009)	USA	Foster / Kinship	RCT
			(Price et al., 2012) (Price, Roesch, Walsh, & Landsverk, 2015)	USA	Foster / kinship	TAU control
		KEEP-2	(Leathers, Spielfogel, McMeel, & Atkins, 2011)	USA	Foster	TAU control
		KEEP-3	(Greeno, Uretsky, et al., 2016) (Greeno, Lee, et al., 2016) (Uretsky et al., 2017)	USA	Foster / kinship	TAU control
		KEEP-4	(Roberts et al., 2016)	UK	Foster / kinship	Pre-Post
NVR	Non Violent Resistance	NVR-1	(Van Holen et al., 2016)	Belgium	Foster / Kinship	Pre-Post
PCIT	SLT and Attachment	PCIT-1	(McNeil, Amy, & Robin, 2005)	USA	Foster	Pre-Post
		PCIT-2	(Mersky, Topitzes, Janczewski, & McNeil, 2015) (Mersky, Topitzes, Grant-Savela, Brondino, & McNeil, 2016)	USA	Foster	RCT
PMTO	SLT	PMTO-1	(Maaskant, Rooij, Overbeek, Oort, & Hermanns, 2016; Maaskant et al., 2017)	Holland	Foster	RCT

Programme: ABC: Attachment and Biobehavioural Catch up. FC: Fostering Changes. IY+CoP: Incredible Years plus Co-parenting. IY: Incredible Years. KEEP: Keeping Foster and Kinship Carers Supported and Trained. NVR: Non Violent Resistance. PCIT: Parent-Child Interaction Therapy. PMTO: Parent Management Training - Oregon

Theory: SLT: Social Learning Theory

Programme / Intervention

Theoretical basis and content of the training.

All the interventions focused on behavioural change, through the use of learning and child developmental theories. The interventions have been grouped into three categories, those for younger children addressing attachment relationships, those using social learning or behavioural theory principles to address behavioural problems and those combining both approaches.

Attachment based interventions.

Attachment and Bio Behavioural Catch-up (ABC) uses attachment theory concepts of the importance of nurturing behaviours to coach carers in maintaining consistent, nurturing and child led responses to infants and toddlers. ABC aims to facilitate the learning of children's self-regulation skills, leading to a reduction in behavioural and bio-behavioural dysregulation. The programme targets infant emotional and behavioural regulation by coaching carers in strategies that help the child learn to identify emotions and to assist the child in learning to change their emotional state. Strategies include strengthening the carer-child relationship through child led play, praise and nurturing. The programme teaches carers to recognise that the way that a child asks for their needs to be met can sometimes be misunderstood by carers, leading to a negative spiral of miscommunication. Looked after children placed with stranger foster carers may be particularly vulnerable to carers misinterpreting children's needs, with children who have experienced abuse or neglect giving confusing and conflicting signals. The programme teaches carers to offer nurturing behaviours, even if the child appears to reject that nurture by turning away, or failing to be soothed.

Social Learning based interventions.

Three interventions, the Incredible Years © (IY), Keeping Foster and Kinship Carers Supported and Trained (KEEP) and Parent Management Training Oregon (PMTO) are all based on a social learning model. All three programmes develop parenting skills in order to reduce challenging child behaviours in children aged between 3-12 years. Webster-Stratton developed IY as a parenting intervention to address child behaviour problems (Webster-Stratton, Reid, & Hammond, 2001), whilst KEEP and PMTO were both developed at the Oregon Social Learning Centre, with PMTO (Forgatch & DeGarmo, 1999) aimed at parents and KEEP targeting foster and kinship carers. KEEP is a less intensive adaptation of the therapeutic model programme Multidimensional Treatment Foster Care (now named Treatment Foster Care Oregon) initially developed for juvenile offenders (Chamberlain &

Reid, 1994). Parenting programmes make the assumption that factors including caregiver stress and child temperament can result in ineffective and coercive cycles of parent-child interactions (Patterson, Chamberlain, & Reid, 1982). All three interventions aim to improve parenting skills so that carer-child interactions become effective, facilitating the development of the children's socio-emotional skills and reducing problematic behaviours. During training, programme leaders' model parenting skills including problem solving and positive interactions. Participants learn and practise child management strategies including child supervision, the use of distraction, child led play and logical consequences and non-harsh discipline for misbehaviour. Participant engagement is developed through collaborative working, where the programme leader helps the participant identify their needs and goals, then coaches the carer to achieve them.

The final programme, Non Violent Resistance (NVR) has socio-political origins where nonviolent protest is used to achieve common goals. This programme has a broader target age range and includes adolescents. NVR teaches parents to deal with violent and self-destructive behaviours in children and teenagers. Parents and carers are taught to use the combined strategies of resistance, awareness and negotiation to reduce difficult behaviours. The parent agrees a contract of behaviour with the child, encouraging compliance through monitoring, a role shared with friends and family. Breaches of the agreement are met with parental resistance without conflict, for example a parent entering a child's room, stating how they feel about the behaviour and remaining until the child engages with a resolution. The programme is more heavily focused on logical consequences than the interventions described earlier, using non-aggressive consequences to encourage alternative child and adolescent behaviours. It teaches techniques such as resistance through increased adult presence, de-escalation of conflict, the importance of reconciliation and ways of improving support networks.

Social Learning and Attachment theory interventions.

Fostering Changes (FC) is a group based training programme developed for foster carers to help with the management and control of disruptive child behaviours. FC programme content is derived from empirically validated parent training programmes based on social learning and cognitive behavioural theories, with the additional inclusion of attachment related content. A theoretical understanding of attachment is included along with information on how disruptions to attachment can impact on the development and behaviour of children looked after. The programme aims to improve child behaviour and promote healthy attachment relationships.

Parent-Child Interaction Therapy (PCIT) is a clinic-based intervention for families of children aged 2-7 years experiencing challenging behavioural problems. PCIT is based on attachment and social learning theories and is aimed at stopping negative and coercive parent-child interactions, which reinforce problematic child behaviour. It uses a combination of behavioural approaches and play therapy to coach carers in child-directed interactions, using enthusiasm and praise to encourage positive behaviours and ignoring or negative language to discourage negative behaviours. Carers are encouraged to reflect language back to the child and to describe the child's actions to increase vocabulary and good communication, with the goal of reducing anger and aggression. The three papers reviewed here are all adaptations of the programme for foster carers, including a one to one coaching model adapted to be delivered as a 3-day group based intervention.

Research Design

Trial type.

Researchers using a control group comparison and randomisation to allocate participants to either the intervention or control group, minimise selection bias and improve the methodological quality of the research. A summary of the studies and trial designs is in Table 3.1. The one attachment based study used a RCT design. Both the SLT and attachment interventions used a RCT design. The SLT based interventions used a mix of RCT (3), treatment as usual group comparisons (4) and pre-post designs with no control group (4).

Sample size.

Sample size is important as small numbers of participants ($n < 25$) in intervention conditions, can increase risk of failing to find a change resulting from the intervention (type 11 error or false negative) (Marszalek, Barber, Kohlhart, & Holmes, 2011). The sample sizes ranged from 11-646 for intervention participants, with two studies having 25 or less and another four having fewer than 50 participants. Pre-post design interventions tended to have the smaller sample sizes, see Table 3.2. Use of pre-post design is associated with pilot trials or service evaluations, where early stage, exploratory research is being undertaken. With the exception of two large KEEP studies (KEEP-1, KEEP-4) study sample sizes were 80 or below for intervention participants.

Participant demographics.

Of the fifteen studies, carer age was reported by twelve studies with a mean carer age of 48 years (39-50 years). Carer gender was reported in eleven studies, with carers being primarily female. The high percentage of female carers suggests that only one carer is

attending training programmes despite NICE guidelines for parenting interventions that recommend both carers attend training. It also suggests that there is limited information about the efficacy of the programme with male carers. Child age varied depending on the target age range of the programme, with all studies reporting mean child ages. ABC mean ages ranged from 1.8-3.5 years; PCIT from 4.6-5.2 years; FC, IY, PMTO and KEEP from 6.2-8.9 years, NVR had a mean age of 12.5 years (Table 3.2).

Participant Recruitment.

Methods of recruitment can introduce bias into research, if participants are not representative of the population targeted. Participants were mainly recruited through collaborations with researchers and fostering agencies or authorities, with the exception of Sprang (2009; ABC-2) who recruited clinic self-referred participants. Carers were recruited at the time of child placement (Dozier et al. 2009., ABC-1; Chamberlain et al. 2008., KEEP-1), or as a result of a clinical rating on a carer reported child behavioural measure (Maaskant et al., 2017, PMTO-1; Van Holen et al., 2016, NVR), with all others recruiting carers who expressed interest in participating. Exclusion criteria mainly related to the target child age for the specific intervention.

Intervention delivery information.

All of the interventions delivered training or coaching to carers, with ABC and PCIT involving the child in some sessions. Individual delivery at home was undertaken for three interventions (ABC; PMTO; NVR), there were an additional three group sessions for the NVR programme. KEEP, IY and FC were all delivered in a group format of typically 6-12 carers, meeting weekly for 1.5-3 hours a week (Table 3.2). PCIT was delivered as a group programme to foster carers, rather than individual clinic based sessions, over two days (McNeil et al., 2005) or two days plus follow up support (Mersky et al., 2016, 2015).

Table 3.2. Participant and intervention information

Prog.	Study	Research Paper	Participant no.	Age (M. SD)	Gender (% Female)	Child no.	Age (M, SD)	Gender (% Female)	Del. Type	Frequency	No. Sessions	Length (Hrs)
ABC	ABC-1	Dozier et al. (2006)	60		56%	104	1.9	52%	Ind/Home	Weekly	10	1
		Dozer et al. (2008)	46			46		59%	Ind/Home	Weekly	10	1
		Dozier et al. (2009)	46				1.8		Ind/Home	Weekly	10	1
	ABC-2	Sprang. (2009)	26	39.9 (6.09)	82%	53	3.5	49%	Ind/Home	Weekly	10	1

Prog.	Study	Research Paper	Participant no.	Age (M. SD)	Gender (% Female)	Child no.	Age (M, SD)	Gender (% Female)	Del. Type	Frequency	No. Sessions	Length (Hrs)
FC	FC-1	Briskman et al. (2010)	34	50 (8)	94%	51	7.9 (3.1)	41%	Group	Weekly	12	3
IY+CoP	IY+CoP	Linares et al. (2006)	80		89%		6.2 (2.3)		Group	Weekly	12	2
IY	IY-1	Nilsen. (2007)	11	44.09 (8.88)		11	8.27 (1.35)	64%	Group	Weekly	12	2
	IY-2	McDaniel et al. (2011)	13	44	69%		11		Group	Weekly	9	2.5
	IY-3	Bywater et al. (2011)	29	46.28 (9.51)		29	8.86 (3.43)	48%	Group	Weekly	12	2
KEEP	KEEP-1	Chamberlain et al. (2008)	359	49.86 (11.8)	94%	359	8.88 (2.2)	50%	Group	Weekly	16	1.5
		Price et al. (2008)							Group	Weekly	16	1.5
		DeGarmo et al. (2009)							Group	Weekly	16	1.5
		Price et al. (2012)	359	49.86 (11.8)	94%	359	8.88 (2.2)	50%	Group	Weekly	16	1.5
		Price et al. (2015)	164	45.10 (10.2)	94%		7.84 (2.5)	47%	Group	Weekly	16	1.5
	KEEP-2	Leathers et al. (2011)	15	49.09 (11.21)	100%	31	8.58 (2.41)	28%	Group	Weekly	16	1.5
	KEEP-3	Greeno et al. (2016)	65	50 (11)	99%	65	8	49%	Group	Weekly	16	1.5
		Greeno, lee, et al. (2016)							Group	Weekly	16	1.5
		Uretsky et al. (2017)	65	50 (7.46)	99%		7.5 (2.29)	49%	Group	Weekly	16-20	1.5
	KEEP-4	Roberts et al. (2016)	646	49.4 (8.99)	85%	646	8.9 (2.55)	42%	Group	Weekly	16	1.5
NVR	NVR-1	Van Holen et al. (2016)	25	49.3 (12.2)		25	12.5 (3.7)	60%	10x Ind/ Home + 3x Group	Weekly	13	1.25 + 3
PCIT	PCIT-1	McNeil et al. (2005)	30			30	5.2		Group	Daily	2	7
	PCIT-2	Mersky et al. (2015)	73	44	89%	44	4.6	56%	Group	Daily	2+1	7
		Mersky et al. (2016)	58			58	4.6	54%	Group	Daily	2+1	7
PMTO	PMTO-1	Maaskant et al. (2016:2017)	46	46.55 (6.91)	52%	86	7.85 (2.36)	54%	Ind/Home	Weekly	M=21.25	

Programme: ABC: Attachment and Biobehavioural Catch up. FC: Fostering Changes. IY+CoP: Incredible Years plus Co-parenting. IY: Incredible Years. KEEP: Keeping Foster and Kinship Carers Supported and Trained. NVR: Non Violent Resistance. PCIT: Parent-Child Interaction Therapy. PMTO: Parent Management Training – Oregon. Delivery type: Ind: Individual

Programme Fidelity of Delivery and Evidence of Efficacy

The use of training programmes that are effective in teaching content and skills that are helpful to foster carers should be an important factor in selecting training programmes by fostering services. All programmes identified here demonstrated that training of foster carers led to measurable changes in child behaviour, using a variety of different measures (see

table 3.4). Programme developers commonly demonstrated that the programme was effective in randomised control trials (RCT), which demonstrated significant change in at least one outcome measure. Three studies (FC-1, ABC-1 & KEEP-1) were all developer led RCT trials that established programme efficacy with a foster carer population. The remaining programmes (IY, NVR, PMTO, and PCIT) had previously demonstrated efficacy with a parent population, whilst the studies included here evaluated their effectiveness within the fostering population. Keeping Foster Carers Supported and Trained (KEEP) is an adaptation from Multi-dimensional Treatment Foster Care (MTFC), which has evidence of efficacy with youth in foster care (Chamberlain et al., 1992) and has Blueprint for healthy youth development status, as does Parent Management Training Oregon (PMTO) (Blueprints Programs & University of Colorado-Boulder, n.d.). The Incredible Years © (IY) series has extensive evidence within the parenting population for children with conduct disorders including a Blueprint promising programme grading (Mihalic, Fagan, Irwin, & Ballard, 2004). Published research demonstrated the efficacy of the Parent-Child Interaction Therapy (PCIT) clinic based model within the parent population (Herschell & McNeil, 2006) and for Non-Violent Resistance (NVR) home delivery with a parenting population (Lavi-Levavi, Shachar, & Omer, 2013; Ollefs, Von Schlippe, Omer, & Kriz, 2009; Weinblatt & Omer, 2008).

Programme content and delivery.

NICE (2013) recommended interventions for children with conduct disorders, include parent training programmes based on social learning theory, that include modelling, rehearsal and feedback to improve skills. For younger children with attachment difficulties, video coaching strategies are recommended (NICE, 2015). Methods of programme delivery for the interventions reviewed here, include role-play, goal setting, use of video clips, homework and coaching (table 3.3). The two interventions that use video coaching methods, both include attachment and behavioural content (ABC & PCIT), whilst interventions based primarily on the social learning model, use modelling, rehearsal and feedback strategies.

Programme fidelity.

The consistent delivery of programmes is important to ensure programme aims are met. Fidelity is addressed in a variety of ways, including assessment of adherence to a programme manual, training, certification and ongoing supervision of programme leaders. All programmes except Parent-Child Interaction Therapy stated the programme had a manual. Attachment and Bio-behavioural Catch-up and Fostering Changes did not provide any information about leader training or certification. Additional methods of ensuring fidelity included weekly checklists of content delivered (IY; NVR; PMTO) and video or audio session recording (KEEP) to check programme adherence.

Table 3.3. Training programme information

Prog.	Study	Research Paper	Efficacy / Effectiveness	Manual	Leader Training and Certification.	Leader Supervision	Role play	Goal setting	Video clips	Home work	Video coaching	Coaching with child
ABC	ABC-1	Dozier et al. (2006)	Efficacy	✓		✓					✓	
		Dozer et al. (2008)		✓		✓					✓	
		Dozier et al. (2009)		✓		✓					✓	
	ABC-2	Sprang. (2009)	Efficacy	✓		✓					✓	
FC	FC-1	Briskman et al. (2010)	Efficacy	✓				✓		✓		
IY+CoP	IY+CoP	Linares et al. (2006)	Effect.	✓	✓	✓	✓	✓	✓	✓		
IY	IY-1	Nilsen. (2007)	Effect.	✓	✓	✓	✓	✓	✓	✓		
	IY-2	McDaniel et al. (2011)	Effect.	✓	✓	✓	✓	✓	✓	✓		
	IY-3	Bywater et al. (2011)	Effect.	✓	✓	✓	✓	✓	✓	✓		
KEEP	KEEP-1	Chamberlain et al. (2008)	Efficacy	✓	✓	✓	✓	✓	✓	✓		
		Price et al. (2008)	Efficacy	✓	✓	✓	✓	✓	✓	✓		
		DeGarmo et al. (2009)	Efficacy	✓	✓	✓	✓	✓	✓	✓		
		Price et al. (2012)	Effect.	✓	✓	✓	✓	✓	✓	✓		
		Price et al. (2015)	Effect.	✓	✓	✓	✓	✓	✓	✓		
	KEEP-2	Leathers et al. (2011)	Effect.	✓	✓	✓	✓	✓	✓	✓		
	KEEP-3	Greeno et al. (2016a)	Effect.	✓	✓	✓	✓	✓	✓	✓		
		Greeno et al. (2016b)		✓	✓	✓	✓	✓	✓	✓		
		Uretsky et al. (2017)		✓	✓	✓	✓	✓	✓	✓		
	KEEP-4	Roberts et al. (2016)	Effect.	✓	✓	✓	✓	✓	✓	✓		
NVR	NVR-1	Van Holen et al. (2016)		✓	✓	✓	✓		✓	✓		
PCIT	PCIT-1	McNeil et al. (2005)			✓		✓				✓	✓
	PCIT-2	Mersky et al. (2015)	Effect.		✓		✓				✓	✓
		Mersky et al. (2016)			✓		✓				✓	✓
PMTO	PMTO-1	Maaskant et al. (2016:2017)	Effect.	✓	✓	✓	✓	✓				

Programme: ABC: Attachment and Biobehavioural Catch up. FC: Fostering Changes. IY+CoP: Incredible Years plus Co-parenting. IY: Incredible Years. KEEP: Keeping Foster and Kinship Carers Supported and Trained. NVR: Non Violent Resistance. PCIT: Parent-Child Interaction Therapy. PMTO: Parent Management Training - Oregon

Measures and Outcomes

Child behavioural outcomes.

Five different carer reported measures of child behaviour were used, with two teacher reported behavioural measures (table 3.4)

Table 3.4. Measures used by studies in this review

Measure	Abbreviation	Authors
Behavioural Measures		
Child Behaviour Check List	CBCL	Achenbach & Rescorla, 2001
Teacher Report Form	TFR	Achenbach & Rescorla, 2001
Eyberg Child Behaviour Inventory	ECBI	Robinson, Eyberg, & Ross, 1980
Stutter-Eyberg Student Behaviour Inventory - Revised	SESBI-R	Eyberg & Pincus, 1999
Strengths and Difficulties Questionnaire	SDQ	Goodman, 2001
Parental Daily Report	PDR	Chamberlain & Reid, 1987
Behavioural Assessment System for Children	BASC	Kamphaus, Reynolds, & Hatcher, 1999
Dyadic Parent-Child Interaction Coding System	DPICS	Eyberg & Robinson, 2000
Attachment measures		
Strange Situation	SS	Ainsworth & Bell, 1970
Quality of Attachment Relationships Questionnaire	QUARQ	Scott, n.d.
Carer Stress and Depression		
Parent Stress Index and Short Form	PSI, PSI-SF	Abidin, 1983
Beck Depression Inventory	BDI	Beck, Steer, & Carbin, 1988
Parenting skills measures		
Child Abuse Potential Inventory	CAPI	Milner, 1990
Parenting Practices Interview	PPI	Webster-Stratton, 1982
Family Functioning Style Scale	FFSS	Trivette, Dunst, Deal, Hamer, & Propst, 1990
Adult-Adolescent Parenting Inventory	AAPI	Conners, Whiteside-Mansell, Deere, Ledet, & Edwards, 2006
The Parenting Scale	PS	Arnold, O'Leary, Wolff, & Acker, 1993.
Discipline and Supervision Measure	DSM	Oregon Social Learning Centre

The CBCL was the most frequently used carer reported child behaviour measure, being used in seven studies (ABC-2; IY+CoP; KEEP-2; KEEP-3; NVR-1; PCIT-2; PMTO-1), with the Teacher Report Form also used in PMTO-1. The ECBI was used in four studies, (IY+CoP; IY-2; IY-3; PCIT-2), with PCIT-2 and IY+CoP using both the ECBI and the CBCL and IY+CoP also using the school report version SESBI-R. Three UK studies (KEEP-4, FC-1. IY-3) used the SDQ, with IY-3 using this in addition to the ECBI, FC-1 using it in addition to the Carer Defined Problems Scale and KEEP-4 using it in addition to the PDR. KEEP-1, KEEP-3, KEEP-4 ABC-1 & PMTO-1 used the PDR and IY-1 used the BASC.

Attachment related outcomes.

ABC-1 evaluated the effect of the ABC programme on child salivary cortisol levels, and the Strange Situation test, comparing pre- and post-intervention data (Ainsworth & Bell, 1970). High cortisol levels are associated with elevated levels of stress, hypothesised to be associated with insecure attachment relationships in the child. The strange situation test is a validated measure used to determine infant and toddler attachment style. Briskman et al., (2010) used a carer-report questionnaire to determine child-carer attachment relationship quality, the Quality of Attachment Relationships Questionnaire (QUARQ) (Scott, n.d.) as a pre-post measure to determine if the relationship changed as a result of attendance on the Fostering Changes programme.

Placement stability.

Price et al., (2008; KEEP-1) and Greeno, Uretsky, et al., (2016b: KEEP-3) reported on the effects of KEEP on numbers of child placement moves, to establish if carer attendance on the programme subsequently reduced the numbers of moves children experienced. DeGarmo et al (2009; KEEP-1) reported the effects on outcome measures of participant engagement by session, to determine whether higher levels of programme attendance reduced the risk of placement breakdown that is associated with multiple previous child placement moves.

Carer stress and depression.

Levels of carer stress were reported in five studies using the PSI (PMTO-1) or the short form (PSI-SF - ABC-2; IY-1, PCIT-2). NVR-1 used a stress index adapted for a Belgian Population. The BDI (Beck et al., 1988) was used in one study (IY-3) to measure levels of carer depression.

Parenting behaviours.

Parenting behaviours were assessed using six different carer report measures in six studies (table 4). The CAPI was used in one study (ABC-2). The PPI and the FFSS were both used to assess co-parenting by IY-CoP. The AAPI was used in one study (IY-1) and the PS in two UK studies (IY-3; KEEP-4). The DSM calculates a ratio of positive reinforcement to discipline technique and was used by KEEP-3.

Observational measures.

With the exception of the ABC studies using cortisol assays, all measures reported above were carer or teacher report. Self-report is subject to reporter bias, with participants vulnerable to influence from perceived researcher expectations, or recent life events. Independent observation of behaviour is regarded as a gold standard objective measurement. In this review, two papers used observational measures, Dozier, Peloso, Lewis, Laurenceau, & Levine, (2008) (ABC-1) reported on child avoidance via observational coding and Merskey et al., (2015) (PCIT-2) used the Dyadic Parent-Child Interaction Coding System (DPICS) (Eyberg & Robinson, 2000) to assess parenting behaviour (table 3.5).

Use of measures with children looked after

The measures listed here have all been used in research with foster or kinship carers and children looked after. However, there was little evidence to indicate that these measures have been tested with this population. Most of the measures listed here are intended for use with parents and children. There appears to be an implicit assumption that the measures are equally effective with children looked after and foster or kinship carers. This assumption may be correct however, there is a lack of data to support this. Measure reliability is determined by testing of the measure on a population sample, to determine if the measure is accurately reporting over time, within a population and what it is designed to measure. If these studies have not been undertaken within the children looked after population, there is an argument that the measures may not be accurately reporting outcomes.

Follow up times.

Post-intervention measures are collected to indicate whether participants changed over time. The length of time after the intervention helps to establish whether post-intervention differences were short- or longer-term effects. Changes that are maintained over longer periods are associated with more successful outcomes (Bywater et al., 2009), suggesting that changes have become embedded.

Follow up times were inconsistently reported, as post-baseline, post-intervention or without specifying which (table 3.5). One study (ABC-2) did not report follow-up time, with ABC-1 reporting follow up as one-month post-baseline. Follow up within two months of intervention completion were reported by six studies (IY-1; IY-2; KEEP-1; KEEP-3; NVR-1; PCIT-1), including three research papers from KEEP-1&3 reporting differently to other papers from the same study. Follow-up within three months was reported by three studies (FC-1; IY+CoP; PCIT-2), four months by PMTO-1. Longer follow-up times of 5-12 months post-baseline were reported by five studies (IY-3; KEEP-1; KEEP-2; KEEP-3; KEEP-4) with KEEP-4 reporting results at both 11 and 17 months post-baseline.

Table 3.5. Training programme, study and research paper outcomes

Prog.	Study	Research Paper	Outcome	FU time	Measure	Main findings
ABC	ABC-1	Dozier et al. (2006)	Salivary Cortisol levels	1 month		Main effect for intervention group (p<.002), reduced levels cortisol compared to comparison group
			Child behaviour		PDR	No significant difference for the whole group, parents of toddlers rather than infants reported significant reduction (p<.05) in behaviours
		Dozer et al. (2008)	Attachment		SS	No significant increase in cortisol in response to the strange situation.
		Dozier et al. (2009)	Attachment behaviours	1 month	Diary	Significant reduction in avoidance (p<.05)
	ABC-2	Sprang. (2009)	Parenting		CAPI	Significant reduction (p=.001)
			Child Behaviour		CBCL	Significant reduction (p=.01) externalising and internalising behaviour
					PSI-SF	Significant reduction (p=.05)
FC	FC-1	Briskman et al. (2010)	Child behaviour problems	3 month follow up	CDPS	Significant reduction (p=.0.3; d=.95)
					SDQ	Significant reduction (p=.030; d=.32) total problems, significant reduction (p=.045; d=.37) hyperactivity sub-scale
			Attachment relationship		QUARQ	Significant reduction (p=.04; d=.4)

Prog.	Study	Research Paper	Outcome	FU time	Measure	Main findings
IY+CoP	IY+CoP	Linares et al. (2006)	Parenting	3 month FU	PPI	Significant difference on Positive discipline d=59
			Co-parenting		FFSS	No Significant difference at follow up (was at post-test)
			Child behaviour		CBCL	No significant difference - Externalising scale
					ECBI	No significant difference
					SESBI-R	No Significant difference
IY	IY-1	Nilsen. (2007)	Child psychosocial functioning	2 week FU	BASC	Not significant / Conduct sub-scale significantly less (d=.82) conduct symptoms in intervention group to comparison (n=7)
			Care-giver child stress		PSI-SF	Not significant
			Parenting knowledge and attitudes		AAPI	Not significant
	IY-2	McDaniel et al. (2011)	Child behaviour	immediate post intervention	ECBI	Significant (p=.08) reduction in Intensity Scale, Non-significant problem scale.
	IY-3	Bywater et al. (2011)	Child behaviour	6 m. post BL	ECBI	Significant (p=.004; d=0.67) reduction in Intensity Scale.
					SDQ	Significant (p=.006; d=0.56) reduction in total scale, and hyperactive scale (p=.013; d=0.50)
			Carer depression		BDI	Significant (p=.026; d=0.46) reduction
			Parenting competence		PS	Non-significant reduction
KEEP	KEEP-1	Chamberlain et al. (2008)	Child behaviour	5 m. post BL	PDR	Significant reductions (d=.26)
			Positive / Negative discipline		PPR	Significant improvement (d=.29)
		Price et al. (2008)	Placement stability			Significant increase in positive exits (p=.005)
		DeGarmo et al. (2009)	Group engagement moderates child behaviour		PDR	Group engagement significantly moderated prior placement history (p<.05)

Prog.	Study	Research Paper	Outcome	FU time	Measure	Main findings
			group engagement moderates negative exits			Group engagement moderated negative placement disruption for kinship carers
		Price et al. (2012)	Child behaviour	2 weeks post intervention	PDR	Significant within group differences in behaviour for kinship carers, and language
		Price et al. (2015)	Benefits generalise to other children	2 weeks post intervention	PDR	Significant reductions in sibling behaviour (p<.001: d=.42)
			Carer stress		PDR	Significant reductions in parent stress (p<.021 : d=.40)
	KEEP-2	Leathers et al. (2011)	Child behaviour	3, 6, (12) months post baseline	CBCL	Significant reductions in externalising and internalising scales
			Mediated by positive parenting		APQ	Not significant reductions, did not mediate behaviour
	KEEP-3	Greeno et al. (2016)	Child behaviour	6 months post baseline	PDR	Significant (p=.0001,)
			Parenting stress		PSI-SF	Not significant
			Discipline and supervision style			Not significant
			Permanency			Not significant
		Greeno, Lee, et al. (2016)	Child behaviour		CBCL	Non-significant reduction
		Uretsky et al. (2017)	Positive reinforcement relation to child behaviour	2 m. post intervention	PDR	Parents with the lowest pre-treatment proportion of positive reinforcement baseline relative to discipline, experienced the lowest PDR counts at follow up.
	KEEP-4	Roberts et al. (2016)	Child behaviour	6 & 12 m. FU (11 & 17 m. post BL)	PDR	Significant reduction (p<.001).
					SDQ	Significant reduction (p<.001).
			Parenting skills		PS	Significant reduction (p<.001)
NVR	NVR-1	Van Holen et al. (2016)	Child behaviour	immediate post intervention	CBCL	Significant reductions in Total (p=.000, d=1.09) Internalising (p=.003, d=0.61) and externalising (p=.000, d=0.89) scales

Prog.	Study	Research Paper	Outcome	Follow Up time	Measure	Main findings
PCIT	PCIT-1	McNeil et al. (2005)	Parenting Stress		NVOS	Significant reduction in 2 of 4 sub-scales.
	PCIT-2	Mersky et al. (2015)	Parenting stress	14 weeks post BL	PSI-SF	Significant reduction (p=.007, d=0.49) total stress, PD no effect, PCDI, sig reduction (p=.004, d=0.60) DC, significant reduction (p=.002, d=0.55)
			Parenting behaviour		DPICS	Significant change (p<.001; d=0.55) praise, composite positive parent (p<.001; d-.39) and composite negative parenting (p<.001; d=.66)
		Mersky et al. (2016)	Child behaviour	8 + 14 week post BL	ECBI	Significant reduction on problems scale, not on the intensity scale.
					CBCL	Significant reduction on externalising and internalising scales.
PMTO	PMTO-1	Maaskant et al. (2016;2017)	Parent stress	4 month	PSI	Significant reduction post intervention, not maintained at 4 month follow up
			Parenting behaviour		PDQ	No Significant results
			Child behaviour		CBCL	No Significant results.
					TRF	No Significant results.

Programme: ABC: Attachment and Biobehavioural Catch up. FC: Fostering Changes. IY+CoP: Incredible Years plus Co-parenting. IY: Incredible Years. KEEP: Keeping Foster and Kinship Carers Supported and Trained. NVR: Non Violent Resistance. PCIT: Parent-Child Interaction Therapy. PMTO: Parent Management Training – Oregon.
FU: Follow up. BL: Baseline

Outcomes

Attachment based interventions.

The delivery of attachment based coaching interventions to foster carers was evaluated in two studies of ABC (ABC1; Dozier et al., 2009, 2008, 2006: ABC-2; Sprang, 2009). Findings indicated the intervention significantly lowered infant stress and reduced avoidance behaviours, lowered the risk of harmful carer behaviours and reduced carer stress. The intervention was less successful in demonstrating reductions in child behaviour problems using the parental daily report (PDR) or in reducing levels of child stress associated with being left with a stranger, in the strange situation attachment measure. ABC

targeted foster carers looking after children under the age of four, working with carers at home to educate and coach strategies for understanding and responding to child cues. This attachment focused intervention targets sensitive responding as a means of developing a secure carer-child attachment relationship but did not measure attachment style or any change in attachment relationship. The focus was on levels of stress as indicated by cortisol levels, with high levels of cortisol associated with negative impact on cognitive development thought to be a precursor to development of later problem behaviours. The short follow-up time for post-intervention measures collection did not establish whether reported improvements were maintained over time.

Social learning theory (SLT) based interventions.

Three interventions were based primarily on a social learning model: i) Keeping Foster and Kinship Carers Supported and Trained (KEEP; KEEP-1; Chamberlain et al., 2008; Price et al., 2008; 2012; 2015; DeGarmo et al., 2009: KEEP-2; Leathers et al., 2011: KEEP-3; Greeno et al., 2016; 2016; Uretsky et al., 2017: KEEP-4; Roberts et al., 2016). ii) the Incredible Years © (IY; IY-1; Nilsen., 2007; IY-2; McDaniel et al., 2011: IY-3; Bywater et al., 2011: IY+CoP; Linares et al., 2006) and iii) Parent Management Training Oregon (PMTO; PMTO-1; Maaskant et al., 2016; 2017). IY and KEEP were both delivered to groups over 12-16 weeks, PMTO was delivered individually over 6-9 months and all targeted carers of the 4-12 years child age group. The KEEP interventions consistently found significant improvements in child behaviour using three different measures, the PDR, the SDQ and the CBCL. Two (IY-2; IY-3) of the four IY interventions found improvements in the intensity scale on the ECBI, but not the problem scale, whilst three studies (IY-1; IY+CoP; PMTO-1) failed to find significant improvements in child behaviour. There were no differences for carer stress in two studies (IY-1; KEEP-3). One study found an improvement but this was not maintained at second follow up (PMTO-1) and one study found improvements in carer stress using the PDR (KEEP-1). There were improvements in carer depression (IY-3) and parenting skills improved in one study (IY-CoP), but not in three others (IY-1; IY-3. PMTO-3), with Bywater et al., (2010; IY-3) finding that the control group also improved post intervention and concluding that the measure may not be appropriate for use with foster carers.

The adaptation of the Non Violent Resistance (NVR; Van Holen et al., 2016) programme for foster carers, included a broader and older age range of child participants than other programmes (aged 6-17 years) and reported significant reductions in child behaviour on all scales of the CBCL and reductions in some of the PSI scales.

Social learning theory plus attachment interventions.

Two interventions met criteria for this category, Fostering Changes (FC-1; Briskman et al., 2010) and Parent-Child Interaction Therapy (PCIT; PCIT-1; McNeil et al., 2005: PCIT-2; Mersky et al., 2015; 2016). Fostering changes had a similar format to the SLT based intervention (KEEP, PMTO & IY) and was delivered weekly to groups, over 12 sessions. PCIT was an adaptation of an individually focused clinic based programme, delivered over two days in a group format with varied amounts of follow up support. Improvements in child behaviour was found in all interventions (FC-1; PCIT-1; PCIT-2), including in an observational measure of behaviour (PCIT-2). There were improvements in carer stress (PCIT-2) and carer-child attachment relationship (FC-1) measured using a questionnaire (QUARQ).

Fidelity.

The two IY interventions that failed to find significant improvements in child behaviours were both adaptations of the programme format. Nilsen (2007; IY-1) delivered additional content as well as the core programme, over the same time frame and also used recently trained foster carers to co-deliver the programme. Linares et al., (2006; IY+CoP) delivered an adapted version, with additional content, to biological parents and foster carers to assess co-parenting, parenting skills and child behaviour. The failure to find significant improvements in outcome measures for IY-1 and IY+CoP, whereas the two studies that adhered to programme content (IY-2; IY-3) did find significant differences in outcomes, may indicate that programme fidelity and the level of programme leader experience and supervision are key factors in successful programme implementation.

KEEP studies investigated a number of different components of fidelity and reported improvements in placement stability for intervention groups, with results influenced by group engagement with higher engagement associated with increased stability. Factors influencing successful outcomes such as fewer reported child behavioural problems, include carer understanding of the skills taught in the programme, rather than number of sessions attended. One study found that lower rates of pre-intervention carer use of reinforcement, predicted the rate of improvements in child behavioural scores over time (Uretsky et al., 2017).

Conclusions

This scoping review examined peer reviewed research evaluating evidence based programmes delivered to foster and/or kinship foster carers since 2000, identifying seven training programmes evaluated in 15 different studies.

Recommended interventions for parents and carers of children with behavioural or attachment difficulties are based on behavioural models, that incorporate social learning principles to coach parents or carers in parenting skills. This review identified training programmes for foster or kinship foster carers that had some evidence of effectiveness in achieving the programme aims. All the identified programmes were parenting interventions, addressing parental skills in order to facilitate changes in child behaviour. The programme addressing attachment (ABC), did not measure attachment constructs using only a biological indicator for levels of stress, as being associated with attachment security. All other interventions used behavioural measures to identify changes in child behaviour after carers had attended the intervention. Whilst there was evidence that the attendance of caregivers on an intervention programme was followed by carer reported behavioural changes in the child, the evidence to support this being a result of changes in parenting skills was weak, with inconclusive results from a number of different parenting measures. Meta-analyses of fostering training literature concluded there is evidence that supports training of carers having an impact on carer knowledge and skills, and on child behaviour (Solomon, Niec, Schoonover, 2017; Uretsky & Hoffman, 2017), whilst also noting that there was insufficient evidence to support the theory that child problem behaviours are mediated by parenting skills (Uretsky & Hoffman, 2017). A later meta-analysis of IY programmes has found evidence that child behaviours are mediated by parent skills (Gardner et al., 2019).

Methodological issues have been found in previous reviews, with small sample sizes (Festinger & Baker, 2013; Solomon et al., 2017; Turner et al., 2007) and lack of a control group or use of a non-randomised control design (Solomon et al., 2017; Uretsky & Hoffman, 2017). In this review, six of the fifteen studies had a sample size of 50 intervention participants or less and only 50% used a RCT design. Previous reviews have also identified an over-reliance on self-report rather than independent outcome measures (Rork & McNeil, 2011; Solomon et al., 2017; Turner et al., 2007) and short follow-up times (Everson-Hock et al., 2012; Festinger & Baker, 2013; Rork & McNeil, 2011; Turner et al., 2007). The studies reviewed here also used predominantly self-report measures and short follow-up times.

The importance of fidelity, defined as how close programme delivery is to the original model, to successful implementation of a programme had been recognised (Eames et al., 2008; Gardner et al., 2010; Webster-Stratton et al., 2011). Fidelity is easier to obtain when

programmes have leader training programmes, programme manuals, course materials and built in supervision. Leader skills can influence outcomes and are part of fidelity if the mode of delivery is specified in the programme (Eames et al., 2009). Two of the Incredible Years © programmes reviewed here failed to find significant changes in outcome measures. Both studies added additional material into the existing course structure, with one study using recently trained foster carers to co-deliver the programme. The ability of leaders to engage with participants in setting and achieving realistic goals is a skilled role, more effectively undertaken by experienced and trained practitioners (Scott & Dadds, 2009; Webster-Stratton et al., 2011).

All of the programmes reviewed were multi-session, with most delivered over 8-12 weeks. Delivery over a longer period allows for more between session home practice, with increased learning opportunities through social learning and modelling (Bandura, 1977). Group based delivery provides opportunities for shared learning through group discussions and shared experiences and also social support (Webster-Stratton et al., 2011). Whilst group based interventions predominated, there were good results from interventions delivered on a one-to-one basis at home, an important consideration for carers if commitments make weekly group attendance difficult. There were no single session trainings found or reviewed here and previous reviews have indicated a lack of research and evidence for single session training (Dorsey et al., 2008; Festinger & Baker, 2013).

Most of the research was undertaken with foster rather than kinship foster carers and carers were primarily female, findings identified in previous reviews (Dorsey et al., 2008; Kinsey & Schlösser, 2013; Rork & McNeil, 2011; Uretsky & Hoffman, 2017). There is limited evidence to support the use of these interventions with male or with kinship foster carers, despite NICE guidelines recommending parenting interventions be attended by both partners where they are a couple. Finally, the majority of the studies were undertaken in the USA, with four in the UK and two in Europe. Parenting programmes have not always been effectively tested across different cultures, or ethnic groups (Baumann et al., 2015). A previous review found different results when studies undertaken in the USA are repeated in the UK, with less impact on child behaviour reported in the UK studies (Kinsey & Schlösser, 2013) indicating that it should not be assumed that interventions will successfully transfer between continents.

This review tentatively supports the view that programmes with an evidence base can be effective in addressing child behaviour problems by training foster carers, a finding supported by previous reviews that recommend the use of evidence based programmes with carers (Benesh & Cui, 2017; Dorsey et al., 2008; Rork & McNeil, 2011). However, the low

number of studies replicating research in the different evaluated programmes, the lack of research including males and kinship foster carers, the methodological gaps including low sample sizes and low use of, and randomisation of control groups, indicates a paucity of data on the effectiveness of training foster and kinship foster carers in parent training programmes.

Limitations

This review was limited to research published since 2000, only two databases were searched and only papers published in English were included. In addition, only programmes with previous evidence from an RCT with change on at least one outcome measure was included. This means that studies of other programmes that may be effective were excluded.

Future Research

Based on this review, suggestions for future research include the use of independent measures, such as observation, in addition to carer self-report. Exploration of the differing results for behavioural measures and how the measures compare in identifying change in a fostering population would be helpful, with measures such as the PDR consistently finding change in the KEEP intervention, whilst results from the CBCL were less consistent. Inconsistent findings may be related to the measures used, fidelity or other factors. The collection of follow up measures over longer periods would help to establish if changes are maintained over time. Attention to programme fidelity and how adherence to the programme is measured and reported, may help elucidate which aspects of the programme delivery are important in producing change outcomes. There appears to be very little research on kinship foster carers, or on the similarities or differences between the two types of carer with lack of kinship research noted by Dorsey et al., (2008) and Kinsey & Schlösser, (2013). Finally, there are only a relatively small number of studies undertaken in the UK, with the majority from the USA. More research on UK foster and kinship carers would confirm whether findings from the USA can be replicated with a UK population. As this review tentatively concludes that evidence-based interventions may be useful for foster and kinship carers, it would be helpful to understand what training programmes or interventions are offered to carers in the UK at present.

CHAPTER 4

Evaluation of Characteristics of Foster and Kinship Foster Carers and Children and Training Delivered in a Local Authority in Wales.

Introduction

In order to explore the characteristics of foster and kinship foster carers and the training offered and accessed that might have implications for their training needs, an evaluation was undertaken of foster and kinship foster (friends and family) carers within one local authority (LA) in Wales. The local authority had developed a training programme and wished to learn how the programme for 2016-17 had been received by foster and kinship foster carers. This provided an opportunity to explore what training was offered and what carers may need. The evaluation collected questionnaire data on the characteristics of a sample of foster and kinship foster carers and their looked after children and details of the training offered and accessed by the carers. This is discussed in terms of indications of unmet training needs.

The data are introduced and reported on in two sections. First, the characteristics of a sample of carers and their looked after children. Second, the general government guidance on the training of carers, a description of the local authority training programme and its goals with carer evaluations of the programme. The paper concludes with recommendations regarding support of foster and kinship foster carers based on the evidence presented.

Characteristics of carers and children looked after (CLA).

Looked after children often enter care with problems associated with previous neglect and maltreatment, with research indicating that 93% enter care having experienced maltreatment (Tarren-Sweeney, 2008; Welsh Government, 2019). These problems can continue whilst in care, with between 40 and 49% of looked after children aged 2-15 years experiencing mental health problems compared with 6 to 12% of the general population (Ford, Collishaw, Meltzer, & Goodman, 2007). Many traditional foster carers take up the role of carer for altruistic reasons, to help and make a difference to children in need (Lawson & Cann, 2019; Rodger et al., 2006), yet they can be unprepared to cope with behaviours that include lack of empathy, self-harming or harming others, that are outside their previous experiences (Murray et al., 2011). Children in care can display a range of socialisation, mental health and problems related to self-esteem, including clinical levels of psychiatric disorders. The most prevalent problems occur in the categories of attention problems, and oppositional or conduct behavioural disorders (Ford, Collishaw, et al., 2007; Tarren-Sweeney & Hazell, 2005). In addition to behavioural problems, high levels of social and interpersonal relationship difficulties associated with attachment problems were found among children in care (n=347) with high levels anxiety related to insecurity also found (Tarren-Sweeney, 2013).

The burden of care and consequences of instability.

Caring for children with complex emotional, behavioural and interpersonal difficulties can be a burden to those who care for them, (Murray et al., 2011) that is only manageable through high levels of support. Foster carer and kinship foster carers operate in a complex environment where they care for children many of whom have high needs, yet for whom parental responsibility remains with, or is shared between biological parents and a local authority. To demonstrate competence to care for looked after children carers undergo a high level of scrutiny from social services and associated professionals. This necessitates maintaining good relationships with the social worker responsible for the child and the carer's social worker, often whilst also managing relationships between children and birth parents.

Traditional foster carers differ from parents in that, if their experience of caring becomes too difficult, they are able to either terminate the placement by requesting the local authority to remove a particular child, or decide to stop fostering altogether. These options are an essential safety net for foster carers. Kinship foster carers also have these options, however are less likely to terminate a placement (Font, 2015). Levels of strain on foster carers have been found to affect their parenting practices, and in turn influence placement outcomes. Negative effects for carers have been found for both external stressors and factors linked to the placement, such as problematic and challenging behaviours, family contact difficulties and problems contacting social workers (Farmer et al., 2005; Farmer & Moyers, 2008). Difficulty in recruiting adequate numbers of foster carers has been ongoing for over a decade (Nutt, 2006), making matching children to suitable placements challenging. Numbers of children in care in Wales rose from 4,635 in 2008 to 6,405 in 2018, a 32% increase over the period. With rising numbers of children entering care (Welsh Government, 2019) and changes in legislation meaning children can stay on in placement until aged 21 should they chose to do so, recruitment and retention of foster carers is an issue. Between 2017 and 2018 that there was a 1% reduction in number of fostering households in England, which represented a 5% reduction in available fostering places due to increasing numbers of children and young people in care (OFSTED, 2019).

Children may move placements in a planned way in order to return home, move to adoption or long-term placement. They can also be unplanned at the request of the child, the carer or the local authority. In the English and Welsh regions of the UK 10% (7,890 England, 630 Wales) of children in care experienced three or more moves during one reporting year, 2017-2018 (Department for Education, 2018; Welsh Government, 2019). Placement stability is associated with better outcomes for CLA with children who experience fewer placement

moves doing better educationally (Luke, Sinclair, & Sebba, 2014) and having better mental health (Ford, Vostanis, et al., 2007). In turn, instability is associated with educational, judicial and health disadvantages (Jones, 2012) and with increased problematic behaviours (Tarren-Sweeney, 2008). UK government statistics for England (Department for Education, 2018) indicate that 36% of placement endings were unplanned, or not due to care planning or a change in placement status (for example changing from a short to long-term placement). The majority (65%) of these moves were a result of a request by the carer for the child to be removed, with child behaviour cited as the reason in 45% of cases.

Carer support is critical for good outcomes.

Placement disruptions can occur because of child factors, such as behavioural problems, and carer factors that include parenting style and carer stressors (Farmer et al., 2005; García-Martín, Salas, Bernedo, & Fuentes, 2015). Parenting style has been shown to be associated with child behavioural problems with critical and punitive parenting behaviours combined with low warmth, linked to child conduct disorders (Morgan et al., 2015). In a UK survey of 58 foster carers, higher levels of behavioural problems are associated with elevated levels of carer stress ($r=.69$, $p<.01$) (Morgan & Baron, 2011). There are also indications that foster carers experience higher levels of stress in response to challenging behaviour than parents do (Vanschoonlandt, Vanderfaeillie, Van Holen, De Maeyer, & Robberechts, 2013), with adaptive responses to stress by carers including less involvement in positive parenting. This is likely to be counterproductive, as increasing positive parenting in response to challenging behaviour has repeatedly been shown to be an effective strategy in reducing problem behaviours (Bywater et al., 2009; Hutchings, Bywater, Williams, & Shakespeare, 2006; Roberts et al., 2016).

Carer characteristics linked with positive outcomes include acceptance of help, emotional resilience, being flexible but firm, warm and child-orientated and able to communicate openly (Sinclair & Wilson, 2003; Social Services Improvement Agency, 2011). Carers subject to repeated, ongoing and multiple stressors are at risk of compassion fatigue (Hannah & Woolgar, 2018). A study of placement success and disruptions indicated the importance of early intervention if carer-child relationships start to develop into negative interactions. Recommendations included the use of behavioural or social learning theory based interventions to help carers to manage difficult child behaviour, which may otherwise lead to placement termination (Sinclair & Wilson, 2003). Indications are that training needs to be delivered before problems escalate, as by the time the placement reaches breaking point carers indicate that they need urgent and practical responses that do not include training, to manage the crisis (Gilbertson, 2003). Carers who receive lower levels of training and support

are more likely to leave fostering than those who are happy with levels of support and training (Rhodes et al., 2001). The Quality Protects report (Department of Health, 1998) found good quality training and support was associated with improved stability and better outcomes for children looked after in the UK. Support for carers that encourages and supports autonomy has been shown to enhance carers' sense of competency in their ability to cope with challenging situations, whilst evidence based and multi-disciplinary placement support for both carers and children looked after is a critical factor in lowering strain and increasing positive outcomes (Farmer et al., 2005; Rushton & Dance, 2002). Carers should have good support networks that include a comprehensive training programme that facilitates their management of complex emotional and behavioural problems. Support for carers to parent competently when faced with emotional and behavioural challenges may reduce levels of stress, that otherwise undermine their ability to continue within the role.

Foster and kinship foster carer training requirements – Wales.

Social care is devolved regionally in the UK, resulting in different regulations and requirements for fostering services between countries. Fostering services in Wales abide by the current regulatory framework and are held accountable by the Care Inspectorate Wales. The regulatory framework detail the management, conduct and standards for fostering agencies, the approval and training of foster carers and roles and responsibilities when placing children. All 22 local authority (LA) and the 23 independent fostering agencies (IFA) operating in Wales (Care Inspectorate Wales, 2019a) are inspected at a minimum of every four years to assess performance, more frequently if necessary. Inspection reports are published on the Care Inspectorate Wales website.

Foster carers are recruited by local authorities and by independent fostering agencies and undergo a comprehensive assessment process prior to being approved to foster and having looked after children placed with them. There are two types of carers, traditional or stranger foster carers who are not known to the child prior to placement, and carers who are friends of, or related to, the child and known as kinship foster carers. Both types of carers undergo assessment, but kinship foster carers differ in that children may be placed with them subject to, but prior to, the approval to foster process being completed. Kinship foster carers are identified and approved by local authorities when children who are subject to a care order, or interim care order are placed with them. In Wales, the majority of fostered children are placed with carers approved by the local authority, with 47% (*n* = 2,200) placed with foster and 25% (*n* = 1,200) with kinship foster carers. The remaining 28% (*n* = 1320) of children are placed with foster carers with independent fostering agencies (Welsh Government, 2019). Once approved, carers receive an annual review for which re-

approval by their agency fostering panel is required to enable them to continue fostering. In Wales there is no mandatory training pathway identifying necessary skills for carers, with the national minimum standards (2003) providing general guidelines for training. Within the standards, there is an expectation that all carers receive induction training. In Wales the induction training programme 'Skills to Foster' developed and run by the Fostering Network has been adopted by both local authorities and independent fostering agencies. This is attended by all carers as part of the assessment for approval process. Skills to Foster is a three-day course covering child development and problems, team working and safer caring and includes opportunities to meet approved carers and children who have been in the care system. The course also provides the opportunity to evidence carer skills, necessary as part of the pre-approval assessment, with social workers attending the course alongside potential carers.

The National Minimum Standards (2003) recommend training that ensures the best possible outcomes for children in care, by providing carers with the skills required to provide high quality care to meet the needs of the children that they care for (Welsh Assembly Government, 2003). However, there is little detail about what type of training may be required in order to do so. Whilst the national minimum standards are advisory, fostering services are expected to meet or exceed minimum guidelines and the Care Inspectorate Wales considers compliance during statutory inspections. Training topics which the standards reference include; health and safety, valuing diversity, safe caring skills, managing behaviour and recognising abuse, promoting contact, listening to the child's views, first aid, health and hygiene, moving on from care and recording life events. Fostering services are expected to review and evaluate their training programme annually. Carers should maintain a portfolio of training undertaken post-approval, with training needs appraised and documented as part of their annual review. The support and training needs of kinship foster carers should be assessed and met in the same way as for any other carer (National Assembly for Wales, 2003; Welsh Assembly Government, 2003).

All Local Authorities (LA) and Independent Fostering Agencies (IFA) in Wales produce their own training programmes against the guidance in the national minimum standards (2003). A previous evaluation investigated UK foster carer training and support with a series of interviews with 21 fostering services, focus groups and a survey of 1,181 foster carers working for them (Ogilvie et al., 2006). A programme of post-approval training for carers was provided by 15 services, with a further two services reporting ad hoc training. Training was attended by 79% of surveyed carers with 41% indicating that they attended four or more training events a year. Focus group feedback indicated that the more experienced carers were requesting both progressive and specialist training programmes.

Research on training delivered to foster carers tends to focus on multi-session interventions, teaching skills based on behavioural or social learning theory (Benesh & Cui, 2017; Uretsky & Hoffman, 2017). However, multi-session skills based interventions may not be representative of the training that fostering agencies actually offer to carers (Dorsey et al., 2008; Festinger & Baker, 2013), with many training programmes consisting of half or one day sessions (Ogilvie, 2019). The foster care network produces a state of the nation biennial survey of foster carers with the 2019 report (Lawson & Cann, 2019) surveying 4,037 foster and kinship foster carers. Eighty-six percent of carers reported that training helped with fostering and the top five subject gaps carers identified were; therapeutic parenting, behaviour management, mental health, specialised first aid and attachment. It is noticeable that the gaps in training identified by carers are, with the exception of first aid, all related to theory or skills based approaches associated with the management of children's behavioural needs.

Aims of This Study

With no national framework for training for foster and kinship foster carers in Wales, fostering services rely on the generic guidance within the national minimum standards to determine what training to provide. Foster and kinship foster carers need support and training to effectively care for the children placed with them and effectively managing challenging child behaviour is important for both carers and children. Fostering services have a duty to provide resources to support carers in their role, however, there is no routine assessment of carer or child mental health undertaken in Wales to inform support needed. Carers identify training needs as part of their annual review process, with service providers determining training programme content based on carer requests, or what the service can provide. There are no requirements within the fostering regulations or national minimum standards that recommend use of evidence based training. There is a lack of information and clarity on what training is being provided to foster carers in Wales, or how closely the training offered reflects the challenges that carer's experience. Study one, reported here, collects data on a training programme delivered by one local authority to its foster and kinship foster carers, to investigate what training is offered and what the needs of the carers and children they care for may be.

Given that levels of carer stress and child problematic behaviour are both indicators of risk for placement instability, the present study uses two measures, one of carer stress and one of child socio-emotional behaviour in order to explore carer and child needs for support. A training evaluation questionnaire was created by the researcher, based on the

courses the authority offered to carers allowing carers to rate the quality and usefulness of the training programmes attended.

The research questions in relation to carer and looked after child need for support were:

1. What levels of stress do carers report in caring for children looked after?
2. What levels of socio-emotional and problem behaviour do carers report in the children and young people they care for?
3. Are there differences between kinship and foster carers reports of carer stress or child behaviour?
4. What training is offered?
5. What training is accessed by carers and how do they rate it?

The results are discussed in terms of the implications for training requirements

Methods

Procedures

The study was undertaken between April 2017 and March 2018. Participants were foster or kinship foster carers approved by the local authority to look after children determined to be in need of care. A letter was sent to all carers in the authority by social services explaining that the authority was asking carers to undertake a survey being conducted by a researcher at Bangor University. The researcher would evaluate the results and provide anonymous whole group feedback to the Authority. Participants were asked to sign a consent form (appendix B) and complete a Parent Stress Index (Abidin, 2012), a Strengths and Difficulties Questionnaire (R. Goodman, 1997) for each child in their care and a training questionnaire, to report on what training they had undertaken with ratings of the quality and usefulness of the training attended.

Ethical approval was obtained from the Ethics and Research Committee, School of Psychology, Bangor University, application number 2017-16086

Measures

The Parent Stress Index (PSI-SF) (Abidin, 2012) is a standardised and validated measure and has been used extensively in previous research including with foster carers in evaluating the outcome of training interventions (Maaskant et al., 2017; Nilsen, 2007). PSI-SF is validated for use with parents or carers of children aged 1 month to 12 years. It has a total stress score and three subscales, Parental distress (PD), Parent-Child Dysfunctional

Interaction (P-CDI) and Difficult Child (DC). Total scores of 114 and above indicate clinically significant levels of stress with PD and DC subscale scores over 39 and P-CDI subscale scores over 36 indicating likely clinical significance (see appendix L).

The Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997) is a standardised and validated screening measure (Goodman, Ford, Corbin, & Meltzer, 2004) that has been used extensively in previous research Including with foster carers in evaluating the outcome of a training intervention (Bywater et al., 2011; Roberts et al., 2016). The SDQ is a carer or parent report measure for use with children aged 2-17. The measure reports a total difficulties score and five sub-scales, each comprising five questions, four subscales are problem focused, emotional symptoms, conduct problems, hyperactivity/inattention and peer relationship problems. These are summed to provide a total difficulties score and a further subscale reports on prosocial behaviour. The measure is completed by selecting one of three responses; not true, somewhat true or certainly true. In this study, the total difficulties score (combined scores of four subscales) is reported, individual subscales and the prosocial subscale are not reported. This is to enable comparisons with other data, which also only report the combined total difficulties score. Total difficulties scores range from 0-40 with scores between 14 and 16 categorised as borderline, and between 17 and 40 in the abnormal range. In England local authorities are mandated under Section 7 of the Local Authority Social Services Act 1970 to report on child behaviour, using the SDQ (Goodman, 1997), on all CLA aged between, and inclusive of, 4-16 years in their annual returns to the UK Government. To fulfil this requirement carers are routinely asked to complete SDQ measures for children in their care. Using the SDQ in the current LA survey meant it would be possible to make comparisons with English findings, as well as establishing a pattern of social, emotional and behavioural needs of CLA within the LA (see appendix L).

Information from the LA training policy document, detailing all training programmes offered to carers, was used to create the training survey. The 42 training courses offered during the previous year were listed and carers were asked to identify whether they had attended the courses using a yes or no response. For each course that they had attended, they were asked to rate the quality of the training on a three point scale of 1=poor, 2= ok or 3= excellent. They were also asked to rate the usefulness of the training to them on a three point scale of 1= not useful, 2= a bit useful, 3= very useful. Results were entered into a spreadsheet recording attendance and ratings for each participant and course attended.

Missing Data and Evaluation

Where two carers were approved in one household, both completed the PSI-SF but only the primary carer for each looked after child was asked to complete the Strengths and Difficulties Questionnaire. Once completed, measures were sent to the researcher by the LA, or posted directly by the carer to the researcher

The LA followed up carers who did not return measures by phone, and then with the offer of a visit by the researcher to assist with completion of the measures. Four households were visited by the researcher for this reason. The local authority provided numbers, gender and age of CLA and numbers and type of carers who did not participate.

Scoring for the PSI-SF and SDQ was undertaken as per the publisher's manual. Item data missing from returned PSI-SF and SDQ measures was managed as per the publisher's manual. The training survey was scored with a yes/no for attendance and a rating of good/poor for quality and usefulness.

Statistical Analysis

Initial data analysis was undertaken using Microsoft excel. SPSS version 22 using paired sample t-tests to establish if there were statistically significant differences between the foster and kinship groups for the PSI-SF and SDQ measures.

Results

Characteristics of Foster and Kinship Foster Carers

In total, the local authority had 57 carers comprising 34 foster and 23 kinship foster carers. Thirty-seven (65%) carers (15 male, 22 female) participated, representing 23 fostering households. This comprised 12 fostering households with 19 carers (8 male, 11 female), 56% of all foster carers and 11 kinship foster households with 18 carers (7 male, 11 female) 78% of all kinship foster carers; (Table 4.1). One fostering household offered respite placements only and did not have a child placed with them.

Table 4.1. All surveyed local authority carer characteristics

Demographics	**All (n=57)**	**Foster (*n*=34)**	**Kinship (*n*=23)**
Number: *n (%*)	37 (65%)*	19 (56%)*	18 (78%)*
Male: *n*	15	8	7
Female: *n*	22	11	11
Age: *M (SD)*	55.62 (10.99)	56.68 (11.79)	54.50 (10.30)
Age - male: *M (SD)*	60.20 (11.15)	60.88 (12.53)	59.43 (10.78)
Age - female: *M (SD)*	52.50 (9.95)	53.64 (10.77)	51.36 (9.44)

*=Percentage of total carer population

The local authority provided numbers, gender and ages of children looked after and numbers and type of carers who did not participate. A greater proportion of kinship foster carers (78%) participated than foster carers (56%), with participating kinship foster carers caring for 79% of looked after children in their placements and participating foster carers caring for 58% of the children in their placements.

Characteristics of Children Looked After (CLA)

Twenty-four participants who were the primary carers for the children looked after, reported on thirty (67%) of the 45 looked after children and young people placed with local authority carers (CLA; 19 male, 11 female), from 22 households. Fifteen children looked after were in 11 foster placements (8 male, 7 female) represented 58% of fostered children and 15, representing 79% of kinship cared for children were in 11 placements (11 male, 4 female; Table 4.2).

Table 4.2. All surveyed looked after child characteristics

	All (n=45)	**Fostered (*n*=26)**	**Kinship (*n*=19)**
Number: *n (%*)	30 (67)	15 (58)	15 (79)
Male: *n*	19	8	11
Female: *n*	11	7	4
Age: *M (SD)*	10.8 (4.20)	12.27 (3.83)	9.33 (4.15)
Age (range)	4-18	5-13	4-16

Summary of Results

Group mean PSI-SF scores were in the normal range, indicating that overall carers reported normal levels of stress (table 3). The total difficulties SDQ mean score (*M*=17.45 *SD*=5.21) for the whole sample was within the abnormal range of 17-40, with 57% of children (*n*=17) scoring within this range, indicating that overall carers reported the children they cared for had significant behavioural problems (table 4.3).

Table 4.3. Local Authority Survey PSI-SF and SDQ results

Measures (Clinical cut off score)	**All. *M (SD)***
***Parent Stress Index (PSI-SF)* (*n*=37)**	
PSI-4-SF Total (114)	79.46 (22.11)
***Strengths and Difficulties Questionnaire (SDQ)* (*n*=30)**	
SDQ Total Difficulties (17)	17.43 (5.21)

The numbers of carers reporting stress levels on the PSI-SF in the elevated or high range was 14% (*n=5)* (Table 4.4).

Table 4.4. Local authority survey PSI-SF percentile bands

Measures	Low	Normal	Elevated	High
	N (%)	*N (%)*	*N (%)*	*N (%)*
All (n=37)				
PSI-4-SF Total	6 (16)	26 (70)	4 (11)	1 (3)

The percentage of carers in England (Department for Education, 2018) reporting children in the abnormal range on the SDQ was lower (39%) than for this sample (57%), with more carers in England (49%) reporting CLA in the normal range, than in this sample (33%) (Table 4.5).

Table 4.5. Local authority survey SDQ comparison with England

	All	England
(SDQ band range)	**(n=30) (*n*)**	**(*n*=38,010)**
Normal range (0-13)	(10) 33%	(15,040) 49%
Borderline (14-16)	(3) 10%	(3,830) 12%
Abnormal (17-40)	(17) 57%	(11,850) 39%

Within Group Results

T-tests showed differences between the foster and kinship foster carer mean scores on the PSI-SF. For the total score, foster carers had a statistically significantly higher score than kinship foster carers $t(36)=2.49$ $p=.018$, $d=.08$, indicating that foster carers ($M=87.68$ $SD=19.45$) were reporting higher levels of stress than kinship foster carers ($M=70.78$ $SD=21.89$). Cohen's d effect size for this difference ($d=.08$) was smaller than .2, indicating this difference is trivial.

The mean total difficulties SDQ scores for children looked after by foster carers ($M=17.87$ $SD=4.53$) and for kinship foster carers ($M=17.00$ SD 5.94) were both within the abnormal range (table 4.6).

Table 4.6. Foster and kinship PSI-SF and SDQ results.

Measures (Clinical cut off score)	Foster	Kinship	T-test	
	M (SD)	*M (SD)*	*t*	*p*
Parent Stress Index (PSI-SF)	**(*n*=19)**	**(*n*=18)**		
PSI-4-SF Total (114)	87.68 (19.45)	70.78 (21.89)	2.49	.018*
Strengths and Difficulties Questionnaire (SDQ)	**(*n*=15)**	**(*n*=15)**		
SDQ Total Difficulties (17)	17.87 (4.53)	17.00 (5.94)	0.45	.657

**=p<.05*

The results in table 4.7 show that 73% of CLA in foster care and 60% in kinship foster care from this sample are reported by their primary carer as having problematic behaviour in either the borderline or abnormal range.

Table 4.7. Foster and kinship SDQ total difficulties results.

	Foster (*n*=15)	**Kinship (*n*=15)**
(band range)	***n* (%)**	***n* (%)**
Normal range (0-13)	4 (27)	6 (40)
Borderline (14-16)	2 (13)	1 (7)
Abnormal (17-40)	9 (60)	8 (53)

Training Evaluation by Foster and Kinship Foster Carers

Local authority training programme.

The local authority provided a copy of their training policy, containing the titles of training courses offered to carers and their expectations for foster and kinship foster carers attending training. The programme is detailed in Table 4.8 and is progressive from level 1 (pre-approval) to level 3 plus additional and optional training. The local authority used the Fostering Network 'skills to foster' training course as pre-approval training, as the carers surveyed were all approved carers who had children placed with them, the pre-approval 'skills to foster' course was not included in this evaluation.

All trainings were one session either full or part-day training, with the exception of a three day nutrition course. The level 2 induction programme comprised eleven courses, six of which were based on a manualised training series by the fostering network. The remaining five induction courses included the topics of safeguarding, recording, first aid, blood borne viruses and a safe and positive behaviour induction. These courses map to the national minimum standards (2003) recommended topics, with the exception of health and safety, valuing diversity, listening to the child and moving on, recommended in the standards and not included in this induction. However, as the content of the training courses was not considered for this evaluation, it is not possible to know whether these subjects were included within other topics, or not covered. Foster and kinship foster carers were expected to complete level 2 induction training within 18-24 months of approval. Level 3 training is linked to individual carer needs identified in their annual training plan and included topics such as looked after child reviews, secure base (attachment) and working with birth families. First aid was to be repeated annually and a safe and positive behaviour annual refresher. Safe caring and safeguarding was to be repeated every three years. Other training topics were provided as one off training set up for all local authority staff but also available to foster and kinship foster carers.

Table 4.8. Local authority training and expectations

Level 1 Pre Approval	***Foster - Mandatory prior to approval. Kinship - ASAP before or after approval***
Skills to foster	
Level 2 Induction / basic training	***Complete within 18-24 months of approval***
Safe Caring (FN Pathways)	Repeat every three years
Attachment (FN Pathways)	
Health (FN Pathways)	
Contact (FN Pathways))	
Behaviour (FN Pathways)	
Education (FN Pathways)	
Safeguarding	Repeat every three years
Recording	Repeat every five years
Safe & positive Behaviour Induction	Annual refresher course required
First aid & Paediatric FA	Repeat Annually
Blood Borne Viruses	
Level 3 Further	***Need identified via annual training plan***
Child Development	
Fostering Teenagers	
CLA reviews	
Parenting teenagers	
Safe Care Level 2	
Secure Base	
Social Media and the internet	
Working with birth families	
Other	***Optional courses that may be offered.***
Introduction to the Social Services and wellbeing act (Wales) 2014	
Attachment based parenting	
Caring for children in the long term	
Contact in permanent foster placements	
Dealing with drugs in foster care	
Diabetes	
Five to Thrive	
Foetal Alcohol Syndrome	
Life Story Work	
Managing allegations	
Managing Risky Behaviour	
Nutrition	
Nutrition 3 days	
Online safety workshop	
Sexually harmful behaviour	
Siblings together or apart	
The Child's World (Scott King)	
When I'm Ready	
Youth Mental Health First aid	

FN = Fostering Network; FA = First Aid

The courses were grouped into groups of training type, each containing a number of courses, for example ‘L2 induction’, contained 11 different courses. The total number of attendances of carers per course group were then counted, with the percentage attendance calculated from the maximum possible number of attendances per group of courses. This data is reported in table 4.9.

Thirty of the 37 carers (81%) who completed the two standardised measures also completed the training questionnaire (15 foster, 15 kinship foster carers). The induction courses had been attended by 54% (178 attendances on 11 courses) of carers (76% foster and 32% kinship). The quality of the induction programme was rated as good by 95% (169 rated good on 11 courses) of carers. The usefulness was rated as good by 74% (132 rated on 11 courses) of all attending carers, foster carers (90%) and kinship foster carers (42%).

Of the post-registration training the highest attendance was on refresher training courses, with 37% (33 attendances on 3 courses) of all carers (60% foster and 13% kinship) attending. The quality of refresher training was rated as good by 100% (33 attendances for 3 courses) of carers. The usefulness was rated as good by 82% (27 ratings for 3 courses) of carers with a difference between foster carer ratings (85%) and kinship foster carer ratings (67%).

Level 3 – further courses were attended by 30% (63 attendances on 8 course) of the participants, quality was rated as good by 83% (52 ratings for 8 courses) and usefulness by 70% (44 ratings for 8 courses) of attending carers.

The other courses were attended by the lowest number of participants with 21% (127 attendances for 19 courses) attending these courses. Of those that did attend, 86% (109 ratings for 19 courses) rated the quality as good and 77% (98 ratings for 19 courses) rated the usefulness as good (Table 4.9).

Table 4.9. Local authority training course survey results.

			Quality	Usefulness
Type of training ***(number of courses)***	**No. Grouped attendances.** ***n* (%)**	**Average attend.**	**No. Ratings of Good (%)** ***n* (%)**	**No. Ratings of Good (%)** ***n* (%)**
All (*n*=30)				
L2 Induction *(11)*	178 (54)	16	169 (95)	132 (74)
L3 Further *(8)*	63 (30)	9	52 (83)	44 (70)
Refresher *(3)*	33 (37)	11	33 (100)	27 (82)
Other *(19)*	127 (21)	6	109 (86)	98 (77)

Foster (*n*=15)				
L2 Induction *(11)*	126 (76)	11	123 (98)	111 (90)
L3 Further *(8)*	50 (24)	7	42 (84)	37 (74)
Refresher *(3)*	27 (60)	9	27 (100)	23 (85)
Other (19)	109 (36)	5	94 (86)	89 (82)
Kinship *(n*=15)				
L2 Induction *(11*)	53 (32)	5	47 (89)	22 (42)
L3 Further *(8)*	14 (4)	1	11 (79)	8 (57)
Refresher *(3)*	6 (13)	2	6 (100)	4 (67)
Other *(19)*	18 (6)	1	15 (83)	9 (50)

Note: Participation has been calculated by counting number of participants within each group of courses,

The quality of courses was rated as good by at least 79% of participants, with refresher courses being rated as good by 100% of the participants who had attended them. The usefulness of the training was generally reported as lower than quality, with less than half (42%) of kinship participating attendees rating the induction courses as useful.

Discussion

The LA provided a series of training programmes, that included an induction programme all carers were expected to complete, further training accessed according to carer need, refresher courses for core induction topics and a set of additional and optional training courses. The mean participant attendance for all courses was 36%, with an average attendance of 11. Foster carers had a mean attendance of 49% with an average of 16 per course and kinship foster carers had a mean attendance of 14% with an average of 2 per course. There were differences between the kinship and foster carer groups in terms of numbers of courses attended, with foster carers attending more than kinship. However, given differences in the length of time that the carers and kinship foster carers had been registered, their training need might be expected to be different and it is not known how many of the carers had accessed these course in earlier years. Of the participating carers who attended training, 91% rated the quality of training good and 75% rated the usefulness of the training as good.

The mean PSI-SF scores for the whole group (M=79.46, SD=22.11) and for foster and kinship foster carers were in the non-clinical range with 14% (11% in the borderline and 3% in the clinical ranges) of the total sample. A UK evaluation of 58 foster carers reported PSI-SF scores of 46% in the normal, 14% in the borderline and 40% in the clinical ranges (Morgan & Baron, 2011). Participants in the Morgan et al (2011) study were not local authority carers, but registered with a national independent fostering agency and so may not

be comparable. Mean PSI-SF scores obtained here are similar to mean scores of 18 foster carers who participated in an Incredible Years© evaluation in the USA (Nilsen, 2007) where the total mean score at baseline (*M*=82.91 *SD*=14.54) is similar to the total mean score found in this evaluation (*M*=79.46 *SD*=22.11).

Looked After Child Behaviour Discussion

The mean total SDQ score of 17.43 for child behaviour problems was in the clinical range (17-40) indicating that carers were reporting significant problems for the children that they look after. This is higher than the mean SDQ score of 14.1 reported by carers of 39,590 children looked after in England (Department for Education, 2018). Carers reported 67% of children looked after in the border line and abnormal range of the SDQ, with 73% of children looked after with foster carers and 60% of children looked after with kinship foster carers reported as having abnormal range scores, results that are comparable with findings by Morgan et al (2011) that 77% children looked after measured in the borderline and abnormal range on the SDQ. These reports are higher than findings reporting high levels of psychiatric disorders within the looked after child population in the UK (Ford, Vostanis, et al., 2007) compared to the general population. In a sample of 1,542 children, 46.4% of children looked after in local authority care were assessed with a psychiatric disorder using the Development and Wellbeing Assessment (DAWBA; Goodman, Heiervang, Collishaw, & Goodman, 2011). The SDQ is a screening tool and part of the DAWBA series, with SDQ population norms taken from the same data set as the Ford et al, (2007) data. Results from this evaluation broadly parallel findings by (Ford, Collishaw, et al., 2007) demonstrating that children and young people looked after have significant socio-emotional and behavioural problems, of which conduct disorders make up a large part. The similarities in the reported levels of behaviour problems found between kinship and foster carers in the Ford, Vostanis, et al., (2007) study is not consistent with a systematic review of 102 studies (Winokur, Holtan, & Ke, 2014), that indicates children in kinship foster care experience fewer behavioural problems, mental health disorders, less placement disruption and better well-being than children placed in non-kinship care and can have better outcomes than children in foster care (Winokur, Holtan, & Ke, 2014). The similarities in child behaviour findings between foster and kinship foster carers in the present study, may be due to the small sample size. Findings may also be influenced by the length of time the children have been in care, with longer time in care being a significant predictor of mental health problems (Tarren-Sweeney, 2008). There is insufficient information regarding length of time in care for this sample to be able to draw any conclusions. Further research and a bigger sample could investigate similarities and differences between children in foster and kinship foster placements.

Carer Training Discussion

Participating carers reported that the training that they attended was of good quality and useful, reporting high levels of satisfaction. The finding is consistent with the literature that carers generally rate the training they receive as good; Ogilvie, Kirton and Beecham (2006) reported that 68% of the carers they surveyed and who attended training rated it good or very good. In this study, the sample comprised 65% of the local authority approved foster and kinship foster carers and so may not have been representative of all carers. It is also possible that the training programme was a newly introduced requirement by the local authority, more information regarding how long the programme had been offered would clarify this. The local authority training programme included most of the topics that the national minimum standards for fostering services, Wales (2003) advised that carers should be trained in, such as safe caring skills, managing behaviour, promoting contact, first aid, recording and health and safety but it was not clear to what extent the managing behaviour component included specific parenting or child management training

How Well Does Training Meet Carer and Child Needs?

In the current study, the training delivered to the carers appeared to meet the requirements of the national minimum standards for fostering services (2003). However, much of the training recommended in the standards addresses the administrative side of fostering, including health and safety, reporting and safeguarding. Attachment and behaviour were both included in the local authority induction-training programme and the topic of managing behaviour is included in the minimum standards. The standards do not specify or recommend use of evidence based training and it is unclear what training programme content would be required to achieve best practice.

This evaluation investigated the characteristics of carers and the children that they look after in terms of carer stress and child behavioural difficulties and the training delivered to local authority foster and kinship foster carers. Carers mostly reported normal levels of stress but high levels of child problem behaviours. Research shows links between carer stress and child problem behaviours (García-Martín et al., 2015), with Morgan & Baron (2011) finding a significant positive association between challenging behaviour and parental stress. With SDQ total scores in the abnormal range, it would appear that training for carers on managing problematic behaviours might be helpful to avoid placement breakdown and all of its challenges in terms of looked after child outcomes.

A meta-analysis of 15 studies on the impact of training for foster carers on parenting skills and child disruptive behaviour found a small mean effect size (-.20) showing that carers attending training reported fewer child behaviour problems (Solomon et al., 2017).

The studies reported in the meta-analysis were mainly group-based, multi-session programmes covering multiple subjects and may not be representative of training delivered to most foster carers. An earlier review by Dorsey et al, (2008) notes that training programmes most frequently used with foster carers in the USA had no empirical evidence to demonstrate whether they were effective, whilst a review of foster carer training by Rork and McNeil (2011) argued for the incorporation of evidence based training for behavioural problems in foster care training programmes. Consultations with carers on what training they would like, indicated that carers were requesting support for managing child behaviour and mental health difficulties (Lawson & Cann, 2019; Murray et al., 2011).

Limitations

The small sample size in this study means that results should be interpreted with caution and may not generalise to wider populations. This is particularly the case where results for foster and kinship foster carers are reported separately since the foster carer sample represented only 56% of that population so may not be representative of all of the carers from the authority. This was the first evaluation with foster and kinship foster carers and a follow up study would help to establish the accuracy of the findings. The study could also be extended to include local authority looked after children placed by the same authority with carers in independent fostering agencies. Follow-up studies may need to visit carers to improve participation rates. Future research would benefit from more information, including demographics for carer and children such as the length of time that the child has been placed, number of prior placements, reasons for entry into care and details in relation to the child's care plan.

The training survey would have benefited from a review of the content of the programmes. The rating scale could be developed to collect more detail on programme content and be supplemented by interview to determine whether trainings are skills or theory based. Information on what training carers had accessed in previous years and what training needs carers themselves identify would give a more informed picture of training needs. Carer factors including how long carers had been approved, previous learning or skills related to employment would be helpful in establishing a fuller picture of the carer population. Examination of any possible links between training attended, carer stress and child behaviour would help to inform the effectiveness of training programmes in giving carers the skills needed to manage any emotional and behavioural problems that they experience.

Future Research

Future research to investigate the content and aims of training provided to foster carers would inform whether training is information or skills based and whether there is evidence that delivered training meets its stated aims. Evaluation to determine whether training is effective when delivered to foster or kinship foster carers, either through acquisition of knowledge or skills would help determine usefulness of training. Given that carers report high levels of behavioural problems, investigation of carer strategies for managing behaviour would help to inform specific training needs. Input from both social workers supporting the carers and the children, could contribute information on what training would support carers to be effective in their role.

Conclusion

This research aim was to evaluate carer stress and carer reports on the socio-emotional and behavioural challenges of the cared for children. A survey of carer attendance at, and satisfaction with, the programme of training delivered by the local authority was also undertaken. Approved foster and kinship foster carers were recruited for the study, by the local authority with 65% of carers participating. Carers reported their own stress levels as being within the normal range, whilst also reporting high levels of emotional and conduct problems with the children that they look after. Recommended interventions for problem behaviour include multi-session, group based parenting programmes based on behavioural or social learning theory. Such interventions evaluated with foster carers have been found to be effective in demonstrating child behavioural improvements (Bywater et al., 2011; McDaniel et al., 2011). Carers liked the training they received and reported it as useful. There was no evidence that the training that carers were being offered was evidence based, or made use of recommended interventions for skills to manage problem behaviour. When research shows that children looked after have high levels of behavioural problems and carers are requesting support for managing these problems, it is a serious omission that training programmes offered to foster carers do not use evidence based programmes to promote behaviour management skills.

CHAPTER 5

Baseline Differences Between Foster and Kinship Foster Carers who Enrolled on a Parent-training Programme.

Introduction

This chapter reports on study two, a comparison of the baseline characteristics of foster carers and kinship foster carers who enrolled on an Incredible Years© (IY) parent training programme run by the same local authority reported on in study one and situated in Wales. Some participants participated in both study one and study two, however the two sets of data were collected separately and participants undertaking both studies were not recorded. Kinship foster carers are an increasing proportion of carers in England and Wales, with legislation favouring early placement of children looked after with close family or friends where possible (Welsh Assembly Government, 2014). Research undertaken with foster carers sometimes includes kinship foster carers, however researchers often make the assumption that foster and kinship foster carers have similar characteristics and needs (Dorsey et al., 2008; Kinsey & Schlösser, 2013; Uretsky & Hoffman, 2017). There is evidence that this may not be the case and that the two groups have some distinct differences (Keller et al., 2001), with research indicating that the children that they care for may present with different needs (Broad, 2004; Nandy & Selwyn, 2011). The baseline characteristics of the foster and kinship foster carers in the present sample and the children that they look after are explored to determine similarities and differences between the two groups, comparing reports of child behaviour, carer-child attachment relationship and carer stress.

Differences between Foster and Kinship Foster Carers Identified in the Literature

Foster carers report more behaviour problems in the children they look after and higher levels of stress than kinship foster carers (Morgan & Baron, 2011; Selwyn, Farmer, Meakings, & Vaisey, 2013). Other differences between foster and kinship foster carers include socio-demographic differences with a greater likelihood that kinship carers are of lower socio-economic status. Nandy & Selwyn, (2011) found 38% of children in kinship care in Wales living in the poorest 20% of the country, compared to 28% of the general population. Kinship foster carers are also more likely to be grandparents, with age associated increased likelihood of health problems (Broad, 2004; Farmer & Moyers, 2008; Harden, Clyman, Kriebel, & Lyons, 2004; Selwyn et al., 2013).

Children placed with kinship foster carers may also have different characteristics and outcomes to those in foster care. In a time-in-care matched comparison of looked after children (n = 636) from 318 foster-kinship pairs, children in kinship care were found to be younger and to have significantly fewer placements (Winokur, Crawford, Longobardi, & Valentine, 2008). Children living with friends and family carers do better in terms of both

behavioural development and mental health than those in foster care (Oosterman, Schuengel, Wim Slot, Bullens, & Doreleijers, 2007), with a systematic review of 102 quasi-experimental studies finding no negative effects of kinship placement compared to placement in foster care (Winokur et al., 2014). Better outcomes for children in kinship care include increased stability (Oosterman et al., 2007; Winokur et al., 2014), fewer behavioural problems, fewer mental health problems and better well-being (Keller et al., 2001; Winokur et al., 2008). Differences in levels of behavioural difficulties between children placed with foster and kinship carers are reported by Keller et al., (2001) who compared children (*n* = 240) placed with foster (*n* = 173) and kinship carers (*n* = 67) in an independent fostering agency in the USA. The sample overall was 50% Caucasian and 55% male with lower rates of Caucasian (19%) and male (45%) youth in the kinship sample. All participants had been in care for around one year. Kinship carers reported significantly lower child behavioural problem scores than foster carers even after adjusting for race and gender. To try and determine whether these results were due to reporting bias or behavioural differences subsequent studies have included teacher reports of child behaviour, with Shore, Sim, Le Prohn, & Keller, (2002) finding that teachers reported the same levels of problem behaviour in children placed with kinship and foster carers. Rosenthal & Curiel, (2006) used data (*n* = 6,228) from two sources to study fostered children in long-term care in both foster and kinship placements. They collected carer and teacher behavioural measures and found that foster carers reported more behavioural problems than kinship carers, whereas teachers rated the problem behaviour of children in kinship care as worse than those in foster care. As carer education level and income rose, teacher reports of child behaviour problems fell. In addition to carer factors, child experience of physical and /or sexual abuse also predicted behavioural problems (Rosenthal & Curiel, 2006).

These studies demonstrate that although kinship carers report fewer behavioural problems in the children they look after than foster carers, this is not supported by teacher reported behavioural measures on the same children. Despite reporting fewer behavioural problems, some kinship carers reported that the children they look after did experience both behavioural and emotional difficulties related to the impact of family circumstances (Hartley, McAteer, Doi, & Jepson, 2019). In a qualitative study with eight kinship carers of teenage children, carers identified stress related to the behavioural problems of the children they cared for (Hartley et al., 2019).

One explanation suggested for the differences between children placed with foster and kinship carers may be differing levels of baseline risk for positive or negative outcomes. Font, (2015) suggests that differences in outcomes between foster and kinship placements are linked to child characteristics, with some children who enter foster care being unsuitable

for kinship care, due to high levels of behavioural difficulties. Children's experiences prior to entry to care influence the development of problem behaviours (Jones et al., 2011; Tarren-Sweeney, 2008), with children exposed to physical or sexual abuse, being more likely to develop behavioural difficulties. Factors including age, previous experience of abuse and child temperament may influence local authority choice of preferred placement (Jones et al., 2011). Younger entry into care and lower numbers of previous placements are both associated with better outcomes for children looked after (Tarren-Sweeney, 2008). Font, (2005) reports lower numbers of placement moves amongst children placed in kinship care. She notes stability differences between foster and kinship carers are in part, due to higher levels of moves by children in foster carer within the first two months of placement. She finds early placement moves are associated with children placed in short-term and temporary accommodation whilst a suitable longer-term placement is located for them (Font, 2005). In an evaluation of 270 children, comprised of equal numbers of children in foster and kinship care, Farmer, (2010) found kin and foster disruptions were similar once planned moves were excluded over a two year period. Poorer quality placements, defined as how well the placement met the needs of the child, were more likely to last longer if the child was placed with kin, than with foster carers.

Differences in outcomes between children placed with foster carers and those placed with friends and family are not fully understood. Suggestions as to why children do better when placed with kinship carers include environmental factors, such as remaining in the same area and attending the same school as whilst living at home (Jones et al., 2011), or social influences such as living with known carers and greater levels of parental support for the placement (Winokur et al., 2008). Limitations on research with kinship carers include poor methodologies and short periods for follow up outcomes (Dickes, Kemmis-Riggs, & McAloon, 2018; Winokur et al., 2014). However, children are increasingly likely to be placed with friends and family, with the expectation of kinship placement being in the child's best interest. Greater understanding of reported behavioural differences in children and differing outcomes between children placed in foster and kinship care would better facilitate informed decision-making. It would also allow the effective targeting of training and support interventions for both types of carers, to best support their needs.

Attachment Relationships as a Contributing Factor to Differing Child Outcomes

One factor that may differ for children placed with foster carers and those placed with kinship carers is the quality of attachment relationship that the child has with the carer. Attachment theory states that infant relationships with care givers influence children's later ability to relate successfully with others (Bowlby, 1969). Secure attachments, where the

child's wants and needs are met consistently, create a learning environment where the child learns how to connect and interact with others and that they are worthy and loveable. Insecure or disorganised attachment relationships form when there is a disruption in this early learning, the child's needs are not fully met and then lead to relationship issues, poor self-esteem, anti-social behaviour and psychopathology (Cornell & Hamrin, 2008; Crittenden, 2006; Wright et al., 2015).

All children in the care system have, by definition, experienced a disrupted attachment and may have significant unmet attachment needs, with 50% found to have disorganised attachment strategies associated with parent behaviours experienced as frightening by the child, including parental abuse and neglect (Prior & Glaser, 2006). Early attachment difficulties are strongly associated with the development of conduct disorders, whereas secure attachment is associated with a lower risk of behavioural problems (Madigan et al., 2016). Having had a disrupted attachment as a result of coming into care, a goal for children in care is to encourage the development of secure attachment relationships with caregivers. Children placed with carers at an earlier age and/or who had who had been in placement for longer, have in general better attachment relationships with their caregivers (Joseph, O'Connor, Briskman, Maughan, & Scott, 2014). Early entry to care is protective for mental health, including lower risk of attachment related behavioural difficulties (Tarren-Sweeney., 2008). Since children living with kinship carers are more likely to be placed at an earlier age than those in foster care (Winokur et al., 2008), this may be another advantage in developing secure relationships with carers than those in foster care, notwithstanding that children in foster care can form good attachments with their carers. Joseph et al., (2014) reported on sixty two adolescents in care who were compared for attachment security with fifty adolescents not in care. The adolescents in foster care demonstrated the ability to form secure attachment relationships with foster carers, despite having had insecure relationships with birth parents.

Investigation of attachment of children in care has primarily focused on the relationship between attachment and development of problematic behaviour, rather than any possible differences in attachment relationships between foster and kinship carers. One study that investigated behaviour and attachment in children (n = 347) in foster and kinship care (86% in foster care), found that social and interpersonal relationship difficulties were marked for most children (Tarren-Sweeney, 2008). Two of the sub-scales on the Assessment Checklist for Children (ACC) measure used in the study are associated with reactive attachment disorder (RAD) as defined in DSM-5 (American Psychiactric Association, 2013). Reactive attachment disorder has two sub-classifications, inhibited RAD associated with emotional withdrawal and indiscriminate RAD where the child is

indiscriminate in their social response and in seeking comfort. The non-reciprocal sub-scale on the ACC is associated with the inhibited form of reactive attachment disorder, whilst the indiscriminate scale is associated with disinhibited RAD. Tarren-Sweeney found that 20% of the sample identified as displaying complex attachment and trauma related difficulties, associated with high scores in both the non-reciprocal and indiscriminate scales. Findings were predicted by previous exposure to maltreatment or abuse and child age at entry to care. Earlier entry to care is protective for mental health, including reduced risk of attachment related behavioural difficulties, with Tarren-Sweeney (2008) also associating unmet attachment needs in children looked after with feelings of insecurity.

In summary there are socio-economic differences between carers, with kinship carers more likely to be of lower socio-economic status, to be older and to have age-related health problems (Broad, 2004; Harden et al., 2004; Nandy & Selwyn, 2011). Children placed with kinship carers are more likely to be younger and to have fewer previous placements, both factors that are associated with lower risk of behavioural problems and increased likelihood of secure attachment relationships with carers (Joseph et al., 2014). Given these differences between foster and kinship carers, however, there appears to be nothing in the literature on possible differences in attachment relationships for children placed with friends and family in kinship care and those placed with strangers in foster care. Given the different outcomes for children placed with the two types of carers, exploration of attachment relationships is called for.

Characteristics of Foster and Kinship Foster Carers Participating in Study One

A previous study (chapter 4) investigated the characteristics of foster and kinship foster carers in one local authority in Wales to inform training needs. The survey of 67% (*n* = 30) of the foster and kinship foster carers approved by the local authority reported a mean score for carer ratings of behavioural difficulties in the abnormal range on the Strengths and Difficulties Questionnaire (SDQ; M=17.43, SD=5.21) with the children they looked after. These figures were higher than the mean SDQ score reported by foster and kinship foster carers (*n* = 39,590) in England (M=14.1) (Department for Education, 2018). Abnormal scores on the SDQ indicate that caregivers are reporting significant difficulties with the behaviour of the children that they care for. In the previous study (Chapter 4), foster carers reported significantly higher levels of stress than kinship foster carers. Carer stress has been associated with higher reported child SDQ scores, with caregivers reporting more stress as ratings of child behavioural problems increased (Morgan & Baron, 2011). Findings in chapter 4 showed all carers reporting high levels of behaviour problems on the SDQ, with foster carers reporting higher levels of stress than kinship foster carers. Despite high levels of

reported behaviour problems the training offered to carers in that authority did not include any of the evidence based training programmes that are recommended for behavioural problems in children looked after (NICE, 2010, 2013).

As a result of the findings reported in chapter 4, the local authority agreed to participate in a trial offering an evidence based parenting intervention designed to support parents in managing challenging child behaviour. Most research on training for foster and kinship foster carers has been undertaken solely with foster carers, or with mixed groups of foster and kinship carers (see reviews; Dorsey et al., 2008; Kinsey & Schlösser, 2013; Rork & McNeil, 2011; Uretsky & Hoffman, 2017). The present study provided an opportunity to compare the characteristics of foster and kinship foster carers who enrolled to participate in the parenting training intervention Different needs and experiences, including socio-democratic differences led to separate groups being offered for foster and kinship foster carers.

Aims of This Study

Significant between group differences among carers enrolling for training may have an impact on training needs and outcomes. Carer and child baseline characteristics are explored in this chapter and an evaluation of the programme is undertaken in the following chapter 6.

Baseline characteristics are evaluated to determine whether foster and kinship foster carers enrolling for a behaviour management course report similar levels of problem behaviours in the children they care for, as well as investigating carer stress levels and carer-child attachment relationships. Three types of measures are used to inform an exploration of any difference in reporting of behavioural problems in the children looked after. Measures include carer report questionnaires collected at one timepoint, carer report of child behaviour over an extended period and direct observation of carer-child interactions.

Methods

Procedures

The intervention for which participants enrolled was the Incredible Years © (IY) group based basic parent programme. The local authority invited all of the authority approved foster and kinship foster carers to attend one of two IY Basic (school age) programmes, one for foster carers or one for kinship foster carers. This chapter explores baseline characteristics of the two populations.

Ethical Approval

Ethical approval was obtained from the Research and Ethics Committee, School of Psychology, Bangor University in January 2017, application number 2017-15923. The Local Authority gave approval for the collection of child data from foster or kinship foster carers where the child was on a full care order. Parental consent was obtained for children not on a full care order. Foster and kinship foster carers all gave informed consent. Data were kept confidentially in a locked cabinet and anonymized on database entry.

Recruitment

The Child Placement Team Leader contacted all local authority foster and kinship foster carers caring for children aged between 4-12 years, to offer them a place on the programme and obtain consent for their details to be passed to the researcher (Appendix D). A visit was arranged to the carers home and interested carers were then given further information about the intervention by the researcher. Participants had an opportunity to ask questions before giving informed consent (Appendix E).

Participants

Twenty-two carers were recruited, 11 foster carers from 7 fostering households and 11 kinship carers from 8 kinship households who between them were caring for 20 CLA, 10 in foster care and 10 in kinship care.

Two participants, one in each group were partners caring for, and reporting on, the same child. The primary carer data has been retained and the second carer data has been removed from these results so that data on each child are only represented once in each analysis

The foster carer group comprised seven female and three male foster carers with a mean age in years of 52.20 (SD = 11.58), from eight households (six individual participants and two couples). These carers looked after four female and six male children (Six households with one fostered child and two with two children) with a mean age in years of 10 (2.63) and an age range of 6-14 years. The kinship foster carer group comprised of eight female and two male carers with a mean age in years of 53.90 (SD = 9.75) living in nine households (eight individual participants and one couple). These carers looked after three female and seven male children (eight households with one fostered child and one with two fostered children) with a mean age in years of 8.20 (SD = 3.08) and an age range of 4-13 years. The recruited participants represented 39% of the local authority approved foster carers and 53% of local authority kinship foster carers.

Measures

Carer report measures were administered to assess child social, emotional and behavioural problems, carer stress levels and carer-child attachment relationships. A demographic questionnaire was used to obtain background information about the carer and child. Participants were given the option to complete questionnaires with the researcher present, or later and return them by post. All participants opted to complete questionnaires whilst the researcher was present.

Demographic questionnaire.

Participant information was collected using a revised version of the Personal Data and Health Questionnaire (Hutchings, 1996). This collects information about the participant, the child, biological relationships, education and housing, etc. The measure has been used in previous studies (Hutchings, Appleton, Smith, Lane, & Nash, 2002; Williams & Hutchings, 2018). In this study items reported include; marital status, home ownership, employment status, state benefit status, length of time carer has been approved, age of carers first biological child, age at which the carer left school and number and status of children in the home (Appendix G).

Behavioural measures.

The Child Behaviour Check List.

The Child Behaviour Check List (CBCL: Achenbach & Rescorla., 2001) is a 113 item caregiver report questionnaire, with 120 responses that enables assessment of aspects of adaptive and maladaptive functioning by rating behavioural, emotional and social problems (see appendix L). It is designed for use in clinical and research environments and two different version are developed for use with children between the ages of 1.5-5, and 6-18 years. It is completed by parents or surrogate parents. Each statement is rated using a scoring system of 0 or not true, 1 or somewhat or sometimes true, and 2 or very true or often true, based on child behaviours over the previous six months. It measures social, emotional and behavioural characteristics on eight sub-scales, which combined form a total problems score, There are two sub-scales scoring internalising and externalising behaviour, the Internalising scale score is made up of the i) anxious / depressed, ii) withdrawn / depressed and iii) somatic complaints syndrome sub-scales. The Externalising scale is made up of vii) rule Breaking behaviour and viii) aggressive behaviour syndrome sub-scales. Raw scores can be transformed using tables to t-scores for comparison with other research. Total t

scores of 63 and above indicate clinically significant levels of problem behaviours. The syndrome scales, including the internalising and externalising sub-scales, have been normalised and test-retest reliability and stability established, with test-retest intra-class correlation for the specific problem scales being .95 ($p<.001$) (Achenbach & Rescorla, 2001). The measure has been validated through use in research including use in pre-post design studies with foster carers (Maaskant et al., 2017; Mersky et al., 2016; Uretsky et al., 2017). In the present study, the amalgamated total score, internalising and externalising behaviour scores are used to compare carer reports of child emotional and behavioural problems.

Assessment Checklist for Children.

The Assessment Checklist for Children (ACC) (Keatinge, Tarren-Sweeney, Vimpani, Hazell, & Callan, 2000; Tarren-Sweeney, 2007), is a 120 item caregiver report psychiatric rating scale measuring behaviours, emotional states, traits and manner of relating to others by children in care (see appendix L). It is designed for use in research, clinical assessment and screening as a part of a package of measures to assess the mental health of children aged 4-11 years. It can be used by clinicians and researchers with foster carers, kinship carers and adopters, where the child has been in placement for six weeks or more. The ACC has two parts, part one focuses on less critical / higher incidence problems and uses a 3-point response of 0 or not true, 1 or partly true and 2 or mostly true. Part two is designed to detect infrequent critical problems such as suicide, sexually harmful behaviours and self-injury, and uses a 3 point response of 0 or did not occur, 1 or occurred once and 2 or occurred more than once. The carer completes the questionnaire and is asked to focus on behaviours observed during the last 4-6 months when answering. Questions are scored by summing the totals into ten sub-scale scores on the scoring and profile sheet with a total clinical score calculated by adding the sub-scales scores together.

Tables are provided to convert the raw score into a T-score and percentiles. Total raw scores of 27 and above are considered to be in the clinical range. Clinical subscale cut off scores vary between scales and range from 4-8. Three sub-scales are ratings of attachment in children looked after, iii) non- reciprocal, iv) indiscriminate and v) insecure (Tarren-Sweeney, 2007).

Internal content, construct and criterion related validity and reliability have been established (Tarren-Sweeny, 2007), however external reliability (test-retest and interrater reliability) have not been undertaken. The test has been normed against the CBCL (Tarren-Sweeney & Hazell, 2006), using intra-rater correlation of scores for items that are highly

similar. ACC-CBCL score correlations for six sets of similar items ranged from .70 to .83. It has been used in previous research with foster carers and children looked after to evaluate child mental health (Hazell, Tarren-Sweeney, Vimpani, Keatinge, & Callan, 2002; Tarren-Sweeney & Hazell, 2006; Tarren-Sweeney, Hazell, & Carr, 2004). The measure has not been validated for pre-post research, so is reported as a baseline measure only. The total score is used and compared with the CBCL. Three of the ten sub-scales associated with child attachment, the Non-Reciprocal, Indiscriminate and Insecure scales are reported (Tarren-Sweeney, 2007).

Parental Daily Report.

The Parental Daily Report checklist (PDR; Chamberlain & Reid, 1987) is a 33 item checklist of negative behaviours, including arguing, hitting others or whining. The list is designed to be completed daily by ticking any behaviour that occurred in the previous twenty-four hours (see appendix L). The primary carer completes the checklist daily over an agreed time-period and typically 3-5 daily scores are averaged to give a total mean score (Keil, 2007). Daily mean scores of six or more have been shown to indicate an increased risk of placement disruption for children in care (Chamberlain et al., 2006). The PDR has reliability as a telephone measure, with collection of seven measures over a four-week period, inter-interviewer r = .98, test-retest r = .6-.82 (Weinrott, Bauske, & Patterson, 1979). The measure has been used extensively with foster carers in evaluations of the training programme Keeping Foster and Kinship Carers Trained (Chamberlain, Price, Reid, et al., 2008; Greeno, Uretsky, et al., 2016; Price et al., 2012; Roberts et al., 2016). In this study, measures were reported over a four-week period and an average of fourteen days was used to create a mean score per child.

Observation measure: Dyadic Parent-child Interaction Coding System.

Carer reported measures are commonly used to evaluate interventions, however they can be subject to bias in reporting. Independent observation of behaviour is the gold standard measure, with participant observed interactions and behaviour recorded through a manualised coding system. The Dyadic Parent-Child Interaction Coding System (DPICS; (Eyberg & Robinson, 2000) is a coding system that records parent and child behaviours in a series of categories, which can be broadly defined as positive and negative behaviours. In this study, two twenty minute observations of different activities per carer-child dyad were recorded by the researcher for later coding. Coding was undertaken as per the DPICS

manual, with each behavioural occurrence tallied, in four five minute time samples, for each twenty minute observation (see appendix L).

The DPICs has been validated and standardised and has shown good reliability *r*=.91 parent behaviour *r*=.92 child behaviour; (Eyberg & Robinson, 2000). It has been used in previous research with foster carers (Mersky et al., 2016). It is used in this study to compare carer-child interactions for the two groups.

Carer Stress Measure: The Parent Stress Index short-form.

The Parent Stress Index short-form, version 4 (PSI-4-SF), (Abidin, 2012) is a thirty-six item self-measure derived from a 120 item questionnaire (see appendix L). The PSI is designed to identify situational stress related to parenting that is most commonly associated with dysfunctional parenting (Abidin, 2012). It is designed for use with parents of children aged one month to twelve years. The scale is composed of a Total Stress score and three sub-scales, Parental Distress (PD) is an indicator of stressors relating to parenting. Parent-Child Dysfunctional Interaction (P-CDI) indicates whether the child meets the expectations of the parent and reinforces their parenting role. Difficult Child (DC) assesses the temperament or behaviour of the child and the impact on the parenting relationship. Participants are asked to respond to each statement with a response on a 5-point scale ranging from 'strongly agree' to 'strongly disagree'. Scales are scored by summing the responses on the carbonless score sheet attached to the questionnaire, two responses are reverse scored. Tables are provided to covert raw scores into percentile ranks and T-scores. For the Total Stress raw score, the normal range is 54-109, between the 16th and 84th percentiles. Scores of 110-113 between 85-89th percentiles are considered high and scores over 114 and the 90th percentile are considered clinically significant. Total stress scores of below 54 and the 15th percentile may be regarded as a false negative and scores interpreted with caution.

Test-retest reliability has been established for the PSI-SF with correlation coefficients obtained of 0.85 for parental distress, 0.78 for difficult child, 0.68 for parent-child dysfunctional interaction and 0.84 for total stress (Abidin, 2012). The scale has been normalised using data from the USA, and has been validated in transcultural research (Abidin, 2012). It has been used in previous pre-post design research with foster carers (Maaskant et al., 2017; Nilsen, 2007). The total stress score is reported in this study to identify levels of stress experienced by carers.

Attachment Relationship Measure: Quality of Attachment Relationships Questionnaire.

The Quality of Attachment Relationships Questionnaire (QUARQ) 'how my foster child and I get on together' (Scott, n.d.) is a sixteen item questionnaire comprised of statements about the relationship between the carer and child, relating to broader attachment concepts (see appendix L). Examples include seeking the carer's help under stress, the ability to accept praise or to show affection. The questions are scored by a 5-point scale based on frequency of occurrence of the behaviour, with statements ranging from 'never' to 'very often'. Scoring is completed by allocating a numerical score to each answer, from 0 for 'never' to 4 for 'very often'. The total score is out of 64 and a high score indicates a better quality of attachment relationship, with a low score indicating insecure or poor attachments. The QUARQ has been used as a primary outcome measure to evaluate the Fostering Changes parenting programme (Briskman et al., 2010). The measure is used in this study to explore any differences in carer-child attachment relationships between foster and kinship foster carers. No evidence of reliability or validity has been reported.

Data Collection

Two visits were made to collect measures prior to programme attendance. The carer report questionnaire measures were completed at the first visit, observations of child and carer interactions were undertaken during a second visit, approximately one week later. Carers received a £10 high street voucher for completing the measures as a thank you for their time. The Parental Daily Report measure was left with the carers to be reported daily over four weeks and then returned. Observations of carer and child interactions were analysed using the Dyadic Parent-child Interaction Coding System (DPICS; (Eyberg & Robinson, 2000). Carers were asked to first choose an activity that would last for 15 minutes, then to ask the child to choose an activity that would last for 15 minutes. All observations were recorded using a handheld video recorder by the researcher for later coding. Twenty minutes of footage, ten minutes from each activity was coded for all carers for: Critical statements and commands, Labelled and unlabelled praise, Descriptive comments, Questions and encouragement, Reflective statements and questions, Indirect and direct commands. Child responses to commands were coded as no opportunity if the command was repeated before the child could comply, as non-compliance, or as compliance. Carers used Welsh or English with the child as they would normally. Two interactions were in Welsh and were coded by the first coder; all other observations were coded by the researcher after training by the first coder.

Inter-rater Reliability

Inter-rater reliability was assessed for 20% of the observations (4 of 19). For the current study, intra-class correlations for combined categories were as follows: Critical statements and commands ICC = .878, Labelled and Unlabelled praise ICC = .851, Descriptive comments and Encouragement ICC = .789, Reflective statements and questions ICC = .866, Indirect and direct commands ICC = .793. This demonstrates a high level of inter-rater agreement between coders.

Statistical Analysis and Missing Data

Analysis was undertaken using SPSS version 22. Exploratory analysis to check for normality was undertaken and between group baseline differences explored. Independent sample t-tests were used to establish whether there were differences between the groups mean scores at baseline for normally distributed measures. Where exploratory analysis determined that data were not normally distributed, a Mann-Whitney non-parametric test was used to compare groups and median and range reported. Categorical data comparisons were undertaken using chi-square to compare groups.

Any items not scored on measures reported by carers were managed as per the author's criteria. For the PSI-SF up to one missing item can be substituted by averaging the other scores in the sub-scale, one sub-scale was adjusted in this way. For the CBCL, scores are calculated as long as no more than eight items are missing. None of the measures had more than eight missing items.

Results

Demographics

Significantly more kinship foster carers (70%) were in receipt of state benefits than were foster carers (20%). In addition, the median time kinship foster carers (1 year) had been fostering for was shorter than foster carers (6.5 years). There were no other statistically significant differences between the two groups. Children placed with foster carers had been in care for longer than children placed with kinship foster carers, this difference approached, but did not reach, statistical significance (Table 5.1).

Table 5.1. Carer and child demographics

Child Factors	**Foster (*n*=10)**	**Kinship (*n*=10)**	**P - Diff.**
Child age, (years): *M (SD)*	10.00 (2.63)	8.20 (3.08)	.177
Child age, range.	6-14 yrs	4-13 yrs	/
Child gender, male: *n (%)*	6 (60)	7 (70)	.500
No. Long term fostered: *n (%)*	7 (70)	5 (50)	.325
Time in care (years): *Mdn (Range)*	4.5 (0-10)	1.5 (0-9)	.089
No. previous placements: *Mdn (Range)*	0.5 (0-9)	0 (0-1)	.123
Carer Factors	**Foster (*n*=10)**	**Kinship (*n*=10)**	**P - Diff.**
Carer age, (years): *M (SD)*	52.20 (11.58)	53.90 (9.75)	.727
Carer gender, male: *n (%)*	3 (30)	2 (20)	.500
Marital status, cohab: *n (%)*	9 (90)	7 (70)	.291
Home owner: *n (%)*	6 (60)	7 (70)	.500
Receive benefits (state or subsidy): *n (%)*	2 (20)	7 (70)	.035*
Employed or self-employed: *n (%)*	3 (30)	4 (40)	.500
No. Foster Children at home: *Mdn (Range)*	2.0 (1-3)	1.5 (1-3)	.529
No. Biological Children at home: *Mdn (Range)*	0.5 (0-3)	0.5 (0-2)	.684
Length approved carers (years): *Mdn (Range)*	6.5 (1.5-21)	1 (0.5-2)	.000*
Age first biological child (years): *M (SD)*	23.44 (5.15)	20.83 (2.93)	.284
Age left school (years): *M (SD)*	16.30 (1.16)	16.20 (0.63)	.813

*=p<.05

Behavioural Measures

Child Behavioural Check List (CBCL).

Descriptive statistics.

Findings for the Child Behaviour Check List indicated that 7 foster carers, (70%), and 3 kinship foster carers, (30%) reported that the children placed with them had a mean total score that was in the clinical range. The mean foster carer total score (M=66.25 SD=8.83) was also in the clinical range (table 5.2).

Foster carers reported the mean scores for the children they looked after to be in the clinical range on three of the CBCL subscales; Social problems (M=68.70, SD=10.48), Attention problems (M=65.70. SD=10.47) and Aggressive behaviour (M=65.60, SD=9.32). None of the kinship foster group mean scores were in the clinical range (table 5.2).

Between group differences.

Comparisons were undertaken between foster and kinship foster carers groups mean scores using independent t-tests and p values were corrected using a Bonferroni adjustment, see table 5.2. Significant differences were found between the two groups for CBCL total score t(18)=3.22 p=.005, d=1.5 and the internalising scale t(18)=1.46 p=.003,

d=1.8. Cohen's d effect size for this difference (*d*=.1.5) was smaller than .2, indicating this difference is trivial. Foster carers reported higher levels of behaviour problems in the children they looked after on the total score and the internalising behaviours scale than kinship foster carers. The difference between groups on the externalising scale did not reach significance (table 5.2).

Table 5.2. CBCL total and sub-scales results

Measures (Clinical cut off score)	**Foster (*n*=10)** ***M (SD)***	**Kinship (*n*=10)** ***M (SD)***	**Independent T-test** ***t***	***p***
Child Behaviour Check List (CBCL)				
CBCL Total (64)	66.25 (8.83)	51.80 (10.12)	3.23	.005*
CBCL Internalising (64)	62.75 (10.74)	46.50 (7.49)	3.63	.003*
CBCL Externalising (64)	62.50 (13.65)	53.20 (13.28)	1.46	.167

*p<.001

The CBCL data indicate that more foster than kinship foster carers reported difficulties in the children they looked after with the mean total score only in the clinical range for foster carers.

Assessment Checklist for Children (ACC).

Descriptive Statistics.

Findings for the Assessment Checklist for Children indicate that seven (70%) foster carers and one (10%) kinship foster carer reported the child that they looked as having a score in the clinical range on the ACC. The mean total group score for the foster carers (M=42.50, SD=22.51) was in the clinical range. For the sub-scales, none of the kinship scores were in the clinical range, whilst the non-reciprocal and insecure mean scores were in the clinical range for the foster carer group (table 5.3).

Table 5.3. ACC descriptive statistics, mean total and sub-scale results.

Measures (Clinical cut off score)	**Foster (*n*=10)** ***n (SD)***	**Kinship (*n*=10)** ***n (SD)***
ACC Total Score (27)	42.50 (22.51)	13.90 (14.21)
ACC sub-scales		
III. Non-Reciprocal (6)	6.90 (4.53)	1.50 (2.76)
IV. Indiscriminate (8)	6.70 (3.56)	3.70 (3.62)
V. Insecure (6)	9.70 (6.11)	1.70 (1.70)

Between group differences.

Initial analysis determined that data were not normally distributed, so a Mann-Whitney non-parametric test was used to compare groups. P values were corrected using a Bonferroni adjustment (Table 5.4).

Investigation of differences between foster and kinship foster groups showed that, after a Bonferroni adjustment, the non-reciprocal and insecure sub-scale were significantly different between groups, with foster carers reporting more problems. The non-reciprocal, indiscriminate and insecure sub-scales are indicative of attachment difficulties (Tarren-Sweeney, 2013).

Table 5.4. Foster and kinship ACC total and sub scale results.

Measures	**Foster (*n*=10)**	**Kinship (*n*=10)**	**Mann Whitney Test**	
(Clinical cut off score)	***Mdn (range)***	***Mdn (range)***	***U***	***p***
ACC Total Score	37.0 (7-71)	9.5 (0-45)	14.00	.021
ACC sub-scales				
III. Non-Reciprocal	7.0 (1-14)	0.5 (0-9)	10.00	.002
IV. Indiscriminate	6.5 (1-15)	2.0 (0-11)	26.50	.075
V. Insecure	8.5 (2-21)	2.0 (0-5)	6.50	.000*

*=p<.001

The findings from the Assessment Checklist for Children indicate that, foster carers reported higher levels of total problems, than kinship foster carers in the children they care for. Foster carers also reported clinical levels of problems on two of the three attachment related sub-scales, reporting higher levels of attachment related problems than kinship foster carers. Foster carers also reported significantly higher levels of insecurity than kinship foster carers.

Parent Daily Report (PDR).

Only four kinship foster carers (40%) and four foster carers (40%) completed the parent daily report (PDR) over a four-week period. Although asked to complete this daily, of those who did return records, the maximum comparable period available for these eight participants was fourteen-days; the first fourteen days of data was therefore used to calculate group means.

Both groups reported a mean score of less than six daily behaviours and there was no statistically significant difference between groups ($t(7)=0.70$, p=.511) (Table 5.5).

Table 5.5. Foster and kinship PDR results.

Measures	**Foster (*n*=4)**	**Kinship (*n*=4)**	**Independent T-test**	
(Clinical cut off score)	***M (SD)***	***M (SD)***	***t***	***p***
Total score (6)	3.50 (3.15)	2.27 (1.58)	0.70	.511

Dyadic Parent-child Interaction Coding System (DPICS).

Ten foster carers and seven kinship foster carers were observed during a play session with the looked after child. Exploration showed data were not normally distributed, so a Mann Whitney test was undertaken to compare means between foster and kinship groups. The test showed there were no statistically significant differences between the two groups on any category (Table 5.6).

Between group comparisons showed that foster carers and kinship foster carers were very similar. There were some non-significant differences, with foster carers using more questions and reflective comments than kinship foster carers, whilst kinship foster carers used more commands, critical statements and praise than foster carers. Children in kinship foster care showed more non-compliant responses to commands than those in foster care (Table 5.6). However, the data indicated that both groups of carers displayed a wide range of parenting behaviours.

It was not possible to compare findings with other studies due to both the low use of observational measures and the wide variation in the grouping and reporting of DPICS observational criteria when they are used.

Table 5.6. Foster and Kinship DPICs results.

	Foster (n=10)		**Kinship (n=7)**			
	Median	***Range***	***Median***	***Range***	***U***	***Exact P***
Carer Behaviour						
Total Critical	10	(1-29)	11	(1-40)	44.00	.42
Total Praise	3	(0-10)	4	(0-25)	40.50	.60
Total Encourage	7	(1-39)	6	(0-26)	29.00	.60
Question	47	(26-113)	31	(12-70)	23.00	.27
Total Reflective	9	(3-30)	3	(1-19)	26.00	.42
Total Commands	26	(12-59)	37	(5-81)	36.50	.89
Child Response						
Total No Opportunity	6	(1-30)	3	(1-34)	35.00	1.00
Total Comply	18	(8-46)	34	(4-35)	39.00	.74
Total Non-Comply	2	(1-8)	2	(0-13)	35.50	1.00

Attachment Measure – Quality of Attachment Relationships Questionnaire (QUARQ)

The QUARQ measures attachment relationships with higher scores indicating stronger attachment relationships. Although the difference between the two groups approached significance, it did not meet the criteria for statistical difference (Table 5.7).

Table 5.7. Foster and kinship QUARQ results.

Measures (Clinical cut off score)	Foster (*n*=10) *M (SD)*	Kinship (*n*=10) *M (SD)*	T-Test *t*	*p*
Quality of Attachment Relationships Questionnaire (QUARQ)				
Total Score	44.10 (13.09)	47.20 (10.77)	-0.59	.57

Carer Stress measure - Parent Stress Index – Short Form (PSI-SF)

Descriptive Statistics.

The mean scores for the foster carer group (M = 92.00 SD = 20.48) and the kinship foster carer group (M = 71.75 SD = 17.82) were not in the clinical range. Individual counts of numbers in the percentile bands for the total stress score showed that three (15%) of foster carer, compared to none of kinship foster carers reported stress levels in the elevated or high range. Defensive reporting scores were reported for two foster carers and two kinship foster carers, with two (20%) of kinship compared to none of the foster carers reported scores in the low range. Defensive responding scores and scores in the low range can indicate under reporting of stress (Table 5.8).

Table 5.8. Foster and kinship PSI-SF total score percentile bands.

	Foster (*n*=10) *n (%)*	Kinship (*n*=10) *n (%)*
Defensive response	2	2
Low	0 (0)	2 (20)
Normal	7 (70)	8 (80)
Elevated	2 (20)	0 (0)
High	1 (10)	0 (0)

Between group differences

Comparisons were undertaken between foster and kinship foster carers group mean scores using independent t-tests, see table 5.9 Significant differences were found between the foster and kinship foster carer two groups for the PSI-SF total score t(18)=2.39 p=.028, d=1.1 indicating foster carers were reporting higher levels of stress than kinship foster carers. Cohen's d effect size for this difference (*d*=1.1) was smaller than .2, indicating this difference is trivial.

Table 5.9. Foster and kinship PSI-SF results.

Measures	**Foster (*n*=10)**	**Kinship (*n*=10)**	**Independent T-test**	
(Clinical cut off score)	***M (SD)***	***M (SD)***	***T***	***p***
Parent Stress Index (PSI-SF)				
PSI-4-SF Total (114)	92.00 (20.48)	71.75 (17.82)	2.39	.028*

*=p<.05

Comparison of PSI-SF findings with other research

The study in Chapter 4, reported the stress levels of 67% of the local authority foster and kinship foster carers. Comparison of the two sets of data using an independent T test, showed that there were no significant differences between the local authority survey participants and those in this study who had enrolled in a behaviour management parenting group (t(57)= -.65, p=.52), or foster (t(27)= -.83, p=.41) or kinship foster groups (t(28)= -.12, p=.91), indicating level of stress was not a predictor of signing up for the programme.

Discussion

This study reports on baseline characteristics of a group of foster and kinship foster carers enrolling on a parent-training programme. There were two significant differences in demographics between foster and kinship foster groups, with kinship foster carers having fostered for a shorter length of time and with more carers in receipt of state benefits. The children cared for by kin carers had been looked after for a shorter period, however the difference did not reach statistical significance. Kinship foster carers have been found to have a lower socio-economic status than foster carers in previous studies (Nandy & Selwyn, 2011), whilst Winokur et al (2008) found children placed with kinship carers were younger at the time of the survey with fewer previous placements than those placed with foster carers. However, it was not possible to consider the effect that demographic differences may have had on enrolment as part of this study.

Findings from the CBCL and ACC indicated that around 70% of foster carers and 20% of kinship foster carers were reporting clinical levels of problems in the children looked after. Between group differences were found, with foster carers reporting significantly higher levels of child behavioural problems on the CBCL, total difficulties and attachment related problems on the ACC and carer stress on the PSI-SF than the kinship foster carer group. There were no significant differences in attachment relationships between the two groups using the QUARQ. The behavioural measure collected over time (PDR) and the observational measure (DPICS) did not find significant differences between the two groups,

however, the sample for both these measures was smaller and this may have influenced findings. This is a small sample, representing 66% of the local authority approved foster and kinship foster carers and as such, results must be interpreted with caution. However, the finding that kinship and foster carers enrolling on a behavioural management programme report different levels of child behavioural problems and experience different levels of stress is important for studies of behaviour of children in care. Studies reporting combined results are unlikely to accurately determine the training needs foster and kinship foster carers signing up for targeted training programmes.

Child Behaviour Findings

Rates of psychiatric disorder, including behavioural problems amongst children looked after have been found to be around 46-47% in the UK (Ford et al., 2007) and the USA (Leslie, Hurlburt, Landsverk, Barth, & Slymen, 2004). Looked after children experience rates as high as 38.9% for behavioural disorders compared to 4.3% in private households (Ford et al., 2007). Differences in reported rates of behavioural problems using the CBCL, where foster carers report higher rates than kinship carers have been found in previous research in the USA (Hegar & Rosenthal, 2009; Keller et al., 2001; Rosenthal & Curiel, 2006; Shore et al., 2002). The CBCL results reported in this study are similar to a study (Keller et al., 2001) that compared foster and kinship carer reports (*n*=240) of child behaviour. The mean scores for kinship foster carers from this study (M=51.8, SD=10.1) are similar to kinship carers results (M=51.9, SD=10.8) in the Keller et al., 2001, study, with kinship carers reporting lower scores on all three scales and particularly the internalising scale, compared to foster carers.

Reasons suggested for the reported behavioural differences in children placed with foster and kinship carers are varied. Child maltreatment, including physical or sexual abuse is significantly related to behavioural problems (Rosenthal et al., 2005) and children with more extreme behaviours are more likely to be placed in foster care, or residential homes (Font., 2015). Short-term post-placement increases in externalising behaviours in kinship carer placements were shown to fall in the longer term, compared to children in foster care (Hegar & Rosenthal, 2009). It may be that the familiarity of kinship carers, along with increased opportunities to remain connected with family and peers makes kinship placement less traumatic than placement in stranger foster care. Reporting differences between foster and kinship carers may be due to differences in perception. Foster carers may be more objective, whilst kinship carers may be less critical, more tolerant of the context of the behaviour or more unwilling to view the child negatively (Farmer, 2010; Keller et al., 2001; Rosenthal & Curiel, 2006). Socio-economic deprivation is associated with a higher frequency

of child behavioural problems, suggesting another explanation for differences in reported child behaviours between foster and kinship carer (Britto et al., 2017). Differences in behavioural ratings of children by teachers, that match those of foster carers but differ from those of kinship carers, support a reporting difference between foster and kinship carers, as opposed to actual differences between the children (Rosenthal et al., 2005). However, no teacher ratings were collected for the present study. Teachers rated children from foster and kinship placements as behaviourally similar (Shore et al., 2002) and some rated children in kinship care as having higher levels of behavioural problems (Rosenthal et al., 2005). An alternative explanation for this difference could be that children in kinship care actually behave better at home than those in foster care, whilst their behaviour at school is worse.

Findings from the Parental Daily Report (PDR) in this study from a limited number of participants (*n* = 8) could indicate support for teacher reports that the behaviour of children in foster and kinship care is similar. Findings on the PDR indicated that the number of behaviours for each group were not statistically different when measured over an extended period. However, data were available for less than 50% of the sample and there were large within sample differences indicating wide variation within groups so overall there was insufficient data to draw any real conclusions.

Findings from the Dyadic Parent-Child Interaction System (DPICS) also indicated no significant differences between the two groups, with a large amount of within group variation. Both groups showed a greater use of questions and commands than praise and encouragement. Parenting style and child behaviour are interlinked, with coercive, authoritarian and punitive behaviours combined with low parental warmth associated with child behavioural disorders (Granic & Patterson, 2006). Both groups had lower rates of praise compared to critical responses. This could indicate that both groups may benefit from attending a parenting intervention, with the strongest programme effects found in a meta-analysis of IY programmes including positive reinforcement (Leijten et al., 2019).

Carer-child Attachment

No significant differences were found between foster and kinship foster carers on the attachment questionnaire (QUARQ). However, differences between groups approached significance on the total score, with kinship foster carers reporting stronger attachment relationships and a larger sample is needed to establish whether this is the case. Briskman et al., (2010), used the QUARQ to evaluate 34 intervention and 29 control foster carers for a fostering changes parenting intervention. At baseline, the mean score was 51 (out of 64) for both groups. In this study, foster carers reported a score of 44 and kinship foster carers a score of 47, with a higher score indicating stronger attachment. However, given the lack of

validity and reliability data for the QUARQ, it is difficult to be certain of the accuracy of the measure. The Assessment Child Checklist (ACC) is specifically designed to assess children looked after and contains sub-scales associated with attachment difficulties. There were between group differences on two attachment related subscales on the ACC with foster carers reporting clinical levels of attachment difficulties, however the differences were not significant. Results for both measures indicated a trend towards children living with foster carers having less secure attachments than children living with kinship foster carers, however the small sample size makes this interpretation unreliable. The insecure scale on the ACC was significantly different between groups, with foster carers reporting children they look after as more insecure than kinship foster carers. A study of children (n = 347) in foster and kinship care (86% in foster care), found attachment related difficulties indicated by the reciprocal and indiscriminate scales on the ACC were associated with insecurity and predicted by maltreatment prior to entry to care (Tarren-Sweeney., 2008).

Carer Stress

Mean carer stress levels as determined by the PSI-SF were within the normal range. There were significant between group differences, with foster carers reporting higher levels of stress than kinship foster carers. Morgan and Baron (2011) investigated the mental health of 56 foster carers, comparing child problems with levels of carer stress measured using the PSI-SF. They reported a mean score of 84.71 (SD 24.26) on the PSI-SF for foster carer stress, which was similar to the mean foster carer score reported here (87.68). This result is not surprising given links between problematic behaviours and carer stress (Morgan & Baron, 2011) and that foster carers were reporting more problematic child behaviours.

Limitations

This study is based on a very small sample of carers who enrolled on a parenting programme offered by the local authority and as such, results should be interpreted with caution. This study recruited 35% (29% of foster carers, 48% of kinship carers) of the LA carers. The use of multiple measures and post-hoc analysis increases the risk of type I and type II errors, the risk of finding a result that is not there, or of not finding a result that is there. A larger sample of kinship and foster carers recruited from more than one local authority would establish whether two different carer types are consistently different among carers enrolling for a parent-training programme, however within both groups there was a wide range of responses on all measures. This sample contains self-selected participants with no control group and it is possible that participants enrolled because they were experiencing problems, as indicated by the levels of reported behavioural problems and meaning the sample is not representative of carers generally. No significant between group

differences in behaviours were found using the DPICS observational data. The use of more structured tasks when undertaking the observations may enable more direct between group comparisons to be made. However, between group comparisons would need to be normalised by age as there is a diverse range within this sample. The results obtained from the PDR would have been more informative if a full set of data had been obtained. Changing the collection of these data by the researcher to daily or weekly, rather than at the end of the recording period may have increased returns. It would have been useful do some direct comparisons with other data, using the SDQ would have enabled comparisons with to the earlier local authority survey (Chapter 4), or the English SDQ data set. However, the SDQ is a screening measure and therefore less informative than the measures used here. The questionnaire measure of attachment (QUARQ) used here, had been used in previous research to report on pre- and post-course changes following a parenting intervention (Briskman et al., 2011), however no validity, reliability and data norms have been reported. The use of a validated measure of attachment such as the Child Attachment Interview to determine child attachment may have been more informative.

Future research

Exploratory investigations serve to identify areas of future research, this study explored differences between a small sample of foster and kinship foster carers who had enrolled voluntarily for a parenting programme focused on child behaviour management and identified a number of areas where foster and kinship foster carers reported different characteristics. The reasons for this are not clear and the samples represented different percentages of the total local authority numbers of both types of carers. It would be useful to determine in future research with a larger sample whether the child behaviour differences are related to reporting differences between carers. More detailed and comparative evaluations between carer and independent reports of child behaviour, such as observation, teacher report, or measures collected over longer time periods may help elucidate whether there are reliable differences in child behaviours between children placed with foster and kinship foster carers. On a similar note, more detailed investigation of attachment relationships between foster and kinship foster carers and the children they care for, would help to better understand whether attachment is a variable influencing outcomes for children and what types of interventions address this. There was wide within group variation in findings, particularly on the observational measure. Investigation of these differences may be informative, with factors such as child history, age and time in care being variables that may have influenced outcomes. This suggests the importance of assessing individual needs alongside whether it is appropriate to offer different interventions to the two types of carers. A study able to explore some of these issues may be helpful. The use of the ACC in addition

to the CBCL has confirmed the usefulness of the ACC as an independent measure to identify behaviour difficulties with looked after children. Tarren-Sweeney provides a short version of the ACC free of charge that could be used within social services settings to assess child mental health, helping to inform support and training needs for carers.

Conclusion

This study and previous research found behavioural challenges within the looked after child population, with 70% of foster carers reporting clinical levels of behavioural problems. However, this was a small sample and only drawn from carers signing up voluntarily for a behavioural parent training course. Differences between kinship and foster carers reporting of child behavioural problems were found, with 30% of kinship foster carers reporting child behavioural problems in the clinical range on the CBCL, compared to 70% of foster carers, a difference that was statistically significant. Exploration of carer stress and carer-child attachment relationship as factors that influenced reported behavioural differences was inconclusive and given the small sample size make interpretation difficult. There were demographic differences between foster and kinship foster carers in this sample with kinship foster carers being approved for a shorter length of time than foster carers, and more kinship foster carers in receipt of state benefits.

The study confirms that both foster and kinship foster carers would both benefit from strategies that would help them to manage difficult behaviours in the children they look after, with both groups of carers enrolling to attend a parenting intervention. Interventions that both promote the parenting skills that help with challenging behaviours and attachment security may be particularly beneficial to the foster and kinship population.

CHAPTER 6

Evaluation of an Incredible Years© Programme with Foster and Kinship Foster Carers.

Introduction

This chapter reports the findings from the delivery of the Incredible Years© (IY) Basic parenting programme to two groups of carers, one group of foster carers and one of kinship foster carers. Children looked after can enter care with problematic behaviours and can also develop difficulties whilst in care such as through experience of repeated instability (Cooley, Farineau, & Mullis, 2015). The development and maintenance of behavioural difficulties is associated with negative parenting strategies that model, focus on and lead to undesirable behaviours from the child (Patterson et al., 1998).The National Institute for Health and Social Care Excellence (NICE) recommends group-based parenting interventions for behavioural problems, based on social learning theory models (NICE, 2010, 2013). There is limited research on the delivery of parenting interventions to carers in the UK (Kinsey & Schlösser, 2013), and even less with friends and family carers, also known as kinship foster carers (Uretsky et al., 2017).

A review of the literature on behavioural problems and children looked is followed by a brief review of parenting programmes and specifically the Incredible Years© (IY) programme. This chapter then explores the differences in outcomes for foster and kinship foster carers attending an IY parenting course, exploring differences between foster and kinship foster carers in terms of carer stress, child behaviour and carer-child attachment both at baseline and post attendance on the course.

Differences between foster and kinship foster carers identified in the literature.

In general children who are looked after and placed with kinship foster carers experience higher rates of stability and have better mental health and educational outcomes than those placed with foster carers (Harwin, Simmonds, Broadhurst, & Brown, 2019). However there are significant differences between kinship and foster carers (Rosenthal & Curiel, 2006) that are not generally explored in research undertaken with carers, including better outcomes for children placed with kinship carers. Secure attachments are associated with less disruptive behaviours (Joseph et al., 2014) and improved outcomes (Scott et al., 2011) and one explanation for differences in outcomes for children placed with foster and kinship foster carers may be the quality of the attachment relationship between child and carer. Nandy & Selwyn, (2011) hypothesise that attachment relationships with kinship carers are more likely to be secure because their relationship pre-dates the child living with them, this may be a contributing factor to differences found between the two types of carers. Foster carers are strangers to children placed with them and therefore the formation of secure attachment relationships would be a priority. Support for parent training programmes promoting secure attachment relationships (Briskman et al., 2010; O'Connor et al., 2013) in

addition to improving child behaviour and effective parenting, means these programmes may be particularly beneficial to foster carers. However both types of carers are likely to benefit from behavioural learning strategies particularly if they are reporting behavioural challenges in the children they care for and foster carers may additionally benefit from strategies that promote attachment security.

Behavioural problems and children looked after.

Many looked after children enter care with a high level of social, emotional and behavioural needs, with 72.3% of children in the UK aged 5-15 years showing indications of behavioural or emotional problems at the time of entry to care (Sempik, Ward, & Darker, 2008). This can be compared to 10% of children showing similar problems in the general population (Meltzer et al., 2000; Vostanis, Meltzer, Goodman, & Ford, 2003). Problematic early experiences are associated with 45% of child mental health difficulties (Green et al., 2014) and once in care, levels of problematic behaviours remain high for many children. A survey of children in long-term care found that 47% had clinically significant behavioural problems (Leslie et al., 2004). The most prevalent mental health problems experienced by children looked after are conduct disorder (CD) and oppositional defiant disorder (ODD) (Ford et al., 2007; Meltzer et al., 2000). Children with aggressive behaviour are at increased risk of abuse, antisocial behaviours, substance abuse, interpersonal problems (Loeber & Dishion, 1983; Patterson et al., 2000) and adult mental health issues (Kessler et al., 2008). Behavioural problems are also related to underachievement both during and post education (Luke et al., 2015) and difficult early experiences are linked to poorer long-term physical and mental health (Bellis et al., 2017).

Factors that influence behavioural problems.

Links between carer stress, problem behaviours and placement instability.

As previously noted in chapter 2, carers are not always prepared for, and can have difficulty managing, difficult child behaviours (Tarren-Sweeney, 2008). There are links between problematic behaviours and placement instability (Cooley et al., 2015; Fisher, Stoolmiller, Mannering, & Chamberlain, 2012; Oosterman et al., 2007), with carer stress a contributing factor (Farmer et al., 2005: Morgan & Baron., 2011). A significant proportion (45%) of unplanned placement moves due to placements ending at the request of the foster carer, are due to child behavioural problems (Department for Education,, 2018; Gilbertson., 2003; Morgan & Baron., 2011; Fisher et al., 2012). Bi-directional influences exist between children and parents, where child behaviour increases parent stress and parent stress increases problem behaviours (Stone et al., 2016). However, Goemans, Geel, & Vedder, (2018) found that this does not hold true for carers and looked after children. They found that

problematic behaviours of children looked after were associated with higher levels of carer stress, but carer stress did not negatively impact child behaviour in that despite higher levels of stress carers parenting skills were not compromised. It was suggested this may be due to foster carers ability to maintain levels of stress below levels experienced as harmful by children. Alternatively, it could be that children were emotionally numb or detached and so not affected by carer stress (Wilson, Hansen, & Li, 2011). However, Goemans et al., (2018) found that for children with a higher number of placement moves, the bi-directional model of stress was a better fit, indicating that where children looked after had experienced higher numbers of placement moves, carer stress and problematic child behaviours were correlated and bi-directional in influence. Carer stress and child behaviour appear to interact in a complex way influenced by other factors, with placement instability a factor for some children and not for others.

Factors influencing placement stability.

Placement instability is a risk factor for behavioural problems (Oosterman et al., 2007; Rubin, O'Reilly, Luan, & Localio, 2007), poor academic achievement (Berridge et al., 2015) and mental health problems (Jones et al., 2011). Factors mitigating early adversity for children include stability and a consistent adult presence (Harker et al., 2003; Hughes, Lowey, Quigg, & Bellis, 2016). Factors that predict placement stability are recent first entry to care, having typical behaviour, and birth parents without serious mental health or behavioural problems (Rubin et al., 2007). Conversely, placements at high risk of being disrupted had risk factors including children with behavioural and impulsivity difficulties, in combination with stressed carers using negative parenting strategies including criticism and rejection (García-Martín et al., 2015). Carers providing warmth, persistence and consistency in response to challenging behaviour were successful in improving child well-being and behaviour and had lower rates of placement disruptions (Wilson, 2006) and children with fewer placement moves have better mental health outcomes (Ford et al., 2007) and educational achievement (Berridge et al., 2015).

Recommendations for promoting looked after children's emotional wellbeing include improving training and support for carers in the use of the parenting strategies that promote placement stability (Bazalgette, Rahilly, & Trevelyan, 2015). Foster carers rated as having good parenting skills are more effective in maintaining a stable placement (Sinclair & Wilson, 2003), indicating that the ability and confidence to manage problem behaviours is likely to improve placement stability, which in turn would promote better outcomes for children looked after.

The use of parenting interventions to address problematic behaviours.

Foster carers report that skills based training that meets the high needs of the children they care for is a priority (Lawson & Cann., 2019) and in many cases existing training programmes are not meeting their needs (MacGregor et al., 2006; Murray et al., 2011). Kinship carers have also expressed a need for more support, requesting increased training and support groups with other kinship carers (Sykes, Sinclair, Gibbs, & Wilson, 2002). The National Institute for Health and Care Excellence (NICE) recommends parent-training programmes for carers of looked after children displaying problem behaviour (NICE, 2010, 2013). Effective interventions for conduct disorders use a social learning theory model, with programmes delivered with fidelity, by trained programme leaders (NICE, 2013). Interventions are based on the idea that difficult behaviours are learned and consolidated through ineffective parent-child relationships. Problematic interactions may be related to inappropriate timing, or ineffective content possibly triggered and compounded by child or parent characteristics, including maternal depression or irritability (Patterson et al., 1982). Interventions based on Social Learning Theory (SLT; Bandura, 1977) coach parents to interact positively with children to strengthen relationships and encourage desirable behaviours, whilst reducing undesirable behaviours through logical and non-punitive consequences. There is a large evidence base showing that parent management training (PMT) is effective in reducing problematic child behaviour when used with parents and biological children (Dretzke et al., 2009; Furlong et al., 2010).

Some courses that have introduced social learning theory principles to carers have been less effective. Pithouse (2004) and Pithouse, Hill-Tout, & Lowe (2002) took the principles of behavioural theory as used in parent management training and used them to deliver a three-day training course to foster carers (n = 53) in Wales. They found that whilst carers liked the training and said that they had applied the principles, there was no effect on child behaviour or carer skills at seven week follow-up. A similar study using a manualised programme, delivered over three days to foster carers (n = 121) in a randomised controlled trial, predicted that better communication would facilitate secure attachments, however no changes in child emotional or behavioural measures were found at follow-up (Minnis & Devine, 2001). In contrast, interventions delivered over an 8-12 week period, using parenting interventions with established evidence of efficacy (Incredible Years©; Keeping Foster and Kinship Carers Supported and Trained) have been effective in producing improvements in looked after children's behaviour (Bywater et al., 2011; McDaniel et al., 2011: Roberts et al., 2016). These interventions use a collaborative approach and focus on individual goal setting, role modelling of essential skills and home practice and are delivered by skilled facilitators

who challenge preconceptions, coach new skills and model prosocial behaviours, (Eames et al., 2010).

Training programme research with carers has tended to focus on foster carers, with some studies including kinship or kinship foster carers. In studies using mixed groups of carers, there is an assumption that foster and all kinship carers have the same training needs, and respond to interventions in the same way. There is also a lack of clarity within the literature regarding which type of kinship carers are included in research – foster kinship carers or kinship carers with private arrangements. However, kinship carers have reported fewer behavioural problems in the children they care for, than foster carers (Shore et al., 2002). Kinship carers also differ demographically from foster carers, with foster carers being younger (Broad, 2004; Cuddeback, 2004) and of higher socio-economic status (Nandy & Selwyn, 2011). However, whilst both kinship and foster carers might benefit from attending an social learning theory based parenting intervention by learning skills to help with difficult child behaviours, their circumstances and experienced challenges may differ and having separate groups may be more effective in enabling a focus on the specific needs of each group.

Attachment theory and SLT interventions.

A review of interventions for children with attachment difficulties indicated that foster families need different interventions to biological families, with foster carers needing support to respond appropriately to child cues and build an attachment relationship (Cornell & Hamrin., 2008). It is not clear how similar kinship relationships with their looked after children are to biological family relationships, or if/how this may affect kinship carer training needs in relation to the child's attachment needs. Advice from the National Institute for Health and Care Excellence (NICE, 2015) on the attachment needs in children looked after, recommends training in recognition and assessment of attachment difficulties, with attachment security linked to positive youth adjustment and outcomes that include placement stability. A review of looked after children's mental health suggested attachment theory should not be regarded as the sole framework for understanding children's behaviour, with effective programmes incorporating social learning theories (Luke, Sinclair, Woolgar, et al., 2014). There is good evidence that social learning theory based programmes may benefit attachment as well as conduct disorders, with one of the recommended interventions for children who are looked after and who have attachment disorders, being positive behavioural management (NICE, 2015; O'Connor et al., 2013). Children in foster care have lower attachment security than children not in care, with higher levels of disorganised attachment relationships (Bovenschen et al., 2016). In a meta-analysis of 165 studies,

internalising behaviours in children were associated with insecure attachment relationships, whereas externalising behaviours were associated with the more severe form of disorganised attachment (Madigan et al., 2016). Disorganised attachments are associated with more severe maltreatment by caregivers in early childhood.

Two randomised controlled trials have investigated whether parent management training influences attachment relationships in addition to child behaviour. O'Connor et al., (2012) used data from an Incredible Years© (IY) programme with parents of conduct-disordered children (*n* = 88) (Scott et al., 2010) and used observational measures to investigate behaviour and attachment pre- and post-intervention. Positive and negative parenting behaviour was coded along with measures of sensitive responding and mutuality. Findings showed improvements in positive parenting and in sensitive responding with indications that these improvements were to some extent independent of each other. In an evaluation of Fostering Changes, a parenting programme developed for foster carers and based on social learning principles with an attachment focus, Briskman, et al (2012) evaluated outcomes for foster carers (*n* = 34) using behavioural and attachment questionnaire measures. They found improvements in carer-defined problems, emotional and behavioural difficulties and quality of the attachment relationship between carers and children. The findings from these papers indicate that behavioural parenting training improves attachment relationships as well as child behaviour. In a study of foster and kinship carers, enrolled in a behavioural parenting programme where the attachment relationships may differ between groups, it would be useful to establish impact on attachment relationships for the two groups.

Parenting interventions evaluated with foster and kinship carers.

There is extensive research on the efficacy of parenting programmes when delivered to parents (Furlong et al., 2010) and the benefits are maintained over time (van Aar, Leijten, Orobio de Castro, & Overbeek, 2017). Evidence based parenting programmes evaluated with foster carers in the UK include Keeping Foster and Kinship Carers Supported (KEEP) (Chamberlain, Price, Reid, et al., 2008; Roberts et al., 2016) and the Incredible Years© (IY) (Webster-Stratton et al., 2001). KEEP is derived from the Multi-dimensional Treatment Foster Care (MTFC) programme designed as a specialist multi-aspect fostering intervention for delinquent youth. MTFC has been widely researched and found to be effective in the USA (Chamberlain, Price, Leve, et al., 2008; Fisher, Burraston, & Pears, 2005). However, results have not been successfully replicated in the UK (Biehal, Ellison, & Sinclair, 2012). There have been large trials of KEEP in the USA (Chamberlain, Price, Reid, et al., 2008; Greeno, Uretsky, et al., 2016; Leathers et al., 2011; Price et al., 2008, 2012). All found

significant improvements in child behaviour using either the Parent Daily Report (PDR; Chamberlain, Price, Reid, et al., 2008; Greeno, Uretsky, et al., 2016; Price et al., 2012) or the Child Behavioural Check List (CBCL: (Greeno, Lee, et al., 2016; Leathers et al., 2011). Greeno, Lee, et al., (2016) also used the Parent Stress Index (PSI) to measure carer stress levels but did not find significant reductions in carer stress post-intervention. There has been one evaluation of KEEP in the UK (Roberts et al., 2016) with a large sample of foster and kinship carers (906 carers and 604 CLA) using a pre-post design with a six and twelve month follow up. Measures included the Strengths and Difficulties Questionnaire (SDQ) and the Parent Daily Report (PDR). There were significant behavioural improvements on both measures that were maintained at both follow up times.

KEEP is designed specifically for the foster care population and results from the UK study are promising (Roberts et al., 2016). However, the relatively recent introduction to the UK means availability of facilitators to deliver the programme is limited. The IY programme has a history of delivery with parents (Bywater et al., 2009b; Hutchings, Gardner, et al., 2007) in North Wales and access to experienced trainers and support is good. It has been extensively evaluated with parents in both the USA and the UK and has achieved recognition of efficacy as a blueprint for violence prevention promising programme (https://www.blueprintsprograms.org/). IY has been evaluated in the UK with foster carers using a non-randomised controlled group (Bywater et al., 2011) and in Ireland in a service evaluation (McDaniel et al., 2011). The Eyberg Child Behaviour Inventory (ECBI) was used in both evaluations with significant reductions in the intensity of behaviour problems post-intervention. The Strengths and Difficulties Questionnaire (SDQ) was also used by Bywater et al., (2011) and showed significant improvements in the total and hyperactivity scales. Both studies were small with 46 carers (Bywater et al., 2011) and 13 carers (McDaniel et al., 2011).

Evidence for the Incredible Years© programmes.

Parent management training aims to reduce child oppositional or antisocial behaviour by improving parenting skills through the use of different strategies and timing of interactions. Reductions in coercive strategies such as yelling, verbal aggression, critical comments or commands are replaced with identification of and subsequent praise and encouragement for positive behaviours and non-aversive discipline strategies (Gross et al., 2003; Kazdin, 1997). The IY BASIC parent training programme has been shown to be effective in significantly increasing positive and non-punitive parenting styles and reducing child problem behaviours (Webster-Stratton et al., 2001).

The Incredible Years© series (IY) combines different theoretical approaches and includes relationship building through child led play (Reitman & McMahon, 2013), coercion theory (Dishion, Patterson, & Kavanagh, 1992) which informs the strategies of ignore, time out and commands; communication and problem solving from work by Gottman & Jacobsen (Katz & Gottman, 1993), and self-control from work on depression by Dr Aaron Beck (1988). The IY model takes a collaborative approach in helping parents to identify their own goals and teaches through discussion, role modelling and interactive learning (Hutchings, Gardner, et al., 2004). Leader skills are key in supporting and empowering parents to help children learn self-management skills that include; problem solving, being realistic about change, accepting imperfections and looking after themselves (Webster-Stratton, 2011). The IY (BASIC) school age programme is a group-based parenting intervention that aims to improve inappropriate child behaviours and increase social and emotional competence, in children aged 6-12 years. The IY model has over 35 years of evidence from research on effectiveness with different populations. A meta-analysis of 18 different interventions for foster families, found evidence that IY improved the parenting abilities of foster carers and decreased child externalising behaviours (Bergström et al., 2019), see also recent reviews by Leijten et al., (2019); Menting, Orobio de Castro, & Matthys, (2013); Pidano & Allen, (2015). The programme is a recommended programme in the Blueprints for Violence Prevention Register in the USA as an intervention effective in preventing coercive parenting and child violence and problem behaviours (https://www.blueprintsprograms.org/). IY has been shown to be effective when delivered as both prevention or treatment programmes for child disruptive behaviours (Leijten et al., 2019), it has also been shown to be equally effective independent of child age across the age range 2-11 years (Gardner et al., 2019).

Aims

This evaluation builds on previous IY research with foster carers by undertaking a pragmatic evaluation of a local authority delivery of the IY school aged programme to both foster and local authority approved kinship foster carers in North Wales. Child behaviour, levels of carer stress and carer-child attachment relationship are measured in a pre-post design to evaluate whether it is effective in benefiting carer reported looked after child behaviour, levels of carer stress and carer-child attachment relationship in two groups, one of foster and kinship foster carers. The data is also explored to see whether the intervention is equally effective with foster and kinship foster carers.

Methods

Procedures

This was a pre- post-intervention of an evaluation of the IY school aged parent programme with kinship and foster carers. A local authority in North Wales invited all of its approved foster and kinship foster carers to attend one of two IY Basic (school age) programmes, one for foster carers and one for kinship foster carers. This chapter reports the pre- and post-intervention results from this evaluation.

Recruitment

The Child Placement Team Leader contacted all local authority foster and kinship foster carers with children aged between 4-12 years, to offer a place on the programme and obtain consent for their details to be passed to the researcher (Appendix D).

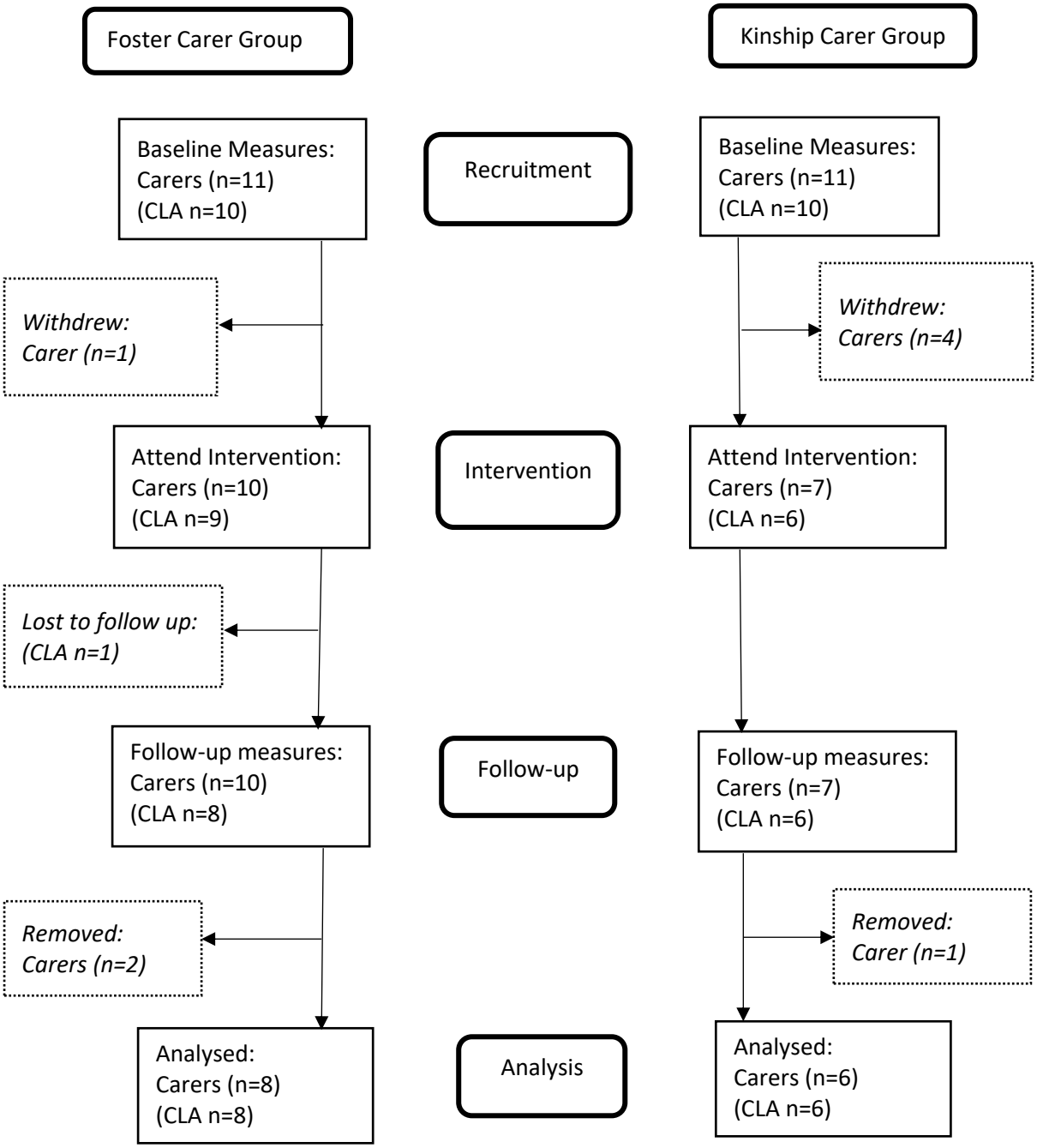
Participants

Eleven foster and eleven kinship foster carers enrolled in the programme, representing 39% of the local authority approved foster carers and 53% of local authority kinship foster carers. Carers with multiple foster children were asked to focus on one child likely to remain in the placement for the six months following baseline measures collected for this study. Couples participating were asked to each report on a different child. The data from two carers, one in each group, was removed from the analysis because they were part of a couple and their partner was reporting data on the same child. One foster carer and two kinship foster carers withdrew prior to the programme starting and a further two kinship foster carers completed baseline measures but did not attend the programme. One child in the foster carer group moved house during the programme and consequently no follow up data was available on that child (figure 6.1).

Ethical Approval

Ethical approval was obtained from the Research and Ethics Committee, School of Psychology, Bangor University in January 2017, application number 2017-15923. The ;ocal authority gave approval for the collection of child data from foster or kinship foster carers where the child was on a full care order. Parental consent was obtained for children not on a full care order. Foster and kinship foster carers all gave informed consent. Data were kept confidential and anonymized on database entry.

Figure 6.1. Flow diagram of IY participants



Measures

Carer report measures were administered to assess child behavioural problems (*Child Behaviour Checklist,* Achenbach & Rescorla, 2001), carer stress levels (*The Parent Stress Index short-form, version 4*, Abidin, 2012) and carer – child attachment relationships (*The Quality of Attachment Relationships Questionnaire*, Scott, n.d.). A demographic questionnaire was used to collect background information about the carer and child (Hutchings, 1996).

Participant demographics.

Participant information was collected using a revised version of the Personal Data and Health Questionnaire (Hutchings, 1996). The questionnaire collects information about the participant, the child, relationships, education and housing, etc. (see Appendix G). The measure has been used in previous studies (Lane & Hutchings, 2002; Williams & Hutchings, 2018). In this study items reported included; length of time carer had been approved, child time in care and number of previous placements.

Child behaviour.

The carer reported Child Behaviour Checklist (CBCL) (Achenbach & Rescorla, 2001) was selected as a measure of child behavioural problems. The measure is validated for use with parents or carers of children aged 0-18 years (Achenbach & Rescorla, 2001) and has been used in previous pre-post-intervention studies with foster carers (Maaskant et al., 2017; Mersky et al., 2016; Uretsky et al., 2017). It measures social, emotional and behavioural outcomes with a total problems score and two sub-scales scoring internalising and externalising behaviour. Total t scores of 63 and above indicate clinically significant levels of problem behaviours..

Carer Stress.

The Parent Stress Index (PSI-SF) (Abidin, 1995) is a standardised and validated measure for pre-post intervention studies and has been used in previous research with foster carers (Maaskant et al., 2017; Nilsen, 2007). PSI-SF is validated for use with parents or carers of children aged one month to 12 years. It has a total stress score and three subscales, Parental distress (PD), Parent-Child Dysfunctional Interaction (P-CDI) and Difficult Child (DC), that measure different mediating factors. Total scores of 114 and above indicate clinically significant levels of stress with PD and DC subscale scores over 39 and P-CDI subscale scores over 36 indicating clinical significance.

Carer-Child Attachment Relationship.

The Quality of Attachment Relationships Questionnaire (QUARQ) 'how my foster child and I get on together' (Scott, n.d.). is a sixteen item questionnaire made up of statements about the relationship between the carer and child. The questions are scored on a 5 point scale based on frequency of occurrence of the behaviour with statements ranging from 'never' to 'very often'. Scoring is completed by allocating a numerical score to each answer, from 0 for 'never' to 4 for 'very often'. The total score is out of 64 and a high score indicates a better quality of attachment relationship, with a low score indicating insecure or poor attachments.

The QUARQ has been used as a primary outcome measure to evaluate the Fostering Changes parenting programme (Briskman et al., 2010). It is used in this study to explore any differences in carer-child attachment relationships between foster and kinship foster carers. No evidence of reliability or validity have been reported.

Procedure

Interested carers contacted the researcher who visited them and gave further information about the intervention (Appendix E). The participant had the opportunity to ask questions before giving informed consent (Appendix E; F). Baseline visits were made to collect care report measures prior to programme attendance, with each carer reporting on one nominated child. Follow up visits were undertaken six months post baseline. Carers received a £10 high street voucher for completing the measures at both time points, as a thank you for their time.

Intervention: The Incredible Years (IY) Basic School Aged Parenting Programme

The IY programme (Webster-Stratton & Hammond, 1997) consists of twelve two-hour sessions delivered weekly. Two trained facilitators delivered the programme, in a group format with up to 12 participants. The programme targets parenting skills with the aim of improving positive parenting, by increasing positive reinforcement and quality time, and teaches limit setting and supervision strategies. Sessions include group discussion, video clips and rehearsal of strategies with homework practice between sessions. The IY groups ran in the daytime during school term.

Implementation Fidelity

Group leaders had all attended the IY three day basic leader training programme and leaders for the foster carer group included an IY mentor. Programme leaders for the foster group included a CAMHS clinical psychologist, also an IY mentor, and a local authority

social worker who was also a certified programme leader. For the kinship foster group, leaders were both from the local authority, one was the same experienced group leader that led the foster carer group and the other a newly trained leader with some experience of programme delivery. The programme mentor had previously delivered the programme to foster and kinship foster carers. Checklists were completed for each session recording what content had been delivered by group leaders.

Statistical Analysis and Missing Data

Analysis was undertaken using SPSS version 22. Exploratory analysis to check for normality was undertaken and between group baseline differences explored. Paired sample t-tests were used to establish whether there were differences between the groups mean scores at baseline and at follow up for normally distributed measures. Effect sizes were calculated using Cohen's d, to determine whether the difference between the two means was trivial ($d > 0.02$), small ($d \geq 0.2$), medium ($d \geq 0.5$) or large ($d \geq 0.8$).

Where exploratory analysis determined that data were not normally distributed, the Wilcoxon signed rank test was used to compare groups and median and range reported. Categorical data comparisons were undertaken using chi-square to compare groups.

Any items not scored on measures reported by carers were managed as per the author's criteria. For the PSI-SF up to one missing item can be substituted by averaging the other scores in the sub-scale, one sub-scale was adjusted in this way. For the CBCL, scores are calculated as long as no more than eight items are missing. None of the measures had more than eight missing items.

Results

Results are reported for eight foster carers, six kinship foster carers and the fourteen children that they looked after. The foster carer group comprised five female and three male carers with a mean age of 54.50 (SD = 10.92), from five households (three individual participants and two couples). These carers looked after three female and five male children with a mean age of 10.5 (2.51) and an age range of 7-14 years, from five households (three households with one fostered child and two with two children). The kinship foster carer group comprised four female and two male carers with a mean age of 54.83 (SD = 11.51), from five households (four individual participant and one couple). These carers looked after one female and five male children with a mean age of 9.33 (SD = 3.27) and an age range of 5-13 years from five households (four households with one child and one with two children).

Demographics

There were two significant between group differences, children placed with kinship foster carers had been in care for a significantly shorter period of time than those placed with foster carers $U = 3.0$, $p<.01$. Kinship foster carers had been approved for a significantly shorter length of time than foster carers $U = 0.0$, $p<.01$ (table 6.1). There were no significant between group differences for child age, gender or number of previous placements, or for carer age and gender.

Table 6.1. Carer and child demographics.

Child Factors	**Foster (n=8)**	**Kinship (n=6)**	***p***
Child age, (years): M (SD)	10.50 (2.51)	9.33 (3.27)	.463
Child age, range.	7-14 yrs	5-13 yrs	
Child gender, male: n (%)	5 (63)	5 (83)	.573
Time in care (years): Mdn (range)	5.5 (1-10)	1.0 (0-2)	.005*
No. previous placements: Mdn (range)	1.0 (0-9)	0 (0-0)	.059

Carer Factors	**Foster (n=8)**	**Kinship (n=6)**	***p***
Carer age, (years): M (SD)	54.50 (10.92)	54.83 (11.51)	.957
Carer gender, male: n (%)	3 (38)	2 (33)	.95
Length of time of approved carers (years): Mdn (range)	12.0 (3-21)	0.8 (1-2)	.001*

*=p<.05

Whole Group Results.

Examination of whole group pre- and post-attendance data, showed that for the total score for the Child Behavioural Check List, 6 (43%) of scores were in the clinical range at baseline, with 5 (36%) of scores in the clinical range at follow up. For the Parent Stress Index (short-form), at baseline, 3 (30%) of scores were in the elevated or high ranges and there were no elevated or high scores at follow up.

To test whether course attendance had an effect on carer report of looked after child behaviour, a paired samples t-test was undertaken on baseline and follow up scores on the Child Behaviour Checklist (CBCL). The test was found to be statistically significant, $t(13)=2.67$, $p=.019$; $d=.41$. The effect size for this difference ($d=.41$) exceed Cohen's (1988) convention for a small effect size ($d=.2$). These results indicate that overall carers reported fewer child behavioural problems ($M=53.71$ $SD=14.35$) after attending the programme, than at baseline ($M=58.93$ $SD=10.85$).

To test whether attendance on the programme had an effect on carer reported stress, a paired samples t-test was undertaken on baseline and follow up scores on the

Parent Stress Index – Short Form (PSI-SF) and demonstrated a statistically significant improvement, *t*(13)=3.47 *p*=.004; *d*=.45 with an effect size (*d*=.45) that exceeded Cohen's (1988) convention for a small effect size (*d*=.2). These results indicate that overall carers reported lower levels of stress (*M*=74.21 *SD*=16.74) after attending the programme, than at baseline (*M*=82.79 *SD*=21.52) (Table 6.2).

A paired samples t-test showed that no significant difference between child-carer attachment at baseline and follow-up (table 6.2).

Table 6.2. Whole group main results.

	Baseline	**Follow-up**		
	All (*n*=14)	**All (*n*=14)**	***t***	***p***
Measure (Clinical cut off score)	***M (SD)***	***M (SD)***		
Child Behaviour Check List (CBCL)				
CBCL Total (64)	58.93 (10.82)	53.71 (14.35)	2.67	.019*
Parent Stress Index (PSI-SF)				
PSI-4-SF Total (114)	82.79 (21.52)	74.21 (16.74)	3.47	.004*
Quality of Attachment Relationships Questionnaire (QUARQ)				
Total Score	32.36 (8.84)	34.43 (7.14)	-1.98	.069

*=p<.05

Incredible Years course participant attendance, fidelity and satisfaction feedback

Mean programme attendance for the sample overall was 8.5 out of 12 sessions (70.8%). For the foster carer group, average attendance was nine of the 12 sessions (73%), with average attendance for the kinship foster care group eight of the 12 sessions (63%). The percentage of the programme content items delivered to participants was 70% for foster carers and 76% for kinship foster carers.

Feedback sheets were completed weekly by all course attendees. Analysis of the weekly satisfaction data gave a mean score of 3.6 (89%) for the foster carer group and of 3.8 (94%) for the kinship foster carer group out of a total of 4 (1= not helpful, 2= neutral, 3= helpful, 4= very helpful). Overall 98% of foster carer and 99% of kinship foster carers rated the programme as helpful or very helpful (table 6.3) indicating a high rate of satisfaction.

Table 6.3. Carer count and percentage of scores from feedback sheets. N (%)

Component	Not helpful	Neutral	Helpful	Very helpful
Foster Group (n=8)				
Content	/	1 (1)	33 (43)	42 (55)
Video	/	10 (19)	19 (36)	24 (45)
Leader	/	/	14 (18)	62 (82)
Discussion	/	/	13 (17)	63 (83)
Role play	/	6 (11)	20 (38)	27 (51)
Kinship Group (n=6)				
Content	/	/	3 (6)	46 (94)
Video	/	1 (2)	11 (23)	36 (75)
Leader	/	/	/	49 (100)
Discussion	/	/	2 (4)	47 (96)
Role play	/	1(2)	8 (17)	39 (81)

Between Group Results

In order to compare the effect of programme attendance on the foster and kinship foster carers, between group analyses were undertaken.

Child behaviour measure – carer report.

Examination of between group differences for the CBCL showed that none of the kinship scores were in the clinical range for any of the scales at baseline or follow up. Six (75%) of foster carers reported child behaviour in the clinical range on the total score at baseline (*M*=65.75 *SD*=8.36), indicating they reported higher rates of behavioural problems at baseline than kinship foster carers. At follow up, five (63%) of foster carer reported children as scoring in the clinical range on the total CBCL scale. On the CBCL externalising scale, at baseline 5 (63%) of foster carers reported clinical range scores, compared to four (50%) at follow up (table 6.4).

Comparisons were undertaken between foster and kinship group mean scores on the total and subscales, p values were corrected using a Bonferroni adjustment, see table 6.4. Within group analysis between baseline and follow-up showed the difference for the sub-scale internalising behaviour t(8)=2.74 *p*=.029 for the foster carer group approached significance, but did not meet criteria after adjustment For the internalising scale, four (50%) foster carers reported scores in the clinical range at baseline, with one (13%) reporting in the clinical range at follow up.

Table 6.4. Between group results - CBCL.

Measure	Baseline	Follow-up		
(Clinical cut off score)	***M (SD)***	***M (SD)***	***t***	***p***
Foster Group (n=8)				
CBCL Total (64)	65.75 (8.36)	61.88 (9.52)	1.86	.105
CBCL Internalising (64)	61.75 (10.44)	54.25 (11.51)	2.74	.029
CBCL Externalising (64)	62.13 (13.26)	60.50 (11.65)	0.4	.704
Kinship Group (n=6)				
CBCL Total (64)	49.83 (5.74)	42.83 (12.64)	1.88	.12
CBCL Internalising (64)	44.67 (7.47)	39.67 (5.89)	1.62	.166
CBCL Externalising (64)	51.50 (6.25)	47.17 (11.55)	0.85	.437

*=p<.001

Carer stress.

Mean scores on the PSI-SF were in the normal range at baseline and at follow up for both groups. At baseline, 3 (30%) of foster carer scores were in the elevated or high range, compared to none at follow up. No kinship foster carers scored in the elevated or high ranges at baseline or follow up, however 1 (10%) scored in the low range at baseline and 2 (33%) scored in the low range at follow up (table 6.5).

Table 6.5. Between group results - total score PSI-SF Percentile Bands.

	Baseline	Follow up
	***n* (%)**	***n* (%)**
Foster Group (n=8)		
Low	0 (0)	0 (0)
Normal	5 (50)	8 (100)
Elevated	2 (20)	0 (0)
High	1 (10)	0 (0)
Kinship Group (n=6)		
Low	1 (10)	2 (33)
Normal	5 (50)	4 (67)
Elevated	0 (0)	0 (0)
High	0 (0)	0 (0)

Within group analysis using paired samples t-tests between baseline and follow up showed foster carer total score t(8)3.49, *p*=.01, showed a statistically significant difference between baseline and follow up. There were no significant differences for kinship carers (table 6.6).

Table 6.6. Between group results - PSI-SF results.

Measure (Clinical cut off score)	Baseline *M (SD)*	Follow-up *M (SD)*	*t*	*p*
Foster Group (n=8)				
PSI-4-SF Total (114)	95.00 (19.32)	83.38 (15.21)	3.49	.010
Kinship Group (n=6)				
PSI-4-SF Total (114)	66.50 (11.15)	62.00 (9.57)	1.38	.225

*=p<.05

Results indicate that for the foster carer group, the total stress score reduced at follow up, indicating lower levels of carer stress on these measures after attending the group.

Carer-Child attachment relationship.

Within group analysis using paired samples t-tests between baseline and follow up showed foster carer total score t(8)=2.35, *p*<.05, showed a statistically significant improvement at follow up (table 6.7).

Table 6.7. Between group results – QUARQ.

Measure	Baseline *M (SD)*	Follow-up *M (SD)*	*t*	*p*
Foster Group (n=8)				
Total Score	43.75 (14.11)	47.75 (10.14)	-2.35	.05*
Kinship Group (n=6)				
Total Score	46.67 (6.77)	45.83 (7.52)	0.35	.74

*=p<.05

These results indicate that for the foster carer group, the attachment relationship improved between baseline and follow up, indicating foster carers reported better quality attachment relationships after attending the course.

Discussion

This study evaluated whether the IY behaviourally based school aged parenting programme, was effective in reducing carer reported looked after child behaviour and levels of carer stress and improving carer-child attachment relationships. Results from combined group data showed that both looked after child behaviour *t*(13)=2.67, *p*=.019; *d*=.41 and carer stress *t*(13)=3.47 *p*=.004; *d*=.45 were significantly reduced with small effect size changes for both results. Despite a lack of control group these results tentatively suggest

that the changes were likely to be due to carers attending the intervention. There were no significant changes for carer-child attachment relationship for the whole sample. Carers reported a high level of satisfaction with the training programme with over 98% rating the programme as helpful or very helpful. Mean group attendance was 70.8%, indicating a high level of attendance. Fidelity of programme delivery, indicated by the amount of the course programme delivered was 70% for the foster carer group and 76% for the kinship foster carers, this is within the parameters of between 60-80% indicated as realistic (Dane & Schneider, 1998). Two of the three programme facilitators were experienced programme leaders. Leaders are important models for parent that in turn, predict child behavioural change (Eames et al., 2009; Scott, Carby, & Rendu, 2008).

Examination of differences between foster and kinship foster carers, showed that foster carers reported higher baseline level problems for children on the CBCL than kinship foster carers and significant post-intervention improvements on the carer-child attachment relationship using the QUARQ. Foster carers reported higher baseline levels of stress on the PSI-SF and significant improvements at follow up for the total score, than kinship foster carers.

Whole Group Findings.

Following programme attendance foster carers reported lower levels of stress and improvement in child behaviours. The findings of improvements in reported stress post-intervention differ from Nilsen (2007) who also measured stress using the PSI-SF in foster carers (n = 18) looking after children of a similar age range (M=8.11, SD=1.61), who attended an adapted IY programme. Nilsen's (2007) findings showed no significant difference between baseline and follow up, with the mean scores increasing slightly post-intervention on the total and all three sub-scales. One of Nilsen's co-leaders in each group was a foster carer, recruited and trained for the study. The programme was delivered in a small group format of three or four care givers per group and additional information related to fostering was included as part of the programme. Follow up measures were taken two weeks after completing the course. Nilsen (2007) reported significant improvements in child behaviour, on the conduct and externalising scales of the Behavioural Assessment Scale for Children, findings supported by other research studies using IY with foster carers (Bywater et al., 2011; McDaniel et al., 2011). Karjalainen, Kiviruusu, Aronen, & Santalahti, (2019), used the ECBI and CBCL along with the PSI, in a RCT of 98 children and families involved in child protection, finding improvements in child behaviour on the ECBI problems scale, non-significant improvement in the CBCL externalising scale and no improvements in carer stress. Bywater et al., (2011) and McDaniel et al., (2011) both used the Eyberg Child

Behaviour Inventory (ECBI) as the primary measure of behavioural change, which measures the intensity of conduct problems and the extent to which they are problematic (Robinson et al., 1980). Both studies found statistically significant improvements in the intensity scale that measures frequency of behaviours, but not in the problem scale that reports how problematic they rated the behaviour.

Findings in this study, using the CBCL indicates that carers ratings of children showed a statistically significant improvement in total behaviour score for the whole sample and non-significant improvements in internalising and externalising scores for foster carers. This is an unexpected finding as parent training programmes target externalising behaviours and other research using the CBCL with foster carers reported improvements in both internalising and externalising behaviours. Keeping Foster and Kinship Carers Trained and Supported (KEEP) (Greeno, Lee, et al., 2016; Leathers et al., 2011) found improvements in the total score and both internalising and externalising subscales as did a study of Parent-Child Interaction Therapy (Mersky et al., 2016). Perry & Price, (2018) found an association between internalising behaviour scores and higher carer stress scores in an evaluation of 310 foster carers prior to attending a parenting intervention, indicating a possible link between carer stress and child internalising behaviours. The lack of significant improvements in the CBCL internalising and externalising sub-scale may be a result of the small sample size providing insufficient data to measure change. Indications are that parenting programmes do influence other aspects of child behaviour, such as internalising behaviours, however research tends to measure and report changes in externalising rather than internalising behaviours (Madigan et al., 2016). As such, it is unclear from research how typical changes in internalising behaviours are as a result of attending a parenting intervention.

Between Group Findings.

The present study did not find whole group significant differences in the Quality of Attachment Relationships Questionnaire, however there was a small but significant improvement in attachment relationship for the foster carer group after attending the intervention. As children placed with foster carers have experienced a different form of attachment disruption when moved away from parents than children placed with kinship foster carers, this may be a contributing factor to the differences found between the foster and kinship groups.

At follow up, foster carers reported significant improvements on the PSI-SF Total Stress score, and in the QUARQ attachment relationships total score. For foster carers, there are indications that reported improvements in child behaviour may link to an increase

in a sense of parenting competence, or vice versa. There were reductions in behavioural and stress measures for kinship foster carers, but these were not statistically significant. One possible contributing factor may be that the kinship sample size was smaller (n=6) than foster carers (n=8). However between group differences were explored at baseline (chapter 5), with kinship foster carers reporting lower baseline scores than foster carers for the CBCL and PSI-SF, and similar scores on the QUARQ.

Previous research has reported differences between foster and kinship foster carers, with kinship foster carers reporting fewer behavioural problems than foster carers (Hegar & Rosenthal, 2009; Keller et al., 2001; Rosenthal & Curiel, 2006; Shore et al., 2002). Keller et al., (2001) found kinship scores on the CBCL to be very similar to a non-care population. In this study, baseline kinship scores for the Total and Externalising behaviour scales are also similar to the normative samples for the CBCL and are similar to the Keller findings. Internalising behaviours reported by kinship carers at baseline were lower than the CBCL normative sample (Achenbach & Rescorla, 2001).

Reasons for the differences between foster and kinship foster groups are unclear and may be due to reporting differences or actual differences between the two groups. The small sample size means that it is difficult to draw conclusions, however some suggestions can be drawn from the literature. Self-report measures, including those used in this study are vulnerable to respondent bias (Dickes et al., 2018) in relation to both self-inflation, and situational or time related effects. Dishion, Rivera, Verberkmoes, Jones, & Patras, (2002) note that relationships between self-report of caregiving behaviour and attitudes and actual parenting behaviour may not be highly correlated. Research indicates kinship foster carers report children placed with them having better socio-emotional health and behaviour with fewer problems than those placed with foster carers (Keller et al., 2001; Rosenthal et al., 2006), however teacher reports on the same children did not support this finding (Rosenthal et al., 2006). Teachers reported similar or higher behavioural problems in children placed with kin carers as foster carers, with carers having lower incomes and being less well educated being linked to higher reports of child behaviour problems. In this study, there were no significant differences between the two groups in the age they left school, however significantly more kinship foster carers were in receipt of state benefits, than foster carers (chapter five).

In the looked after population in general there are differences between foster and kinship carers, with kinship carers more disadvantaged, with less family support, a lower socio-economic status and higher levels of unemployment (Sykes et al., 2002). Despite this, kinship carers can have more stable placements with lower levels of reunification with

parents, or adoption (Winokur et al., 2008). Children in kinship care are in general, securely attached and securely attached children are at lower risk of disruptive behaviour (Farmer & Moyers, 2008). There are significant advantages for children to being in kinship care including continuity of family identity, increased access to relatives and a pre-existing relationship prior to placement making removal from home less traumatic. These advantages may, in part, explain between group differences found here.

Kinship carers receive less training than foster carers (Cuddeback, 2004; Palacios & Jiménez, 2009; Sykes et al., 2002), with Selwyn et al., (2013) finding that 90% of kinship carers want more support. Kinship carers may be reluctant to participate in formal training but be more open to support groups made up of other kinship carers (Sykes et al., 2002). In this study a higher number of kinship foster carers withdrew or failed to attend the intervention than foster carers. Kinship foster carers reported fewer baseline problems than foster carers and post intervention improvements were non-significant. However, kinship foster carers liked the course and, of those that attended the course, 99% rated the course contents as helpful or very helpful.

Limitations

This study was an evaluation of two group based IY parenting programmes delivered by a local authority to their foster and kinship foster carers. The small sample and lack of control condition are significant limiting factors when interpreting results. The participant report measures have been used in previous research with foster carers, but have mostly been validated with parents and biological children, not with children who are looked after. However this does enable comparisons of children looked after with children within the population in general. Obtaining teacher reports of child behaviour could have been a way of verifying carer reports of child behaviour. The use of a more detailed attachment measure such as the Child Attachment Interview (Target, Fonagy, & Shmueli-Goetz, 2003) may have gained more information about any changes in attachment relationships, however numbers of participants would still have been a limiting factor. The groups were delivered by leaders with different levels of experience and the kinship group leaders did not access supervision despite it being offered.

Future research

Future research could build on these findings with a larger efficacy trial with separate groups of kin and foster carers. More in depth investigation of behavioural change to determine which aspects of behaviour change, along with evaluation of parenting skills before and after intervention could help to inform how the programme promotes change in both carers and children. The evidence that attachment relationships may be strengthened

by training carers in behavioural skills through SLT based interventions is worthy of further research.

Conclusion

Whole sample findings indicated benefits from attending the programme with improvements in child behaviours and carer stress, however separate evaluation of the two groups reveals that these benefits mainly occurred for the foster carers, with kinship foster carers also liking the course but reporting fewer baseline difficulties. Foster carers liked the course and reported benefits in improvements in stress and carer-child attachment relationship.

The tentative finding that the IY group based parenting programme may help foster carers to improve carer stress and their attachment relationships is important and worthy of further research. There were no significant findings for the kinship foster carer group, however this may be due to the small sample size or due to the fact that they were reporting lower levels of problems. There are indications from the satisfaction survey that parenting interventions are helpful to both foster and kinship foster carers. Carers undertake a difficult role, with limited resources and support, therefore identifying a training programme that can support them and potentially improve outcomes for the children they look after is important.

CHAPTER 7

Evaluation of Facilitator Training and Barriers to the Implementation of an EPaS Programme by Social Workers.

Introduction

This chapter reports on a project that initially aimed to evaluate the delivery of the Enhancing Parenting Skills (EPaS) programme to foster and kinship foster carers by their supervising social workers. Five social workers were trained to deliver the EPaS programme, however, they were unable to recruit participants within the time-frame of the PhD. Instead, social workers experience of the training, including benefits and constructive feedback were explored through semi-structured interviews. Five social workers attended the training, however by follow up, two had left the service so interviews were undertaken with the remaining three social workers. Organisational and individual factors that can act as barriers to effective implementation of new interventions are also explored.

Foster carers report high levels of behavioural problems with the children they care for (Ford, Vostanis, et al., 2007), yet are often not offered behaviourally based, parenting interventions as recommended for parents and carers of children with challenging behaviours (Chapter 4; NICE, 2013). Group based interventions are not always effective for all participants (Scott & Dadds, 2009) and in rural areas travel distance can be a barrier to accessing interventions. One to one programmes allow training and support to be tailored to the specific needs of the participant, can be delivered in the home and so may be more acceptable and appropriate for some carers. Foster and kinship foster carers are supported by supervising social workers, who facilitate access to training and individual support. Training supervising social workers to deliver a one to one behaviourally based intervention could provide a means of providing carers with an easily accessible behavioural intervention tailored to their needs.

Foster and kinship foster carers can experience difficult child behaviours for which they are often not well prepared (Murray et al., 2011). In turn, child behavioural problems can contribute to placement instability through placement breakdowns (Hannah & Woolgar, 2018) when carers are no longer able to manage difficult behaviour and request that a child is removed. Despite the recommended interventions for conduct problems and behavioural difficulties being behaviourally based parenting interventions (NICE, 2013), carers are not always routinely offered these programmes (Chapter 4; Barth et al., 2005). Some carers offered group training indicate they prefer dedicated training programmes due to concerns around confidentiality (Hutchings & Bywater, 2011), whilst up to a quarter to a third of families attending a group based intervention do not benefit (Scott & Dadds, 2009). One way to address these difficulties would be to deliver a one to one intervention in the carers home, enabling the intervention to be tailored to the carers specific needs (Reyno & McGrath, 2006). All foster and kinship foster carers are supported by a supervising social

worker, who acts as a point of contact for support, training needs and administrative difficulties. Supervising social workers routinely visit carers, usually on a monthly schedule to provide support and supervision for the fostering role. Training supervising social workers in a behavioural intervention, would give them skills to support carers and enable easy access to support for carers, which could be delivered at home.

One to one interventions.

Parenting interventions are typically delivered in a group setting, with the joint benefits of multiple participants making interventions cost effective and providing peer support. Some group based interventions such as the Incredible Years© programme can also be delivered as a home coaching version, either to catch up with missed sessions, or where it is the most appropriate form of delivery for the individual (Webster-Stratton, 2011), however, it has yet to be evaluated as a one to one home delivery. Other interventions have been delivered and evaluated with individual parents or a caring couple. Three parent training programmes (Attachment and Bio-behavioural Catch-up; Parent Management Training Oregon; Non Violent Resistance) have been evaluated as individually based interventions with foster or kinship carers and one programme (Parent-Child Interaction Therapy) that has both group and one to one versions has to date only been evaluated as a group delivery to foster carers. All four programmes have been reviewed in detail in chapter three.

Attachment and Bio Behavioural Catch-up (ABC) for carers of children with an age range of 1-4 years, targets communication, aiming to strengthen relationships and increase nurturing. Two randomised controlled trials (Dozier et al., 2006; 2008; 2009; Sprang, 2009) have evaluated ABC with foster carers, both finding post intervention improvements in child behaviours, parenting skills and child avoidance. Parent Management Training Oregon (PMTO) targets parenting behaviours associated with child difficulties, with carers coached in parenting skills to decrease ineffective parenting strategies. A randomised control trial evaluating a home delivery to foster carers, looking after children (mean age 7.85 years) in Holland (Maaskant et al., 2016; 2017) failed to find significant changes in child behaviour at follow up.

Non Violent Resistance addresses violent and self-destructive behaviours in children and teenagers, with parents or carers taught to use resistance, awareness and negotiation to improve compliance and reduce difficult behaviours. An evaluation with foster and kinship carers (Van Holen et al., 2016) was effective in reducing behavioural problems in children looked after (mean age 12.5 years). Parent-Child Interaction Therapy (PCIT) is a clinic based intervention for children aged 2-7 years, which coaches' parents in positive

interactions, play and effective discipline strategies, aiming at reducing the negative and coercive interactions associated with behavioural problems. Trials of PCIT with foster carers (McNeil et al., 2005; Mersky et al., 2015 ; 2016) were undertaken in a group delivery format, including one to one coaching and found significant reductions in parenting stress and improvements in positive parenting strategies and child behaviours.

The limited research on individual interventions with foster and kinship foster carers is mainly positive, with some reports of improvements in child behaviours and carers parenting skills at follow up. Most of the programmes briefly reviewed above are manualised programmes, teaching a generic set of skills to help parents or carers manage problem behaviours. ABC and PCIT work with the parent and the child and address some specific difficulties with each dyad, however, given that they are manualised with a set curriculum, the specific needs of the carer in relation to the child are addressed in a generic way. The programme used in this review, the Enhancing Parenting Skills programme is different in that it uses a model that has a strong focus on the assessment of difficulties and their functions that leads through a case analysis to the identification of realistic participants' goals and a tailored intervention for each participant.

The Enhancing Parenting Skills Programme (EPaS).

The Enhancing Parenting Skills (EPaS) programme was developed (Hutchings et al., 2002; Hutchings, Lane, & Kelly, 2004; Lane & Hutchings, 2002) for families referred to Child and Adolescent Mental Health Services (CAMHS) experiencing challenging child behaviours. The programme is based on social learning and social construction theories, which propose that learning occurs within a social environment through modelling and reinforcement, with all behaviours, including problematic ones, having a function of producing a desirable consequence or reducing or avoiding an undesirable consequence. It comprises three stages; an initial assessment stage, a case analysis based on assessment findings and a targeted intervention, providing a customised intervention specific to the needs of the participant. During the initial assessment phase, a range of measures are used to identify family information, child problem behaviours, the probable functions of the behaviours and the child and families strengths and goals. This information is used to develop a theory of the function of the problem behaviour and identify strengths and supports that will facilitate behavioural change and the achievement of the identified goals for replacement behaviours. This case analysis is discussed and agreed with the family and short and longer-term family specific goals agreed. The facilitator then supports the family through the intervention phase by coaching them in behavioural strategies, such as use of

rewards and consequences to teach new, alternative behaviours and encourage change to achieve the family goals.

An early intensive version of the programme has been evaluated with a randomised control trial in CAMHS, North Wales in 1999, with parents of children referred with severe behavioural problems (Hutchings et al., 2002; Hutchings, Lane, et al., 2004). The control condition was standard CAMHS based clinic appointments. The EPaS intervention was delivered on a one to one basis by clinical psychologists in a combination of home and clinic sessions. Two day long clinic visits for the parent/s and child collected information and observational data from a range of parent and child led tasks, followed by case analysis and three, five-hour clinic sessions where parents were coached, using video and bug in the ear feedback, to use different parenting strategies to achieve agreed goals. These sessions were followed with further home visits to support generalisation of skills to the home environment. At six month follow up, there were significant improvements for both intervention and control families in child behaviour, parenting strategies and parental mental health however these were greater in all cases for the EPaS group. At four year follow up intervention effects had persisted for the EPaS group whereas the standard CAMHS treatment group, who had predominantly received didactic behaviour management advice, had reverted to baseline problem levels (Hutchings, Lane, et al., 2004). Furthermore costs of services used at four year follow-up were significantly greater for the standard CAMHS treatment group however as the children had grown older these had primarily moved from health to social care (Muntz, Hutchings, Edwards, Hounsome, & Ó'Céilleachair, 2004).

To widen the accessibility of this intervention, the EPaS programme was developed into a weekly one to one home delivery using the same core components. This was evaluated when delivered by health visitors to families they were supporting in North Wales, in 2001 (Lane & Hutchings, 2002). The health visitors attended a twelve week, half day a week training programme, whilst supporting families using the intervention. Findings showed improvements in child behaviours and parental mental health, compared to a non-randomised control group. Health visitors also reported significant increases in knowledge and use of behavioural strategies and in their confidence to deliver a behavioural intervention programme. A further randomised controlled trial of EPaS delivered by health visitors was undertaken by Williams and colleagues, in North Wales during 2017 (Williams, Hoare, Owen, & Hutchings, 2019). The health visitors were trained over three full day sessions (one on each phase of the programme) and recruited and delivered the intervention to families in their caseload. At post intervention, significant reductions in child behaviour problems were found.

The current study planned to recruit and train supervising social workers who would receive three days of EPaS training, and enable them to recruit and deliver the programme to the foster or kinship foster carers they supervised. Five social workers were recruited and trained, however, difficulties in terms of other demands and recruiting carers meant no participants were recruited, so at follow up any other benefits of the training and barriers to the delivery of the intervention were explored with the social workers.

Barriers to implementation.

Successful adaptation of a programme from initial developer trials that demonstrate efficacy, to use in real world settings is a difficult process (Durlak & DuPre, 2008). In developer trials, adherence to programme implementation and fidelity, use of skilled facilitators and screening of participants help ensure successful outcomes (Fixsen, Blase, Naoom, & Wallace, 2009; Hutchings, Daley, et al., 2007). Adoption and delivery of interventions by organisations outside of research based organisations is necessary for the successful and ongoing use of the programme with target users (Chamberlain, Price, Reid, et al., 2008). Interventions can fail to be successfully adopted, or implemented for multiple reasons that can be linked to organisational values and priorities, or individual skills and motivations (Durlak & DuPre, 2008). Three reviews (Durlak & DuPre, 2008; Fixsen et al., 2009; Greenhalgh et al., 2004) identify eleven factors that are important in effective implementation; funding, a positive work climate, shared decision-making, co-ordination with other agencies, task formulation, leadership, programme champions, administrative support, provider skill proficiency, training and ongoing intervention support (Durlak & DuPre, 2008). Structures and cultures within organisations including management priorities, funding and resource constraints can influence choice and implementation of interventions (Newman, Papadopoulos, & Sigsworth, 1998), whilst individual factors including motivation, role clarity and pre-existing skills etc influence effective programme delivery and successful outcomes.

Interventions based on behavioural principles rely on practitioner skills to build a collaborative working alliance with the participant that will engage and support them through behavioural change (Scott & Dadds, 2009). Behavioural change is difficult and practitioners need to build relationships and trust with participants through active listening, sharing, acknowledgement and validation, praise and encouragement (Schmidt, Chomycz, Houlding, Kruse, & Franks, 2014). This relationship, or therapeutic alliance needs to be built over a short time frame (Dishion et al., 2014), with practitioners using techniques that help achieve behavioural change such as motivational interviewing, or cognitive behavioural therapeutic skills facilitating the process (Axford & Berry, 2018). The need for these skills is a requirement of many evidence based interventions, either prior to entering a leader training

programme or as part of the training itself (Eames et al., 2010; Layzer, Goodson, Bernstein, & Price, 2001; Scott et al., 2008). Traditionally, social work has not focused on delivering interventions with evidence of effectiveness (Weissman et al., 2006) and there is limited information as to what factors influence the adoption and implementation of interventions in social care (Chamberlain, Price, Reid, et al., 2008). In addition, there is limited research on role of the supervising social worker, their perspectives and experiences (Cosis Brown et al., 2014).

Aims

This study aimed to better understand the challenges in providing and supporting training for the implementation of the EPaS programme for foster and kinship foster carers, by training supervising social workers. The aims were to obtain social worker feedback on their experience of the EPaS training and of the barriers and enablers to delivery of EPaS by social workers to carers.

Methods

Study Design

This mixed-methods evaluation was undertaken to gain feedback on the training and better understanding of the difficulties experienced by supervising social workers in recruiting participants for the delivery of the EPaS programme, An approach to a Welsh local authority, led to the recruitment of supervising social workers to be trained to deliver the EPaS programme to foster or kinship foster carers. Five social workers participated in the three day training spread over October and November 2018. A semi-structured interview and a questionnaire were completed with the three social workers who remained with the local authority in April 2019.

Participants

Three female participants, mean age 48.7 years (SD = 11.0) completed the questionnaire and the qualitative interview. All were fully qualified and experienced social workers with over 12 years (M=15.33, SD=2.31) working experience.

The Enhancing Parenting Skills Programme

The Enhancing Parenting Skills programme (EPaS) is a one to one parenting intervention based on a model used with families of children with behavioural problems in a Child and Adolescent Mental Health Service (CAHMS) in the 1990's (Lane & Hutchings, 2002). It has been developed into a home visiting programme and has been evaluated with

Health Visitors (Lane & Hutchings, 2002; Williams & Hutchings, 2018) and is published as a manual (Hutchings & Williams, 2019). The programme has three stages; assessment, case analysis and intervention. During the assessment stage, a collaborative relationship is built with participants whilst information is gathered about the family, their circumstances and child related difficulties. The information gathered during the assessment is used to inform understanding of the history and current functions of the problem behaviour, along with strengths available that will support change. The case analysis informs the goals for behavioural change, which are discussed with the family and a contract for change agreed. The facilitator then works with the family to introduce and coach the parenting strategies needed to achieve the desired goals. Progress is monitored through record keeping and weekly support until the goals are achieved.

Programme content and delivery.

The programme is based on the social constructional model (Goldiamond, 1974; 1975) and uses strategies based on behavioural and social learning theory to facilitate change (reviewed in more detail in chapter two). It is based on the theory that parents play the primary role in reinforcing problematic child behaviours (Bandura, 1977). It contains components identified as key for effective interventions (Hutchings, Gardner, et al., 2004). These include a comprehensive assessment that informs a functional analysis of behaviour, to enable development of appropriate intervention strategies. The use of facilitator-participant collaboration, developed through empathy, acceptance and warmth to establish the positive relationship that will support participant engagement and lead to change. Finally the use of behavioural principles to coach participants in behavioural skills, such as relationship building and praise to strengthen relationships and strategies such as logical consequences and ignoring to reduce problem behaviours. The programme is designed to be delivered weekly over 10-12 weeks. The assessment takes three weeks, the case analysis one week and the length of intervention is tailored to participants needs but is generally 6- 8 sessions.

EPaS Facilitator training programme.

The facilitator training programme is delivered over three sessions. Session one covers the first three sessions with the family, which introduce the components of the assessment stage and cover the measures and tools to use with parents or carers to identify the problems or difficulties they are having with a nominated child. The second training session covers the fourth session with the family, where the case analysis is presented containing an interpretation of the information from the assessment stage, a functional analysis of behaviour and relevant and achievable goals are agreed. After is discussed with

the participants, goals for change are identified and a contract for change agreed. The third session, (intervention) teaches tools and strategies for behavioural change, including some case examples of how different scenarios have been managed. The training, delivered monthly, is intended to run alongside delivery of the intervention, so that facilitators can be coached through the different stages. In this study, it was agreed to deliver the training programme over a six-week period with facilitators recruiting participants prior to the training. Training was delivered by the programme author, Professor Hutchings.

Ethical Procedures

This study was granted ethical approval by the University of Bangor Psychology Ethics Committee (2018-16314). An amendment was approved in March 2019 (A14507), for the collection of additional data from the social workers. Consent was taken prior to attendance on the training programme and prior to interview for the qualitative interview (Appendix I). All participants had the right to decline to participate and to request to have their data removed from the study.

Quantitative Data Collection and Analysis

Five social workers were recruited from the team within the local authority that supervised authority approved foster and kinship foster carers. All five supervising social workers attended the three-day EPaS facilitator training programme. Two subsequently left the authority and the remaining three social workers were interviewed and completed the behavioural questionnaire for a second time in April 2019.

Quantitative data was evaluated using a paired samples t-test to establish whether there were any differences on the behavioural questionnaire between baseline and follow-up. The behavioural questionnaire was developed for a study (Hutchings & Nash, 1998) to assess health visitors knowledge and skills. It records current skill use and knowledge in relation behavioural intervention skills, as insufficient behavioural knowledge can be a barrier to implementation of an intervention (Shapiro, Prinz, & Sanders, 2012). The questionnaire is in two parts, the first part asks about the current frequency of use of specific behavioural intervention techniques and strategies, when working with children and families. The second part asks about views on, and use of, a behavioural approach in working with children and families, ability and confidence in the application of knowledge of the behavioural approach (Appendix K). It was used with Health Visitors in previously published research (Williams & Hutchings, 2018). In this study, the questionnaire was completed by participants prior to the training and again six months later.

Qualitative Data Collection

Data collection.

The interviews took place during April 2019 at the social workers work place in North Wales, lasted for about one hour and were recorded on digital recorders and transcribed verbatim by an independent transcriber. The social workers were all bilingual Welsh-English, with interviews conducted in English. Participants was interviewed individually by the researcher. A semi-structured interview guide was used to examine the following themes: a) usefulness of the different parts of the training to the social workers role, b) what aspects of the EPaS training they thought could be improved, and c) what were the barriers to implementation.

Qualitative data analysis.

A combined inductive and deductive approach to data analysis based on a thematic analytic approach was used to investigate themes within the data. The researcher assessed and coded the transcripts based on the three broad theme groupings identified from the literature; organisational factors, collaborative working and training effectiveness. Coding was undertaken using NVIVO, v12 software. Initial codes were grouped into categories using the interview themes as a guide. The themes were modified according to the topics found within the data, with topics containing coding from all three transcripts and/or higher numbers of coded text being incorporated into the existing themes.

Trustworthiness and researcher bias.

Data were analysed from both the qualitative and quantitative information, to strengthen the validity of findings. The audio-recordings were transcribed by an external transcriber and checked by the researcher, to accurately capture the data. The transcripts were then coded by the researcher. A coding diary was maintained by the researcher to identify developing thoughts and themes during the coding process. The researcher is also a foster carer with experience of working with supervising social workers from a different local authority. As such, the researcher was aware she might bring some bias to the formulation of questions and interpretation of the transcripts. The questions for the semi-structured interviews were approved by both supervisors and the interviews were independently transcribed, to reduce bias. The researcher reflected on the process of interpretation and selected the themes referred to by all three participants, with the highest number of codes allocated during analysis to generate the results.

Results

Participant Attendance and Satisfaction

The EPaS training course was attended by five social workers, two workers missed one session each, with an overall attendance of 86.7%. Three social workers were available for follow up interviews, one of these three workers missed one training session, the overall attendance for the participants interviewed at follow up was 88.9%.

Immediately after completing the training course, social workers completed feedback sheets about the delivery of the training course. Responses of 5= 'very helpful' and 4= 'helpful' were counted and the percentage calculated, results are presented in table 7.1. All five participants completed the feedback sheets and indicated they were very satisfied overall with the course (100%).

Table 7.1. EPaS training course feedback.

Training feedback (n=*5*)	**Helpful/very helpful *n (%)***
Meet expectations?	4 (80)
Objectives explained?	4 (80)
Well structured?	1 (20)
Clearly presented?	4 (80)
Trainer knowledgeable?	5 (100)
Trainer involved group?	5 (100)
Range of participatory methods used?	4 (80)
Content relevant?	4 (80)
Able to put into practice?	4 (80)
Pack/Handouts clear and presentable?	4 (80)
Visual aids clear / presentable?	4 (80)
Satisfied overall?	5 (100)

General comments included in the feedback sheets indicated social workers were very positive about the training:

"Really enthusiastic about wanting to be involved in using this intervention. I feel this will be really beneficial for the foster carers"

"Thought provoking and useful pointers and ideas that can be incorporated into supporting foster carers"

Some participants had suggestions for improvements to the course:

"lots of information to take in … felt presentation of material was good, but would have been useful to use a specific case study when looking at questionnaires. Am a bit worried that I may miss using one of the key questionnaires"

"Careful consideration will need to be given to language used and the nature of praise given as some children do struggle with praise"

Behavioural Questionnaire

All social workers who enrolled on the EPaS training were asked about their use of behavioural strategies using the Behavioural Questionnaire, the questions are included in table 7.2. Results are reported for the three social workers who participated at baseline and at the follow up time five months later. Part one of the questionnaire records use of behavioural techniques on a scale of 1= Always to 5= Never, whilst part two measures confidence in the use of behavioural strategies using a scale of 1= Very confident to 5= Very unconfident. The total mean scores for both parts are presented in table 7.2 and no significant differences were found between baseline and follow up mean scores for part 1, behavioural strategies or part 2, confidence.

Table 7.2. EPaS behavioural questionnaire pre-post results

Questions		**Baseline**	**Follow up**	***t*-test**	***p***
Part 1 - Behavioural techniques	M (SD)	33.33 (8.33)	38.67 (7.77)	-0.60	0.61
Part 2 - Confidence	M (SD)	9.67 (2.89)	8.67 (0.58)	0.66	0.58

Social workers reported use of behavioural strategies less than half the time, even after attending the EPaS training. Table 7.3 shows the mean score at follow up for each of the ten questions on the behavioural questionnaire, along with the three confidence questions. The mean score for each question is reported along with the equivalent response rating.

At follow up, social workers were confident that the behavioural approach would be helpful for carers, however, felt unconfident about their knowledge of and ability to, implement behavioural strategies.

Table 7.3. EPaS behavioural questionnaire, follow up results.

	Question	**Mean (SD)**	**Mean Response**
Part A: In your work with children/families, how often do you:			
1	Record what is happening at the time, whilst observing the child and parent/carer?	3.00 (1.00)	Half the time
2	Design record sheets for parent/carers and ask them to keep records of child behaviour?	4.00 (1.73)	Only sometimes
3	Agree and provide a written summary of specific homework tasks for parent or carers?	3.67 (1.53)	Only sometimes
4	Set homework tasks for parent or carers in reading about behaviour problems and child management?	3.67 (0.58)	Only sometimes
5	Provide parent or carers with written agreements or specific goals?	4.00 (1.00)	Only sometimes
6	Provide star charts and record sheets for parent or carers and children to record successes?	4.67 (0.58)	Never

7	Use your observations and records to determine precisely what works best as reinforcement or punishment for a particular child?	4.00 (0.00)	Only sometimes
8	Provide specific feedback to parent or carers on their child management skills based on their records and /or your observations of their behaviour?	3.00 (1.00)	Half the time
9	Teach parent or carers how to reinforce behaviours that are alternative to, or incompatible, with problem behaviour?	3.33 (1.56)	Half the time
10	Discuss with parent or carers specific factors in the home environment which appear to be reinforcing problematic behaviour?	2.67 (1.16)	Half the time
Part B			
1	How confident are you that the behavioural approach is helpful for the families of children with whom you work?	2.33 (0.58)	Confident
2	How confident are you that you have sufficient knowledge to work behaviourally with children with developmental difficulties?	3.67 (1.16)	Unconfident
3	How confident do you feel about implementing behavioural programmes with these families?	3.67 (1.16)	Unconfident

Note: higher scores report less frequent use 1-always, 2-often, 3-half of the time, 4-only sometimes, 5-never.

Barriers and Enablers to the Implementation of EPaS

This section of the results reports on the findings from a qualitative analysis of the semi-structured interviews recorded with the social workers. Thematic analysis of interviews with social workers identified three overarching themes; organisational factors, collaborative working and training effectiveness. Social worker experience and feedback on the EPaS training is explored in the theme training effectiveness. The two themes, organisational factors and collaborative working explore factors that influenced and/or acted as barriers to the use of the EPaS programme.

Organisational factors.

Organisational factors included lack of time to implement the intervention, conflicts in the supervising social worker role and issues around which team would be the best to implement the intervention and challenges related to the placement of children with behavioural difficulties.

Organisational factors - Workload pressures.

Participants identified workload pressures as barriers to using EPaS. Some of these pressures were linked to recent staffing issues that meant that social workers had increased

caseloads. Therefore, social workers had less time available to spend with carers and to help them to address difficulties and/or to suggest strategies to support carers.

> *"We are short staffed at the moment as you might have gathered and that's putting pressure on everybody who's left, because all the ones are leaving or off all their cases have just been shared between whoever's left, so it doesn't give you the space that you know, the psychological space to do this kind of thing"*
>
> *"ideally you would have much more time to be able to do it and to be able to see it work"*

Some of the work pressures were related to the role of a social worker, with multiple competing demands on their time making it difficult for them to commit to a regular weekly pre-arranged sessions, in order to work with carers using the EPaS intervention.

> *"being called away because, I don't know, court has directed something, or and you just don't want to feel that you are leaving the families in limbo"*
>
> *"I think as Social Workers, its sometimes difficult to keep to those structured times"*
>
> *"we have got a lot of connected persons assessments coming in at the moment and that's kind of flooding our service in fostering. Because it's court directed so it's just taking over from everything else."*

Organisational factors - Role conflicts.

Social workers identified conflicting demands within their supervisory role that made delivering interventions to carers more difficult. Some of these conflicts were in relation to supporting kinship foster carers who sometimes become local authority carers at very short notice. These carers found they had to manage a role as an existing relative of the child, and new roles as both a parent and kinship foster carer. These roles often conflicted, meaning that social workers had a difficult task to help kinship foster carers transition to a fostering role, before they could consider supporting them with child behaviour difficulties.

> *"we are dealing much more family and friends who haven't signed up to become foster carers"*
>
> *"we are having to be supporting connected carers who often struggle to reach the fostering competencies, struggle with the regulations that fostering brings and just want to be either Nain or Taid (grandmother or grandfather) or Auntie and Uncle and can't quite understand why they have to have these certain rules in place."*

Other conflicts were in relation to the social workers' statutory role of supporting carers with practical solutions and administrative issues, ensuring the carer is meeting the needs of the child, whilst also being a supportive and listening ear for difficulties that they experienced. Social workers have to undertake statutory visits in order to provide support for carers, and reported that there was not enough capacity within their existing role to accommodate additional intervention work with carers.

"I think in a sense, we are limited because of the fostering, social worker role that we have, our time is taken up by the statutory duty and also what they are going through, and they just feel that that's their outlet too, which it should be"

"I think the way we work now which is to have a supervision session like once a month, you know we are covering kind of set things, there's a pattern there if you like and I don't think we'd get into the small sort of practicalities really and you know we do try and advise or point people in the direction of different services or whatever, to sort out I don't know, payments and things you know practical things like that, so we don't focus so much upon working with children directly."

Organisational factors – Which team should deliver the intervention.

Without additional time available to use the EPaS intervention with carers, all the social workers suggested that a different team would be better suited to deliver the intervention. They identified a team that worked intensively with families, called the Edge of Care team as being more appropriate, as they already delivered family interventions.

"I mentioned the Edge of Care Team would be in an excellent position to be able to offer it,"

"Edge of Care and then you know they are really well experienced support workers and key workers, you know, who do this every day. You know, it's they are working intensely with families"

As the carers supporting and supervising social worker, it was acknowledged that the social workers would need to understand the EPaS intervention structure and aims, even if a different team delivered the intervention.

"even if it's not the actual Social Workers who are actually rolling out the training and the strategy and the intervention, I think it we need to have that awareness, we need to understand that this is what it is and this is what they are hoping is going to be the outcome."

Social workers also noted that currently, the Edge of Care team did not routinely work with foster carers, with their primary role to work with families with children at risk of entering care. This meant there was no identifiable team with the capacity, skills and remit to work with carers to address behavioural difficulties with the children they care for.

"because they don't generally work with our foster carers unless it's very close to placement break down, so that's quite rare"

"mostly they're not involved with foster care parents, and I think there is a role for working with foster carers"

Organisational factors – Child related challenges.

A child labelled with challenging behaviours can make it hard for social workers to find a suitable carer match to place the child. EPaS provides techniques and skills to give carers confidence in their ability to manage difficult child behaviours, potentially increasing the likelihood of quickly identifying a suitable placement. Social workers were aware that children entering care can display challenging behaviours that are difficult for people to manage.

> *"we've got several that are coming into care quite recently and they're, you know very complex, challenging behaviours"*

They spoke of how it could be difficult to place children with behavioural problems, with known information about the child shared with prospective carers. This facilitates transparency in matching foster carers and children, however can make it difficult to find placements for children with more extreme behaviour problems. Potential carers were viewed as having reservations about their ability to help children to address behavioural challenges, to understand the process could take time and to be fearful of failing, potentially leading to another placement move for the child.

> *"I think people do see certain aspects or certain behaviours down on black and white, and they just think well that's, you won't be able to change those behaviours"*

> *"it's about seeing whether or not we can get people to understand that actually you can, but it's not going to happen overnight."*

> *"I think it's scary for some people, because they think you know if we, they don't want to be a part of maybe another possible change for a young child, that if they feel that they cannot make those changes"*

The social workers recognised that behavioural difficulties are both a cause and a consequence of children moving placements whilst in care, not just a result of experiences prior to entry to care. Children who move placement, sometimes against their wishes to live with people they may not know, are likely to be unsettled and display difficult to manage behaviours.

> *"I think the problem is then that that they have had 7-8 months of living with Nain and Taid, and now people are saying that that's not possible and neither is living with parents. I think you are already setting them up really with what kind of behaviours are you going to expect, you know, you are going to expect a lot,"*

> *"you try and reflect back to how the children's behaviours were prior to all of this chaos and transition happening, and the behaviours weren't as evident or weren't as, I don't know, significant shall we say, and it's down to what they have experienced within that short space of time."*

> *"It's not always because of what they've experienced in the care of, you know, the parents"*

Collaboration challenges.

One of the key factors in successful parenting interventions is the establishment of a collaborative relationship between the intervention facilitator and the parent or carer. This empowers the carer to become the locus of change in child behaviour through modification of their own behaviours. The EPaS facilitator plays a key role in highlighting what is happening, through objective feedback, supporting the identification of realistic goals and coaching the parent or carer in changing their behaviour.

Collaboration challenges - Carer resistance.

The first step in collaborative working is engaging the participant. Social workers anticipated barriers in implementing the programme with foster or kinship foster carers. There were concerns about carer resistance to change and that use of a behavioural intervention could be interpreted as a criticism of carers parenting skills. Carers who had been fostering for longer were seen as being more resistant to change.

> *"I feel now that sometimes it's difficult for foster carers to take on board maybe using a different type of parenting, especially with foster carers who've been fostering for years."*

> *"have to be careful how you do it as well because people do see it as a criticism don't they? So, it's a very delicate balance sometimes with some people more than others, but you know you can be quite frank with some people and other people then no, they are quite sensitive to their parenting methods."*

> *"I think there would be a lot of barriers to break down because she's been fostering for so long. 'You know me and I do a lot of reading and I do this and I do that and I've tried everything, you know nothing works', and I think there's a lot of work to try and kind of, get people on board"*

Social workers could identify that some carers would be more receptive to the EPaS intervention than others would, and they would prefer to work with a carer they felt would engage with the intervention.

> *"I think some foster carers might be more open to it than others"*

> *"she would be somebody I'd feel comfortable in trying it with because I think she would be open to it. And wouldn't see it as a criticism"*

Collaboration challenges - Previous failures reduced confidence.

Social workers recognised the wealth of knowledge carers had about the children they looked after. However, they also recognised carers sometimes found it difficult to remain objective. This, combined with a lack of thorough understanding of strategies for

behavioural change could contribute to failed attempts to change child behaviour. They recognised that carers used their own initiative to understand and meet children's needs, doing their own self-development through reading, and then implementing strategies. Carers seemed to be implementing new strategies without an integrated plan or ongoing support to help them overcome difficulties that they may experience. Sometimes this approach resulted in failure, which then acted as a barrier through a reduction in carer confidence in the effectiveness of behavioural change strategies.

> *"Because we are not living with the children, we are not the experts on the children they are"*
>
> *"foster carers feel that they are so in it at the time and that they are doing everything that they can, and that they are taking the strategy advice from different agencies"*
>
> *"I know for a lot of our foster carers they would feel, but we are doing everything we can, and we've tried this, and we've tried that"*
>
> *"this particular foster carer I'm thinking of she's very ready to say what she's done about something or this is how we deal with it, and I've tried different things but this works, so they stick to it, but she doesn't ask why does it work or how does it work. And then the next time I go maybe that's stopped working now because it only works with her like for a week and then she reverts back to the behaviour."*

Collaboration challenges - Social workers role in facilitating change.

Social workers recognised that EPaS was a new approach for them, a more structured way of working with carers. They acknowledged they used a mixture of theoretical approaches to problem solving and one of the main theoretical models they used was the secure base, underpinned by attachment theory.

> *"I suppose it's not how I've worked before and I suppose in terms of, I think there is so, like different people have different views and within our team there's been focus on like the secure base and using that as a kind of a, I suppose the foundations of the things that we do with our carers"*
>
> *"in terms of introducing a new manual, a new way of thinking and a bit more well, very structured way of thinking is that, perhaps, in our usual every day work with foster carers yes we will have supervision, we will reflect about different issues, we will come up with solutions but it's not a specific model or I suppose it's just your general knowledge base of everything really that we use rather than a specific model."*

They recognised the approach EPaS takes, is about being objective and using a structured approach to the analysis of what is happening whilst supporting carers who are having difficulties. Key to the approach is the ability of the social worker, as part of the assessment and case formulation to identify how patterns of behaviour were being maintained within the carer – child relationship, then translate this into a collaborative programme for change.

"I know as professionals we should be kind of stepping back and taking the kind of objective stance to help you interpret what is going on."

"I think it's you coming along and kind of trying to guide things when they feel that they've done everything they can and they've got all these years of experience of fostering behind them with all different children, with all different problems"

"In terms of looking at what the behaviour is, what the child is trying to get out of that behaviour, and I suppose analysis is looking at what they are trying to achieve, and as to what is, whether the, the reaction of the carer is then feeding into that"

Social workers were sympathetic to the difficulties being experienced by the carer as a result of their experience of child behaviours.

"because they are in the groove like all of us you know it's like, when I look at my own it is difficult isn't it to change things and that's changing their behaviours in order to help change the behaviours of the children. I think that's where I'm finding difficulty I think of a barrier."

"we are not you know applying this to the child but I'm applying it to the foster carer"

Training effectiveness.

The social workers routinely undertook training, but were unfamiliar with some of the assessment strategies and content of the EPaS training course. This impacted on their confidence in feeling able to successfully deliver the programme, although they acknowledged that being unable to recruit participants and obtain data for the training had contributed to this situation.

"I think if we could have done it in the way that we should have done it would have been better. So, if I had somebody that I was doing it with, as we were going along, so we would kind of be learning by doing rather than learning it sitting in a class room kind of environment."

Training effectiveness – speed of content delivery.

All social workers commented on the quantity of information within the programme finding the rate of programme delivery challenging.

"in terms of being presented with the different tools, there was a lot of different things to consider. Lots of different questionnaires and I suppose it's the sense of coming away with maybe not quite fully understanding as to what to do first."

"What I found sort of, was that there was that there was too much too quickly, because there was a lot of information there, useful information but you weren't having the time to process it and absorb it, and try it out in small steps"

The lack of familiarity with the assessment measures in stage one meant there was a lack of confidence in the social workers ability to administer and interpret the questionnaires:

"It was a lot to take in in terms of how to do the questionnaires, and to make sure that you were collecting the right data"

"I think what I found most challenging was when I was scoring up the questionnaires, I remember several of us and I don't know, it's just how to interpret the information I think and how to score it."

These factors contributed to a lack of confidence in their ability to successfully implement the programme:

"it being so different to the kind of usual things that we did do in our work, that was possibly overwhelming as well"

"you get to the point that if you failed at the first hurdle it's like that catch up then isn't it and they you're on to section 2 and then it was quite quickly to session 3 and then failure, failure"

The social workers recognised that their confidence was a barrier to them using EPaS with carers.

"I don't feel, I suppose I don't feel confident in my own interpretations of how best to analyse or deal with different behaviours"

"if I was like 100% confident I would give it more of a go wouldn't I, so I'm being like the foster carers really and being defeated before I even started in a way."

Training effectiveness – what would help?

They had suggestions for strategies that would have helped them gain confidence, such as creating their own internal support group:

"*we should have on our part potentially had more of an emphasis of getting together here, to then refresh so that we could help each other."*

They suggested having a full case study example, rather than the various extracts from a range of cases, including all the questionnaires would have been helpful:

"Practice all through to finish, in that respect, like a case study that we could see specifics."

"a pack of questionnaires that I suppose, the idiots guide to the questionnaires but that they were all there together so that we could work through them."

Having a mentor or ongoing supervision so that they could discuss issues as they came up:

"a mentor of the programme to be available maybe an afternoon or whatever a week to discuss cases together, and to give some kind of leadership I suppose and guidance on whether we were using it in the right way, or you know to kind of support people in implementing"

Undertaking the training over a more extended period seemed to be important to help build confidence:

"I think it would be helpful to develop the confidence through doing it more slowly and trying it out like in little steps"

"It's just that the confidence to be able to do it really more than anything"

Training effectiveness – programme usefulness.

Although the social workers identified a lack of confidence in using the programme, they did indicate that attending the training had influenced how they were thinking about situations and that they had gained in confidence to question what was happening in carer-child relationships:

"I think I'd try and challenge the foster carer a bit more about how they're dealing with things"

"So, it kind of maybe prompts me to, or encourages me to prompt them to look at well why do you think that is"

Despite the difficulties with the training and barriers to implementation, the social workers were very positive about the programme, recognising it could be useful for them and for foster and kinship foster carers. They identified that this programme gave them useful tools they could use to change behaviour, in contrast to some training that was based on theory only. This practical aspect of behavioural interventions was seen as valuable by the social workers.

"I think there's a lot of useful things in it that you could apply to try it and improve situations and families and to, I suppose improve the quality of the children's lives."

"sometimes, you know training is advertised and you think oh, that sounds really good and then you go on it expecting it give you certain tools to actually use, but it isn't what you anticipated at all and it doesn't actually give you the tools, it talks about the things. I suppose it talks about things theoretically but it doesn't give you the practical tools which this does, and I think that's good about this one because it's not just defining the problems, giving you potential solutions as well which is good compared to some training that talk about things in a sort of waffly way."

"I found it all useful. I didn't find any of it you know kind of irrelevant or not useful."

Discussion

The supervising social workers enjoyed the training and found it useful. They recognised that the EPaS programme would be beneficial to the foster and kinship foster carers that they support by helping them with specific strategies to manage difficult child behaviours. Much of the content and structured format of the intervention was new to them and they found the volume of information and the skills they needed to develop challenging.

This contributed to a lack of confidence in their ability to successfully deliver the programme without further support. Social workers also identified a range of barriers to programme implementation, including organisational factors such as work pressures and anticipated difficulties with participant engagement and collaborative working. The social workers all felt a different team within the local authority would be better placed to deliver this intervention as they had more scope to work intensively with participants. The complexity of the social workers role and the challenges and conflicts they face were apparent from their feedback, these difficulties, combined with lack of confidence are helpful in understanding the difficulties of programme implementation in real world settings.

Social Worker's Experience of Training Effectiveness

Social workers lacked confidence in using the assessment measures, lacking familiarity with their use and confidence to interpret results. As the key EPaS measures are validated questionnaires, the Strengths and Difficulties, the Parenting Scale and the Warwick-Edinburgh Mental Wellbeing scale all focused on determining child and family functioning, it was surprising that social workers had not come across these, or similar measures during routine family assessments. The use of assessments to determine the problem and inform an outcome is common in evidence based clinical, and behavioural approaches. There are indications that evidence based and behavioural approaches are not widely adopted in social care (Fagan et al., 2019; Jaggar, 2018). Rather, theoretical models based on attachment and trauma dominate thinking and underpin approaches (Hughes, Golding, & Hudson, 2015; Golding & Hughes, 2012). A collaboration with fifty local authorities social services in England to explore ways of increasing the use of evidence based approaches to improve services, identified barriers to the development of an evidence based environment that included a blame culture and fear of 'getting it wrong' (Barratt, 2003). There were references in this present study of social workers fears of letting foster carers down, or of failing to be able to help particularly where carers are finding the situation difficult and looking to the social worker for support. Supervising social workers have a difficult role, in that they not only act as a support for carers, but also have a supervisory role, requiring them to ensure that the carer is able to meet the needs of the child (Cosis Brown et al., 2014). The conflict between being an emotional support for carers and the supervisory role where child protection is paramount (Jaggar, 2018) was also evident in this study.

All three social workers reported that they lacked confidence to deliver the intervention following the EPaS training and that this may be in part, a result of not delivering the programme alongside the training, enabling them to receive ongoing feedback. Research

indicates active forms of learning, such as modelling, role play and feedback promote effective acquisition of skills (Dufrene, Noell, & Duhon, 2005). A meta-analysis of teacher training found that training composed of theory, discussion, demonstration practice and feedback led to 5% of teachers using the newly taught skills in the classroom, where as when the teachers were coached on the job, around 95% used the newly taught skills (Joyce & Showers, 2003). So ongoing supervision may be as important in effective implementation as the initial training course, for skill development. An evaluation of 174 providers of the Positive Parenting Programme (PPP), undertaken two years after training (Shapiro et al., 2012) reported that the self-confidence of the provider was a key variable that predicted the use of the programme, with additional factors including fit with caseload responsibilities, pre-existing knowledge or skills relating to behavioural interventions and post-training support. Factors influencing provider self-confidence included training quality and post-training support, with participants satisfied with both training and support being more likely to implement the PPP programme.

The EPaS training model is designed so that the programme is delivered to participants whilst the training is ongoing, allowing case studies to be brought and discussed at second and third training sessions. This process was not followed in this study due to the failure of participants to recruit families and social workers recognised a lack of actual case studies had made learning the necessary skills more difficult. Changes to the training programme such as including a full case example, rather than the examples of each component from actual case material and the provision of ongoing supervision or mentoring during implementation, were suggested as ways that the training course could be improved. The adoption of programme champions within organisations, who can both support programme delivery and act as an intervention advocate, can be influential in the successful implementation of new programmes (Durlak & DuPre, 2008). Provider skill proficiency and self-efficacy also play a key role in successful programme implementation, with research on the implementation of a school wide anti-bullying programme in Norway (Kallestad & Olweus, 2003) reporting that teachers sense of self efficacy, as well as school climate and leadership all predicted implementation success.

Organisational Factors as Barriers to Delivery

Social workers in this study identified workload, in part due to staff shortages, as a difficulty in being able to commit sufficient time to deliver the intervention. There are references in the literature to large caseloads being a difficulty in social care, with over-burdened case workers (Horwitz, Chamberlain, Landsverk, & Mullican, 2010) and limitations on staff time, including work being crisis led, less capacity to offer emotional support and

lack of trained staff noted by Jaggar (2018). The need for staff to have time away from work commitments to read and reflect on new interventions was highlighted by Barratt, (2003), also noting that managers were finding it impossible to facilitate this time due to the high level of vacancies. Social workers in this study were expected to undertake the intervention within their existing work commitments, which were already disrupted by the need to prepare reports for family court hearings, with inflexible deadlines. Individual motivation to apply learning in practice can be influenced by perceptions of organisational support for changes and risks associated with failure. The existence of 'blame cultures' within organisations and services can prevent implementation of new practices (Barratt, 2003).

The perceived benefit of the intervention is another factor influencing successful delivery (Shapiro et al., 2012) with adoption of empirically supported interventions felt to provide better client outcomes by social workers (Grady et al., 2018). In turn, using empirically supported interventions adds to provider and client confidence that the intervention will be effective, with the organised, methodological approach to the investigation and resolution of the difficulty being supported by a body of knowledge demonstrating efficacy (Grady et al., 2018). Newly qualified social workers interviewed by Grady et al., (2018) felt that an evidence based approach was beneficial, however they did not fully understand the terminology around evidence based interventions. Grady et al., also identified a mismatch between what social workers were taught and what they did when on placement in the field, citing lack of resources including high workloads, limited access to research evidence and supervisors' lack of knowledge about empirically supported interventions as barriers to adoption and use of evidence based programmes.

The social workers in this study suggested that the barriers to the successful delivery of the EPaS intervention meant they were not the best team within the local authority to deliver the intervention to foster and kinship foster carers, although they acknowledged the importance of their understanding of the intervention in order to appropriately support carers. All three workers identified a team known as the Edge of Care Team that already operated within the authority to support families through intensive work, working with participants weekly, or several times a week. However, they also acknowledged that the Edge of Care Service was not routinely available to foster and kinship foster carers, even though they could see that carers could benefit from its support. This appears to be a gap in the Local Authority services, with a range of preventative services available to families where there is a risk of children entering the care system, yet once in the care system these support services are no longer available to the carers who look after the same children.

Collaborative Factors as Barriers to Delivery

Effectiveness of parenting interventions is, in part, dependant on the skill of the facilitator leading the intervention. Fixsen et al, (2009) describes the importance of characteristics when selecting practitioners to deliver evidence based interventions that include; knowledge of the field, professional skills, common sense, sense of social justice and ethics, willingness to learn and intervene and empathy, raising concerns about availability of suitable practitioners and funding for training to provide necessary skills. The importance of appropriately trained and skilled facilitators for evidence based interventions has been highlighted in research (Gardner et al., 2010; NICE, 2013; SCIA, 2011) along with appropriate and ongoing supervision. However, acquisition of these skills comes at a cost in terms of time and funding, with Lewis, (2011) whilst evaluating parenting programmes implemented in England, citing one coordinator as stating it was too expensive for local authorities to allow health visitors or social workers to deliver parenting interventions. In the same evaluation, facilitators found the three-day training for the PPP intervention both too intense and too short, a similar finding to feedback from social workers in this study. Ongoing support through supervision is one way of coaching additional skills and providing support to providers. Hutchings, Bywater, & Daley, (2007) describe a trial in which staff who had attended a three day practitioner training course for the delivery of a group based parenting programme, were allocated a day and a half a week to deliver the programme and provide follow up contact with families, preparation time and three hours of supervision per week. The supervision addressed issues that acted as barriers to collaboration and meeting participants' goals.

Social policy in the UK in recent years has been focused on child protection more than the needs of the child, leading to the social workers role as one of expert, assessing and intervening in decisions regarding removal of children from families where there are difficulties (Featherstone, Morris, & White, 2014). Featherstone et al., (2014) argue that the focus on the child protection role has led to a reduction in support for families and collaborative working, where families are supported and empowered to solve their difficulties. The use of collaboration is a key principle for parenting and behavioural interventions, where the participant is encouraged and supported to identify and resolve their own problems. Social workers in this study appeared to lack confidence in their ability to develop a collaborative relationship in relation to delivering the EPaS programme with foster and kinship foster carers, citing their dual role as supervising social workers, concerns about participants engaging with the intervention and previous failed attempts to change behaviours acting as barriers to engagement in behavioural change. An understanding of behavioural principles is important in the effective facilitation of behavioural change. The

behavioural questionnaire used in this study, indicate that like health visitors in the Lane and Hutchings, (2002) study social workers are not using behavioural approaches frequently during their work.. However, the very small number of participants in this study means any conclusions are unreliable in relation to this population more generally. However, social care may be overly reliant on attachment based theory with limited use of evidence based interventions (Cosis Brown et al., 2014; Fagan et al., 2019).

An evaluation of the integration of Keeping Foster and Kinship Carers Supported and Trained (KEEP) into the child welfare system in the USA, took a holistic approach to intervention adoption. Social worker practitioners attended a five day training in the use of the programme and supervisors were trained in a behaviourally based supervisory model using reinforcement strategies to encourage strengths and steps taken towards achieving agreed goals (Chamberlain, 2017). In a second case study in a different state, caseworkers and supervisors all undertook a two day foundational training programme, with only some of the social workers undertaking the additional three day KEEP practitioner training (Chamberlain, 2017). Weekly supervision of caseworkers by supervisors was supported by weekly consultations with the developers by supervisors. As a result of this rigorous implementation of the KEEP training programme along with supported supervision, there was a 17% saving in costs to the service, even after reductions in social worker caseloads in order to facilitate training and implementation were factored in. These cost reductions were linked to faster rates of achieving permanency in the intervention group and a non-significant 18% lower rate of placement moves, indicating that an empirically supported, behaviourally based intervention can be successfully implemented in social care environments, given sufficient planning, resources and support.

Limitations

This evaluation was undertaken based on the first stage of an unsuccessful plan to implement the EPaS programme. At the time of follow up, five months after training two of the five participants had moved on, so only three social workers were available to evaluate the training. Their views, although similar to each other, may not be fully representative of all participants. The behavioural questionnaire was undertaken pre- and post-training, however the small number of participants means that results are not generalisable. Qualitative research is vulnerable to researcher bias, inexperience and the use of one researcher only in undertaking and evaluating this research, combined with the researchers' experience as a foster carer may have influenced the interpretation of results.

Future research

Qualitative research generates a rich understanding of peoples lived experiences, providing information that can be missed when using quantitative methodologies. The aim of this research was to understand barriers to, and enablers of, the implementation of the EPaS programme. In the process, it has highlighted the complex and challenging role of supervising social workers in terms of both the difficulties that they experience and in the ways they are able to support foster and kinship foster carers. Further research exploring carers views and the experiences of caring for the children that they look after would give a much richer understanding of limitations, difficulties and strengths within the social care system. Future delivery of the EPaS programme within social care, could provide higher levels of concurrent and ongoing support for practitioners delivering the programme, such as regular supervision, use of programme champions or follow-up training.

Conclusion

This study investigated ways of supporting supervising social workers to deliver one-to one behavioural interventions to carers by training them to deliver a one-to-one tailored intervention to carers at home. Lack of skills, combined with organisational pressures that included work pressures and role conflicts led to failure in implementing the programme with carers. Social worker feedback on the training indicated that although they liked the programme and found it useful, they lacked the confidence to deliver it. Social workers recognised many of these difficulties as barriers to implementation and suggested that an alternative service, the edge of care team, may be more suited to intervention delivery. However, social workers also identified that this team did not routinely work with foster and kinship foster carers, leaving a serious gap in provision of a resource for foster and kinship foster carers.

Social worker unfamiliarity with structured, evidence based approaches that contain skills in behavioural analysis indicated a systemic lack of use of behavioural theory to train carers in addressing difficult behaviours in children looked after, despite behaviourally based parenting approaches being the recommended intervention for problem behaviours (NICE, 2013). The future implementation of the EPaS programme would benefit from a more robust support package, as despite issues with confidence to deliver the programme, social workers were enthusiastic about the intervention and recognised the benefits it could bring to foster and kinship foster carers.

CHAPTER 8

Discussion

Thesis Outline and Objectives

The main objective of the thesis was to explore ways of supporting foster and kinship foster carers through training. Behavioural challenges presented by children, predict placement breakdown and poor outcomes and providing carers with the skills to manage difficult behaviours may positively influence child outcomes. This was explored through a series of themes that run through the thesis:

1. The evidence base supporting training available to foster and kinship foster carers
2. The main challenges and difficulties in relation to children looked after experienced by carers
3. The similarities and differences between kinship and foster carers
4. The potential for parenting interventions to address attachment relationships and behavioural problems
5. The challenges in delivering of training to foster and kinship foster carers.

There were two novel areas examined in this thesis; an investigation of carer-child attachment relationships after attending a social learning based parenting intervention and an evaluation of the EPaS programme with social workers.

Thesis Summary

A survey of a Welsh local authority approved foster carers identified that both foster and kinship foster carers reported mean levels of socio-emotional and behavioural difficulties in the children they looked after in the abnormal range. The survey also identified a lack of evidence based training being offered to these carers, such as the behaviourally based parenting programmes. The local authority agreed to run the Incredible Years© school age parent programme to both foster and kinship foster carers, with one group dedicated to each carer type. Baseline and follow-up evaluations by the participants who signed up for these courses identified that foster and kinship foster carers reported different levels of child behavioural problems and carer stress. Foster carers reported more child difficulties at baseline and lower stress, improvements in child behaviour and carer-child attachment relationships at follow-up. Exploration of attachment relationships as a factor that contributed to variations in outcomes for children placed with foster and kinship foster carers, was unsubstantiated. Kinship foster carers did not report significant problems at baseline and improvements in child behaviour and carer stress were non-significant at follow up.

There were difficulties in recruitment; for the local authority survey there was a low response rate to postal surveys, with final numbers made up through home visits. For the IY intervention, eleven participants were recruited for both groups, however a number of these

were couples with one couple in each group reporting on the same child. There was a high level of drop out between recruitment and attendance, with five kinship foster carers and one foster carer enrolling but not attending the IY programme. For the EPaS intervention, five social workers were recruited, but five months later two of these had left the authority.

The difficulties with recruitment for the group-based IY intervention, particularly for kinship foster carers, led to a one-to-one training intervention being offered. Training in the Enhancing Parenting Skills (EPaS) programme was provided to supervising social workers in a different local authority, to enable them to work with the foster and kinship foster carers on a one-to-one basis, to develop individualised behaviourally based interventions according to carer needs. Social workers undertook the training, but did not recruit participants. At follow-up, their views of the training for EPaS and the barriers to implementation were explored. Social workers liked the training and felt that it would be useful to foster and kinship foster carers, despite finding the training intensive and the volume of information challenging. They lacked confidence in their ability to deliver the training and made some suggestions that could help with this, including ongoing supervision. They also described the complexity of their role in both supporting and supervising foster and kinship foster carers, with many competing demands on their time. Organisational barriers to implementation of EPaS included work load, resource limitations and concerns about their ability to engage participants in the collaborative intervention. The following section provides a summary of the chapters containing the three studies that make up the thesis.

Thesis Findings

Chapter 4 – Training survey.

This study was undertaken with a local authority to evaluate the training needs of carers approved by the authority. Measures of carer stress and carer reports of child behaviour were taken and the training offered by the authority to carers explored. A series of training programmes were offered to carers, including induction courses, optional ongoing training and refresher trainings. Foster carers had a mean attendance for all courses offered in the previous year of 49% with an average of 16 participants per course, with kinship foster carer mean attendance being 14% and an average of two per course. Of the carers who attended the training courses 91% rated the quality of training as good and 75% rated the usefulness as good. Levels of carer stress were measured using the Parent Stress Index (PSI), with mean scores for the whole group (M=79.46, SD=22.11) in the non-clinical range, with 11% of carers reporting scores in the borderline and 3% in the clinical ranges. Foster carers reported higher levels of stress than kinship foster carers, with 23% of foster carers

and 5% of kinship foster carers reporting scores in the elevated or clinical ranges. Looked after child socio-emotional and behavioural difficulties were evaluated using the carer reported screening measure the Strengths and Difficulties Questionnaire (SDQ). The whole group mean total SDQ score was 17.43 and in the abnormal range for the measure. Foster carers reported 60% of the children and kinship foster carers reporting 53% of children in the abnormal range.

Despite foster and kinship foster carers reporting high levels of behavioural problems in the children that they cared for, it appeared they were not being offered access to the evidence based behavioural interventions recommended for carers of children with behavioural difficulties. Following these findings the local authority agreed to deliver two Incredible Years School aged group based parenting groups, one for foster carers and one for kinship foster carers.

Chapter 5 – IY baseline results.

This chapter reports on the baseline characteristics of the two groups of carers, one foster and one kinship foster group, who enrolled to participate in the IY group based parent-training programme. Eleven foster carers and eleven kinship foster carers enrolled and data is reported for ten participants from each group, representing 35% of the carers from the participating local authority.

Demographic differences between the two groups included significantly more kinship foster carers in receipt of benefits and foster carers being approved for a longer period (6.5 years) than kinship foster carers (1 year). Seventy percent of foster carers and 30% of kinship foster carers reported clinical levels of behavioural problems using the Child Behaviour Checklist (CBCL), with the group mean comparison showing a significant difference in the total score $t(18)=3.23$ $p=.005$ and the internalising sub-scale $t(18)=3.63$ $p=.003$. The Assessment Checklist for Children (ACC), a measure designed specifically for children looked after, also showed foster carers reporting more problems than kinship foster carers, with 70% of foster carers and 10% of kinship foster carers reporting scores in the clinical range.

Between group differences were not supported by the behavioural measure collected over an extended period, the Parental Daily Report (PDR) did not find between group differences, however, only four kinship foster carers and four foster carers returned completed data. Observational data was collected and coded for interactions with carers and looked after child from ten foster carers and seven kinship foster carers. The use of commands and questions was higher than the use of praise or encouragement for both groups, but there were no significant between group differences. The attachment

questionnaire, the Quality of Attachment Relationships (QUARQ) also did not show significant between group differences. Finally, the measure of carer stress, the Parent Stress Index (short form; PSI-SF) showed neither the foster or kinship foster carer mean scores showing clinical levels of stress, however, foster carers did report significantly higher levels of stress than kinship foster carers t(18)=2.39 p=.028 for the total stress score.

The finding that foster carers report more problems and higher levels of stress than kinship foster carers is important for studies of children looked after. Studies that combine results from both types of carer are unlikely to accurately determine training needs for foster and kinship foster carers who sign up for targeted training. The small sample size and lack of between group matching on placement length, child age and number of placements, may have contributed the between group differences. Although foster carers reported more difficulties than kinship foster carers, there were indications that both groups of carers would benefit from attending a parenting intervention and that an intervention that promoted attachment security as well as effective behaviour management strategies may be particularly suitable.

Chapter 6 – IY pre-post results.

This chapter reports on the findings from eight foster carers and six kinship foster carers who attended an Incredible Years© school aged parenting group. Whole group results showed that carers reported lower levels of stress $t(13)=3.47$ $p=.004$; $d=.45$ and improvements in child behaviour $t(13)=2.67$, $p=.019$; $d=.41$ after attending the programme. There were no changes in carer-child attachment relationship for the whole group. When the two groups of carers were evaluated separately, between group differences were found. Foster carers reported reductions in levels of total stress t(8)3.49, $p=.01$ and improvements in carer-child attachment relationship $t(8)=2.35$, $p=.05$. There were no significant improvements for the kinship foster carer group. All carers reported a high level of satisfaction with the programme.

The limitations of this study, mean that findings are tentative, however indications that attending an IY programme may benefit foster carer attachment relationships, as well as improve carer stress is important. Training programmes that can support carers to both manage child behaviours, develop attachment relationships and reduce carer stress would address three major difficulties experienced by foster carers. The finding that kinship foster carers and foster carers were different from the outset and may have responded differently to the programme is also important and worthy of further investigation with a larger sample.

Chapter 7 – EPaS training and barriers to implementation.

This chapter reports on an evaluation of the delivery of the one to one programme, Enhancing Parenting Skills (EPaS) training to five supervising social workers. Training and intervention were to run consecutively to enable feedback and supervision as part of training, however, the social workers failed to recruit any foster or kinship foster carers. At follow up, the three remaining social workers participated in a semi-structured questionnaire to evaluate their experiences of the training and the barriers to, and enablers of, delivery of the programme. Semi-structured interviews were evaluated qualitatively and three main themes were identified; organisational factors, collaborative working and training effectiveness. Evaluation of a behavioural questionnaire, indicated that social workers remained unconfident about programme implementation after training. These findings were supported in the interviews, where social workers reported organisational barriers, role conflicts and lack of confidence in their ability to deliver the intervention, and to successfully engage participants.

An alternative service, the edge of care team, was identified to deliver the EPaS intervention, however, this team did not routinely work with foster and kinship foster carers. This gap in skills provision and support for foster and kinship foster carers around behaviour management, combined with limitations in behavioural knowledge within the social work team, is a concern, given that the recommended interventions for behavioural problems are behaviourally based parenting interventions (NICE, 2013).

Social workers liked the intervention and recognised that it would be beneficial for foster and kinship foster carers, They suggested that more ongoing support would be helpful, through supervision or programme champions within the service, and recognised that the programme gave them practical tools that would help carers overcome difficulties with useful ideas and strategies that could be used to support carers.

Discussion of Research Findings and Implications

The thesis objective was to explore ways of supporting foster and kinship foster carers through training, in order to benefit the children that they look after. Five themes were identified as part of this process;

1. The evidence base supporting training available to foster and kinship foster carers
2. The main challenges and difficulties in relation to children looked after experienced by carers
3. The similarities and differences between kinship and foster carers

4. The potential for parenting interventions to address attachment relationships and behavioural problems
5. The challenges in delivering training to foster and kinship foster carers.

Each theme will now be explored in more detail.

1. Evidence based training for foster and kinship carers.

Reviews of research undertaken on training for foster carers indicate most research is undertaken on multi-session training programmes (Dorsey et al., 2008; Solomon, Niec, Schoonover, 2017; Uretsky & Hoffman, 2017). This is consistent with National Institute for Health and Care Excellence (NICE) recommendations for interventions to help parents and carers of children with behavioural difficulties (NICE, 2013). There is evidence to show that multi-session training provided to carers is effective in improving child behaviour and attachment security (O'Connor et al., 2013; Uretsky & Hoffman, 2017). However, findings from research reported in chapter 4, indicate that the training being delivered to carers tends to be one session, or one day, rather than multi-session. In the UK, there is currently no recommended pathway for post approval training for foster and kinship foster carers, with the National Minimum Standards for Foster Care (2003), recommending training topics that include behaviour management and attachment.

Training foster and kinship foster carers can both improve carer competence and broaden parenting skills, with competence linked to lower levels of stress (Farmer et al., 2005; Rhodes et al., 2001). High levels of carer stress negatively impact parenting quality (García-Martín et al., 2015; Morgan & Baron, 2011), with children in care requiring skilled carers to help them through difficulties experienced prior to entry into, and within, the care system (Murray et al., 2011; Tarren-Sweeney, 2013). After attending an IY intervention, carers reported lower levels of stress and improvements in child behaviour, however differences were only significant for foster carers, with kinship foster carers recruited for the IY intervention reporting fewer difficulties at baseline. Indications are that carers benefited from attending an IY programme and these benefits led to reported improvements in child behaviours. Parenting quality, particularly the use of sensitive responding and calm discipline positively impacts children from infancy to adolescence (Conn et al., 2018; Horwitz et al., 2010) and provision of training to carers that promotes high quality parenting skills would seem appropriate.

Adoption of new programmes is influenced by a range of organisational factors that include socio-political factors and funding constraints (Greenalgh et al., 2004). Interventions are adopted to resolve an identified problem, however the choice of programme is dependent on the organisation culture, priorities and leadership with decisions to select

evidence based programmes in part dependent on previous exposure to such programmes (Horwitz et al., 2010). Social care in the UK has been slow to adopt both evidence based interventions and programmes based on social learning and behavioural theories (Cosis Brown et al., 2014; Luke, Sinclair, & Sebba, 2014; Luke, Sinclair, Woolgar, et al., 2014), with the supervising social workers interviewed in chapter 7, reporting use of attachment related secure base theory and limited use of behavioural strategies (chapter 7). This is despite government recommendations to the contrary:

"It is important that professionally qualified social workers base their practice on the best evidence of what works for clients and are responsive to new ideas from research". (Department of Health, 1998. p. 5.32).

The motivation for organisations to adopt new interventions was noted to be challenging unless there was management accountability (Rapp et al, 2010), with managers driving change through setting expectations and monitoring compliance. One way in which social services are held accountable is through annually collected and reported performance statistics. These are routinely collected by the Welsh Government from all local authorities and published through the Stats Wales website (Welsh Government, 2019). Unlike England, where local authorities annually complete the Strengths and Difficulties Questionnaire, an socio-emotional and behavioural screening measure, on all children looked after, in Wales, data on child mental health is not routinely recorded or reported. The lack of data on the mental health and wellbeing of children looked after in Wales, may be a contributory factor in the limited delivery of evidence-based behavioural interventions for foster carers, and chapters 3, 4 and 5 showed carer need and a positive response to the offer of attendance on an IY course from both foster and kinship foster carers. However, barriers to delivery of evidence based interventions may be more systemic. Barth et al., (2005) notes that for interventions to be successfully delivered they need to have accessible manuals, good administrative support, sufficient validity to convince managers to try them and be acceptable to the groups to which they are delivered (Barth et al., 2005). The main features of programmes used in child welfare were; brevity, low cost, the use of low skilled trainers and containing easy to communicate concepts. Barth notes these programmes do not require much change in parenting skills and tended to be used because 'everyone liked it and no one had complained'. The challenges described by social workers in chapter 7 indicate the importance of organisational support, including staffing and time allowances for skilled workers to consolidate learning. There also appears to be a gap in the provision of appropriate services for foster and kinship foster carers, with the neither social workers nor the edge of care team undertaking the role of training providers to carers. It would appear that the findings by Barth et al., (2005) apply to foster and kinship foster carers, with brief,

easy to communicate, low cost and low skilled trainers being provided to train carers looking after some of the most challenging and vulnerable children within society. Whatever the reasons for the limited use of social learning based interventions and behavioural theory in training carers, given the high levels of behavioural difficulties reported by carers with the children they look after, this highlights a serious omission in the commissioning of appropriate training for carers.

2. Carer challenges in relation to children looked after.

The differences in mental health and academic achievement between children in care and those not in care are significant (Ford, Vostanis, et al., 2007) with children looked after underperforming compared to peers. Behavioural difficulties are the most prevalent mental health issue experienced by children in care (Ford, Collishaw, et al., 2007; Ford, Vostanis, et al., 2007), with problematic behaviours also linked to academic underachievement (Berridge et al., 2015). A significant number (44.5%) of unplanned placement moves are attributed by carers to child behavioural problems (Department for Education, 2018). In turn, placement instability is associated with behavioural problems in children looked after (Blower et al., 2004). With 93% of children entering care having been maltreated (Tarren-Sweeney, 2008) and 49% of children within the care system experiencing difficulties (Ford, Vostanis, et al., 2007) it is unsurprising that foster carers can find their role challenging (Murray et al., 2011). Behavioural problems are associated with carer stress (Vanschoonlandt et al., 2013), particularly when the child has a history of instability (Erskine et al., 2016). Stressed carers are less likely to meet children's needs (Farmer et al., 2005), use lower quality parenting strategies (Vanschoonlandt et al., 2013) and perceive children to have behavioural difficulties (Farmer et al., 2005). Findings in chapter 4 indicated both foster and kinship foster carers reported abnormal range mean scores on the SDQ, indicating a high level of child behavioural challenges. This was combined with 11% of foster carer and 3% of kinship foster carers reporting clinical levels of stress, using the PSI-SF. Carers recruited for the IY intervention also reported behavioural problems in the children they looked after, with 70% of foster carers and 30% of kinship foster carers reporting clinical levels of child difficulties using the CBCL. Poor parenting quality is associated with difficult child behaviour, with sensitive and responsive carers able to parent more effectively, associated with a reduction in difficult behaviours (Patterson et al., 2000). Given the carer reports of behavioural difficulties and levels of experienced stress, it is likely both kinship and foster carers would benefit from attending a parenting intervention that could help them with effective parenting strategies that could reduce behavioural difficulties and lower levels of stress.

Adequate and appropriate support is important to carers to enable them to manage the difficulties that they encounter (Berridge, 2017; Hannah & Woolgar, 2018; Rhodes et al., 2001), with social worker contact, availability and support found to be important (Farmer et al., 2005; Rodger et al., 2006). Theoretical explanations for the difficulties experienced by many children looked after include disrupted or unmet attachment needs (Bowlby, 1969) and neuro-biological changes relating to early care or experiences (Siegel, 2014) leading to behavioural problems and socially mediated learned behaviours (Bandura, 1977; Goldiamond, 1974). Indications are that the dominant theoretical approach within social care is attachment theory (Barth et al., 2005; Luke, Sinclair, & Sebba, 2014). The attraction of attachment theory can be in part explained by the focus on past experiences influencing the present, however this can put the onus on change on the child, whilst minimising the impact that current parenting strategies may be having on prolonging or reinforcing difficulties, or failing to identify and teach pro-social behaviours. In short, it may be better to focus on developing secure relationships in the present (Barth et al., 2005). The focus on attachment as integral to the problems experienced by children, is despite a lack of evidence based interventions for attachment difficulties (O'Connor & Zeanah, 2003). Recommendations issued by NICE are that appropriate interventions for behavioural problems in children should be based on social learning theory (NICE, 2013) with a review of attachment difficulties in children looked after, recommending interventions that include behavioural approaches (NICE, 2010, 2015). The evidence that children's attachment based difficulties can be the underlying triggers for behavioural problems may contribute to the failure to deliver evidence based programmes to address current problems being experienced by children looked after in placements (Woolgar & Baldock, 2015) despite their effectiveness addressing both attachment and behavioural challenges (Joseph et al., 2014; O'Connor et al., 2013).

The continuing disadvantage experienced by many children looked after has multiple inter-related and complex causes, some of which have not yet been measured or fully understood (Dickes et al., 2018). However, there are consistent findings that carers with good parenting skills, able to respond sensitively and appropriately to the children they look after, report fewer difficulties (Morgan et al., 2015; Sinclair & Wilson, 2003). The findings in chapter 6 that foster carers reported improvements in carer-child attachment relationships as well as lower experienced stress and reductions in difficult child behaviour indicate carers can benefit from attending parenting interventions, with these benefits having positive effects on the children they look after. Dealing with child behaviour problems is one of the main difficulties carers face and given the considerable evidence supporting the positive effect that good parenting skills have on child behaviour, it would seem logical to ensure that social

workers and carers routinely attend parenting programmes. However, this does not appear to be the case. Foster and kinship foster carers are dependent on training offered by their fostering agency, with social workers not routinely using behaviourally based approaches and low adoption of evidence based approaches. It would appear that foster and kinship foster carers are not being given the opportunity to gain skills that could be regarded as essential for their role.

3. Similarities and differences between foster and kinship carers (attachment).

Legislative changes in England and Wales mean that friends and family carers must be considered as alternatives to living with parents in the first instance (Welsh Assembly Government, 2014). Suitability assessments on possible carers are undertaken and submitted to the family court when a local authority applies for a care order for a child. If family and friends (kinship) placements are unavailable or not suitable for the child's needs, children are placed in stranger, or foster care. Research undertaken with carers, doesn't usually differentiate between foster carers and kinship carers, however there are notable differences between the two types of carers, including demographic differences, child outcomes and reports of child behaviour. Demographically, kinship carers have a greater likelihood of being of lower socio-economic status than foster carers (Nandy & Selwyn, 2011). However, the outcomes for children living with kinship carers are reported to be better (Oosterman et al., 2007) than those living with foster carers. Despite research showing reporting differences between foster and kinship carers (Keller et al., 2001; Winokur et al., 2008; Winokur et al., 2014) with kinship carers reporting fewer child behavioural difficulties than foster carers, these findings were not supported by teacher evaluations of the same children (Rosenthal & Curiel, 2006; Shore et al., 2002). Teachers reports of child behaviour were related to carer educational and income, with higher earning, better educated carers reported by teachers as having children with fewer difficulties (Rosenthal et al., 2005).

Broad, (2004) reported that kin carers believe that the family is the best place to raise young people, indicating there may be an underlying motivation to minimise problems. However, research shows kinship carers can report experiencing high levels of stress associated with economic constraints, lack of social or family support, ill health, or problems related to birth parents and contact (Hartley et al., 2019; Nandy & Selwyn, 2011; Palacios & Jiménez, 2009). There are indications that kinship carers are very committed to the children they care for, tolerating behavioural difficult behaviours for longer than foster carers (Farmer et al., 2005) and be more willing to relate them to previous experiences (Keller et al., 2001; Rosenthal et al., 2005). Kinship carers also identify the children that they care for as more likely to experience mental health problems than peers not in care, (Broad, 2004; Fergeus,

Humphreys, Harvey, & Herrman, 2019; Hartley et al., 2019). Data from the 2001 census, indicates that kinship carers reported a third (34%) of children as having SDQ scores in the abnormal range and as having difficulties in expressing and managing emotions, with indications that adolescents have more problems than younger children (Ford, Vostanis, et al., 2007). Most studies of foster and kinship carers reported here were evaluated for a relatively short period of time, with little information on any differences in outcomes for foster and kinship placements over a longer period. A four year evaluation of differences between youth delinquency in foster and kinship care indicated a significantly higher risk for those in kinship care, with rates of delinquency highest for those with increased placement breakdowns, particularly when those moves were associated with problem behaviours. (Ryan, Hong, Herz, & Hernandez, 2010).

The conflicting findings relating to differences between foster and kinship carers indicate a need for further research to establish similarities and differences. It may be that the range of variation within foster and kinship carer groups is as great as the differences between them. It is notable that many studies fail to differentiate between foster and kinship carers and where they do report on kinship carers, it is often unclear which category of kinship carers they are reporting on. However, the preference for children to be placed with family or friends in the first instance when entering care, is based on evidence that children in kinship care do better. Understanding the reasons why, would be helpful.

It was suggested in this thesis that some of the differences between outcomes for children placed with foster and kinship foster carers may be related to attachment security. To the researchers' knowledge, this is a novel suggestion within research, with differences in attachment relationships between the two types of carers not having been evaluated to date. Children placed with kinship foster carers may have experienced a less traumatic attachment disruption, or may achieve secure attachment with new carers faster, than those placed with strangers in foster care. It may also be, however, that children placed in foster care have more difficulties when they enter care than those placed with kinship foster carers. However, this thesis did not find between group differences in attachment relationships at baseline for the carers that enrolled to attend the IY intervention. However, there were between group differences at follow up for the carers that attending the intervention, with foster carers reporting improvements in attachment relationships with the children they cared for.

4. The potential for parenting interventions to address attachment in addition to behavioural difficulties.

Parenting interventions mainly address child behavioural problems through training parents or carers in parenting skills, including positive attention and non-punitive discipline strategies. Parenting interventions essentially teach strategies to strengthen relationships along with behavioural tools to help problem solve existing difficulties and learn alternative behaviours. Factors associated with problem behaviours include parental negativity and insecure attachment relationships. Some research has been undertaken to evaluate whether parenting programmes address other difficulties as well as the externalising behavioural difficulties that they are associated with. Research using the Incredible Years© (IY) found that parents attending the programme showed improvements in sensitive responding associated with attachment relationships in addition to, and independent of, child behavioural improvements (O'Connor et al., 2013). An evaluation of Fostering Changes, a parenting programme based on a social learning model and including attachment theory components, also found improvements in attachment and child behaviour when delivered to foster carers (Briskman et al., 2010).

Secure attachments are associated with less disruptive behaviours and improved outcomes for children (Joseph et al., 2014; Scott et al., 2011), with the promotion of secure attachment associated with the sensitive responding to a child, or the accurate and prompt interpretation of their needs and wants and facilitating them being met in an age appropriate way. Parenting style specifically associated with sensitive responding includes limit setting and supervision, strategies linked with parental monitoring in the IY programme (Scott et al., 2011). The origins of attachment difficulties are strongly associated with younger children of five and under, however attachment relationships continue through life. Influential factors associated with the development of secure attachment relationships in adolescents in care, indicated that a longer period in care, with warmer and more sensitive carers were important (Joseph et al., 2014; Scott et al., 2011).

In this study, differences in attachment relationships at baseline between foster and kinship foster carers were explored, with no significant differences found. However, foster carers showed a significant improvement in attachment relationships measured using the Quality of Attachment Relationships Questionnaire, after attending the IY programme. Difficulties relating to measures of attachment in terms of their reliability and validity and the skills needed to use such measures, are likely account for the limited research on the impact of parenting interventions on attachment relationships (Madigan et al., 2016).

The aspects of the IY intervention that may have contributed to improvements in attachment relationships, may be linked to strategies for teaching emotional literacy and regulation and providing structure, or improvements in accurately identifying behavioural function. Cornell & Hamrin, (2008) note the problem in attachment-disordered children of misinterpretation of child cues leading to an inappropriate carer response. Recommended practices include close supervision, limiting choices and providing structure for the child to allow the child feel secure, whilst they learn systems of internal organisation. It may be foster carers have found the IY strategies of positive interactions with calm and predictable responses and logical consequences in response to misdemeanours, beneficial. In turn, children looked after may have found calm and predictable responses enable them to relax and engage more readily. Parenting interventions teach and promote the skills of staying calm, being predictable and giving logical consequences in conjunction with warmth, attention and the use of high levels of praise. The reductions in anxious and withdrawing behaviours indicated by lower internalising behaviour scores on the CBCL found in this study (chapter 5) may be facilitated by increases in positive attention and predictability. These factors are very similar to the construct of a secure base promoted in the attachment literature where the carers role is one of a stable, consistent and predictable other, which promotes a lowering of child anxiety levels (Schofield & Beek, 2005).

Given that children looked after have both high levels of insecure attachments and behavioural difficulties, along with a predilection for social services to utilise attachment theory rather than behavioural theories, a training programme addressing both, could be helpful. This has been shown for the IY and Fostering Changes parent programmes and should be recommended. If other parenting programmes were shown to be able to address both challenging behaviour and improve attachment relationships, there would be a very clear benefit for their delivery to carers looking after children with multiple and complex difficulties.

5. Challenges to the delivery of training to foster and kinship foster carers.

The interviews with supervising social workers in chapter 7, highlighted some of the difficulties faced by people working within the social care team around the looked after child. Funding constraints, combined with worker skills shortages, mean that many areas of social services are underperforming, with high staff turnover exacerbating problems (Care Inspectorate Wales, 2019b; Welsh Assembly Government, 2018). Changes in legislative focus leading to an increase in kinship foster carer suitability assessments, was highlighted by social workers as one factor dominating their schedules (chapter 7). Lack of flexibility within their workload meant that social workers did not feel able to schedule the dedicated

time needed to implement the EPaS intervention. Indications are that foster and kinship foster carers are more reliant than ever on supervising social workers, as pressures across the service mean child social workers are less available to help with problem solving (Cosis Brown et al., 2014). With research indicating adequate support is essential for carers to enable them to undertake their role (Farmer et al., 2005; Murray et al., 2011), factors that restrict the availability of that support should be a cause for concern.

Organisational factors such as funding and understaffing are not readily resolved within social services departments. However, the use of an evidence based approach to decision making, could be achievable at departmental level. With strong research evidence that child behavioural problems can be addressed by training parents or carers in programmes based on social learning theory models, it is hard to understand why such programmes are not routinely offered to foster and kinship foster carers. A contributing factor may relate to the lack of information on the mental health of children looked after, particularly within Wales. Performance statistics reported annually to the Welsh Assembly do not currently include an assessment of child emotional or behavioural health. Neither are reasons for unplanned placement moves reported, as they are in England (Department for Education, 2018). In addition, in England, OFSTED collates and reports on recruitment and numbers of foster carers (OFSTED, 2019), meaning that in England, it is much easier to get a clear picture of the strengths and weakness within the system. Adoption of similar reporting standards within all UK regions would make comparative reporting simpler and provide motivation for local authorities to address child mental health, including behavioural issues (Welsh Assembly Government, 2018).

The pressure that social services departments are under, as well as a culture where failure can have a profound, negative impact on individuals and public perception (Barratt, 2003; Grady et al., 2018), would seem to make adoption of interventions with external evidence of efficacy a logical step. That this does not appear to be happening in relation to training offered for foster carers, may indicate a skills and resource gap social service departments are not currently able to bridge. Provision of easy to implement interventions, with easy access to ongoing support may be a way forward. Chamberlain, (2017) evaluated a supported roll out of the Keeping Foster Carers Supported and Trained (KEEP) intervention in two different states in the USA. Managers were trained in a supervisory model as well as social workers trained to deliver the interventions, with researchers providing remote support on a weekly basis. The model indicated departmental cost savings and reductions in placement instability at follow up. This type of supported intervention could be a model for helping social services departments to adopt interventions that could be beneficial to all carers.

Policy Implications of Present Research

There are areas identified in this research where gaps could be addressed by changes or additions to policy. There is currently no recommended training pathway for foster and kinship foster carers, although this may change with the introduction of the post-approval learning and development framework for foster carers (AFA, 2019). Given that foster and kinship foster carers care for some of the most vulnerable children in society, facilitating the provision of adequate and effective training would appear paramount. At present, fostering services offer training based on their identification of needs or at the request of carers, in line with broad guidelines contained within fostering services regulations (2003). A review of the statutory guidance to include a clearer training pathway that includes social learning, behavioural and attachment theoretical approaches would give carers a broad theoretical knowledge base. Given the prevalence of behavioural problems within the looked after child population, it could be argued that it would be beneficial for attendance on a parenting course to be part of a compulsory induction process for all foster and kinship foster carers.

It is clear from this study (chapter 7) that whilst social workers may seem good choices for delivery of training interventions, the reality of competing demands on their time means this is unlikely to be practical. The supervising social workers interviewed in chapter 7 all identified the Edge of Care Team as more appropriate to deliver training to foster and kinship foster carers, as they already worked intensively and one to one with families. However, it was also acknowledged that the Edge of Care team did not routinely work with foster and kinship foster carers. A change in the remit of these teams to include support to foster and kinship foster carers, who will be in many instances, looking after the same children the team work with prior to entry to care, would seem a sensible move. This would enable targeted support for carers and children looked after to maintain relationships with workers supporting them whilst at home, whom they lose access to when they enter care. It would also mean that there is a team within each local authority with the skills and experience to deliver training programmes that could include parenting interventions and one to one targeted interventions, helping to support parents, carers and the children they look after.

Mental health support within Wales is under huge pressure. Between 2007 and 2011, there was a 100% increase in referrals to the Child and Adolescent Mental Health service (CAMHS), in one Welsh Health Board (T4CYP, 2016). Provision of parental training programmes routinely to carers may help prevent referrals to CAMHS and could be key in starting to address the issues, whilst benefitting carers and children looked after.

Adoption of training programmes with evidence that they are effective, could be encouraged by a more detailed focus and understanding of the difficulties experienced by foster and kinship foster carers and facilitated through government specification. Routine assessment of child mental health, would facilitate transparency in relation to child and carer needs. Recording and reporting the reasons for unplanned placement moves in Wales, in the same way they are reported in England, would also provide clarity for understanding some of the difficulties. Neither England nor Wales appear to collate and report total numbers of placement moves per child, preferring instead, to report numbers of placement moves per year. There is evidence (Luke et al., 2015) that there are a small minority of children within the care system who experience significant challenges including placement moves and negatively impact outcome statistics for all children. Identifying these children may enable more accurate reporting for the population as a whole whilst identifying those most in need of support. Given that 38% of the young people in youth offending institutions have experience of the care system, compared to 2% of the general population in Wales (Laming, 2016), assisting those most in need must have potential for significant cost savings in relation to health and harmful behaviours across a lifespan (Bellis et al., 2017; Hughes et al., 2017).

Foster and kinship foster carers are different and may benefit from different support packages. At present, there is a lack of consistency in reporting different types of carers, both within research and government statistics. In Wales, kinship foster carers, foster carers and children placed with parents are included in the same set of statistics, whilst foster and kinship foster carers are not always identified separately in research. Transparent reporting would help to identify similarities and differences within, and between, the different types of carers and help to understand why outcomes differ between groups. Further research, including long term outcomes for children placed with kinship foster carers may help to understand why outcomes for these children are different and often better.

Thesis Strengths

One of the main strengths of this thesis is the pragmatic nature of the research working with service providers of foster and kinship foster carers and the children they look after. Research with children looked after is limited and complex to undertake, with challenges relating to the transience of the population and gaining appropriate consents. This is despite children in social care being some of the most vulnerable in society and having the potential to benefit significantly from appropriate, targeted and effective support.

Feedback from the IY group based course was very positive and included stories shared with the researcher at follow-up on how the children that carers looked after had

changed and benefitted from the carer attending the course. Some of the comments from the feedback sheets are included below;

> "*It would be excellent for new carers, should be compulsory! Allows carers to analyse previous practices and gives encouragement. Gives support when in doubt"*
>
> *"All of it was very helpful/useful to know about. Play and ignoring has really helped"*
>
> *"It helped me to see different ways of dealing with situations that can/do arise at home. To stay calm and be clear with what behaviour you expect from your child".*
>
> *"loved it. x*"

In attempting to understand what works and why it is essential to facilitate the provision of effective services and robust support, this thesis has a small contribution to make to the discussion about what works for children looked after in relation to training foster and kinship foster carers in two main ways;

1. Examining similarities and differences between the two types of carers and demonstrating that it might not be in carers best interests for assumptions to be made that there are no significant differences between them.
2. Exploring how parenting interventions can help both child behaviour and attachment relationships and suggesting that parenting interventions be considered as fundamental part of carer training.

Thesis Limitations

The research undertaken as part of this thesis has been undertaken with very small samples and no control groups. As such, findings cannot be assumed to be robust or transferable. There are very few measures designed to be used with foster or kinship foster carers (Dickes et al., 2018), most measures used in this research were designed and normed with parents and biological children. This led to some issues with terminology, such as the use of the word parent, rather than carer in some measures. There were difficulties collecting full sets of data, which further made the interpretation of results challenging. This was particularly the case where it would have been useful to be able to compare between group findings from carer reported questionnaires, carer reported measures collected over time (Parental Daily Report) and the observation measure. The wide age range of the target children in both groups, meant it would have been helpful to have been able to explore age related norms, however the sample size was too small for this to be possible. Collection of additional data, including children's history, information relating to siblings and more detailed demographic information on carers may also have helped to interpret some of the findings, with more clarity. The follow-up time for the IY groups was six months, a longer follow-up of

twelve months or more would have been informative in relation to stability of findings over time.

Future Directions

Further research on similarities and differences between foster and kinship foster carers is recommended, it may be that the differences within the populations are greater than the differences between them, however a better understanding of this would enable much more effective, targeted support. Further evaluation of how parenting interventions could benefit both the behavioural difficulties and attachment issues of looked after children, may be a way of establishing a firm data base and potentially demonstrate an excellent training resource for foster and kinship foster carers, whilst also supporting the acceptability of these interventions within existing social care departments. Supported training for social workers or other teams could be a cost effective way of delivering effective training to carers, with potential benefits to children looked after.

Final conclusions

Given the considerable difficulties that can be experienced by children looked after, it is surprising there are not robust and comprehensive training programmes in place for carers who look after them. The pressures within social services, including under-funding, staff shortages, increasing numbers of children entering care are challenges to provision of high quality training. However, these are not the only explanations for the lack of use of behaviourally based training programmes that have evidence of efficacy, as recommended by NICE for the behavioural problems common with children looked after. Providing effective support for carers may reduce unplanned placement breakdowns and some of the negative impacts these have on the children and carers involved. It would seem at times that

"society appears to be guided more by politics than science, and politics is more about the art of the possible or generally acceptable than what is rational or might work best". (Davies et al. 2000, p. 14).

It would be easy to be disheartened by the failings of the system and the depth of the problems within it, however, the feedback from participants in this study evidences the fact that small, achievable changes can make a difference.

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APPENDICES

APPENDIX A

History of Children Looked After and Current Day Statistics

Start of Care – Protection from Harm.

Historically, responsibility for destitute children lay with the Church until the child was apprenticed into a trade, a process formalised in 1601 in the Poor Law. From the 17th century, there was a move towards protection of children, with patronage funding the establishment of homes for destitute children. During the 19th Century, the concept of protection was extended to all children, not just the destitute, with regulation of child labour improving working conditions, limiting working hours and making education compulsory. The Poor Law amendment of 1834 made destitute children the responsibility of the state and created workhouses that accommodated children unable to live with parents. Following the formation of the NSPCC the first laws were enacted to protect children, raising the age of consent to sixteen and outlawing begging. By the early 1900's a court could determine who was a 'fit person' to care for a child and children could be protected from parents if in danger or subject to ill treatment, including mental cruelty. Children gained legal rights that included giving evidence in court, whilst the withholding of medical treatment, familial incest and prostitution became an offence. In the 1930's the introduction of supervision orders for children at risk of harm, enabled the state to remove children from parents.

Recognition that there were risks to children not living with parents meant that families who took in children under seven were required to register with the local authority from 1908. The report into the death of a 13-year-old boy at the hands of foster carers in 1945, identified failings in Local Authority supervision and discrepancies between children boarded out (an early form of fostering with a family, for children placed in the workhouse) under the poor law, and those placed under the Children Act, recommending care system reform (Monkton, 1945). The Curtis report (1946) acknowledged that state interventions focused on the ability of the parent to provide financially for the child, rather than parental maltreatment. The report proposed that children be cared for in a way that resembled a family, rather than in an institution and that where possible they be returned home. The abolition of the Poor Law system, gave Local Authorities responsibility for destitute children and set up children's departments, provided trained officers and a committee, which oversaw the management of children's homes, residential schools and the selection and supervision of foster carers without recourse to the courts.

Promotion of Welfare

Post war, a combination of an increase in children needing care and awareness of child developmental needs (Bowlby, 1951; 1953) led to a focus on child welfare as well as protection. Local authorities began to working with families by providing support to prevent entry to care. Children's departments were amalgamated with health, disability, elderly and

young offenders' functions, with social workers remit including all aspects of family support. Safeguarding failings identified following the death of Maria Colwell (Field-Fisher, 1974), led to the setting up of area child protection committees (ACPC's) in England and Wales. The Abortion Act 1967 resulted in fewer infants needing adoption and a new focus on adoption from children in the care of local authorities, to provide permanent homes for children spending long periods in care (Rowe & Lambert, 1973). The Children Act 1975 and the Adoption Act 1976, extended children's rights, made provision for birth families to have contact with children taken into care and reduced parental rights in favour of local authorities, foster and adoptive parents to promote permanence for the child through adoption or fostering.

During the 1980's, recognition of poor outcomes for children in both education and when leaving care led to a strengthening of child and parental rights. Children were given the right to have their welfare safeguarded and be consulted regarding decisions made about them (Children Act, 1989). It was determined children were usually best looked after within the family (Children Act, 1989). Local authorities were required to obtain parental rights through court and voluntary accommodation facilitated care as a support for families in duress. The Looked After Child (CLA) system of planning to assess and promote good outcomes developed. Children's rights were enshrined in law through the European Convention on Human Rights (ECHR, 1953) and the United Nations Convention on the Rights of the Child (UNCRC, 1989), made law in the UK in 1992.

Improving Outcomes

The investigation into abuse of children in local authority homes (Utting, 1991; 1997), following a decade where the majority of children were placed in residential homes, led to a strengthening of safeguarding policies and an increase in children placed in foster care. The increased need for foster carers resulted in the formation of Independent Fostering Agencies (IFA) to provide placements for children local authorities were unable to house. Safeguarding policies were the focus of the Children's Act 1989, with checks on people working with children and compulsory notification to the Department of Health of anyone known or suspected of harming children, introduced in 1999.

Local authority failings and children leaving care worse off when they entered identified in the government report 'Quality Protects' (1998), led to the introduction of mandatory recording and reporting criteria, financial and training support for foster carers, registration of IFA's, private children's homes and the provision of independent mediators for children. The 'Quality Protects' programme (Department of Health, 1998) placed a legal and moral duty on the local authorities to provide the same care that a good parent would for a child. In 2000,

local authorities were given a duty to promote the welfare of children leaving care at 16 and to provide support for this process. Changes to adoption legislation widened the scope of people able to adopt, making the adoption process simpler.

The report on the abuse and death at the hands of her carers, of Victoria Climbié (Laming, 2003), identified failings that included late intervention and a lack of information sharing and accountability. The government response included the appointment of a Minister for Children, the replacement of Area Child Protection Committees with Local Safeguarding Children's boards, that supported the establishment of CAFCASS (advisory and support service for family proceedings) in 2001 and appointment of regional Children's commissioners in 2004. Within local authorities, improvements included appointment of a Lead Director for children's services; foster carer registration schemes and implementation of information sharing protocols. Local authorities had a duty of care to promote the welfare and educational achievement of children in their care and to determine the child's wishes prior to service provision.

Welsh Devolution and Service integration.

Responsibility for health, social care and education were devolved to the Welsh Assembly from 2006, from this point on Welsh and English social care came under different legislating authorities. In Wales, the Care Inspectorate Wales (CIW) undertakes the regulation of conduct of fostering services including both local authorities and Independent Fostering Agencies, against The Fostering Services (Wales) act 2003. National Minimum Standards for Fostering Services (Welsh Assembly, 2003) outline standards of care, which service providers should aim to exceed, with CIW monitoring success. Inspection schedules include a baseline inspection every three years and two focused inspections in the interim; however, inspections can vary according to concerns or performance (Care and Social Services Inspectorate Wales, 2014). Inspection reports are publicly available on the CIW website and failures or concerns are included in the reports. Failure to meet standards can result in the issue of a compliance notice, with repeated or serious breaches of legislation leading to suspension or revocation of service registration. In the first full reporting year (2017) there were 44 fostering services registered with CIW (22 Local Authorities, 22 IFA's), with 85 concerns raised and no compliance notices issued.

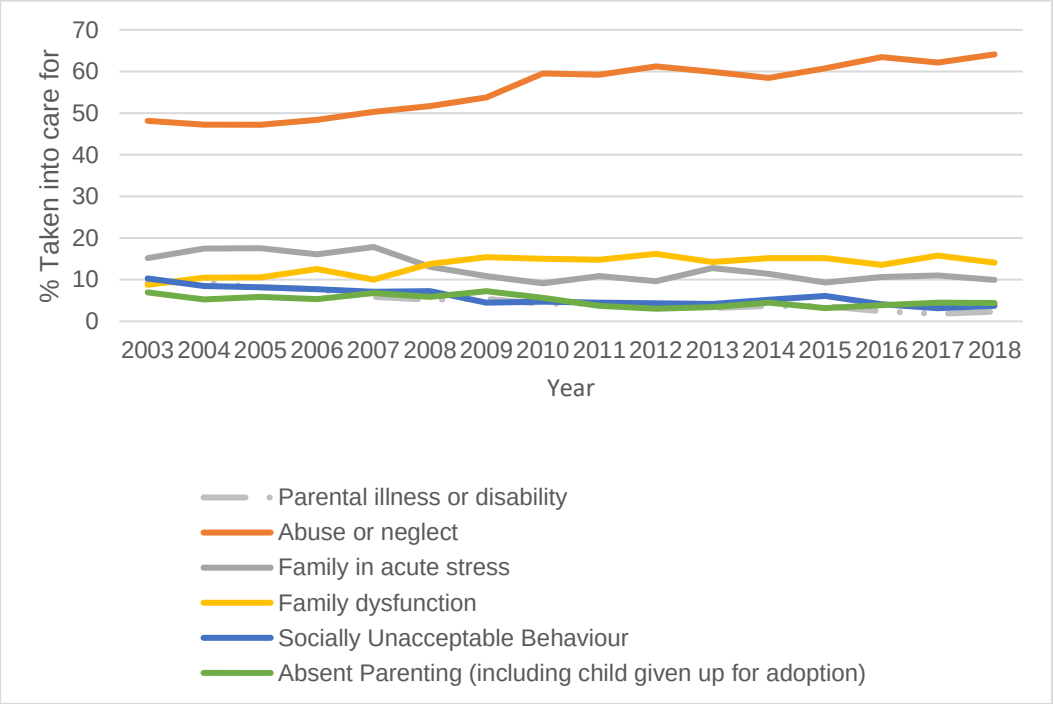
The Welsh Assembly identified a need for improvements in care planning and integration across services such as health and education (Welsh Assembly, 2004), including making placement stability a service objective through the Placement of Children (Wales) Regulations, 2007. This led to a series of changes aimed at improving the process of placing children and their experience whilst in placement. The newly formed Welsh Social Services

Improvement Agency (SSIA) had a reemit to promote excellence and use of evidence based practice. Their report (SSIA, 2007) promoted supported local foster and kinship placements as preferable to residential care. This led to the setup of the Children's Commissioning Consortium Cymru (4C's), to provide a framework and tendering process for children's placements, improving transparency and removing the need for a full procurement process for each placement. The Welsh Assembly published guidance (Welsh Assembly, 2011) to enable foster carers to make day-to-day decisions on overnight stays, UK holidays and haircuts by delegation of authority. Processes to support foster carers included a national minimum allowance payment and an independent approval and reviewing panel for adopters and foster carers. CLA were enabled to remain in care post 18 through the 'When I am ready' initiative. Private fostering legislation (Welsh Assembly, 2006) required local authority notification and included standards and guidance. In 2017, the two organisations, Social Services Improvement Agency and Care Council for Wales merged becoming Social Care Wales.

Recognition that CLA educational attainment needed improving led to local authority and school based designated CLA coordinators, responsible for child educational needs and their personal education plan. Further measures (Wales Audit Office, 2012) introduced targets and publication educational statistics for CLA, promotion of educational achievement and provision of pupil premium funding to schools for looked after children. Children were empowered to be participants in decisions made about them (Welsh Assembly, 2007) in a move towards child led and child focused provision. This process was formalised in the Social Services and Well-being (Wales) Act 2014, which replaces part III of the Children Act 1989, and the Care Planning, Placement and Case Review (Wales) Regulations 2015. Together, this legislation puts the focus on prevention and early intervention and places the individual at the centre of decision-making about their wellbeing and what services they need.

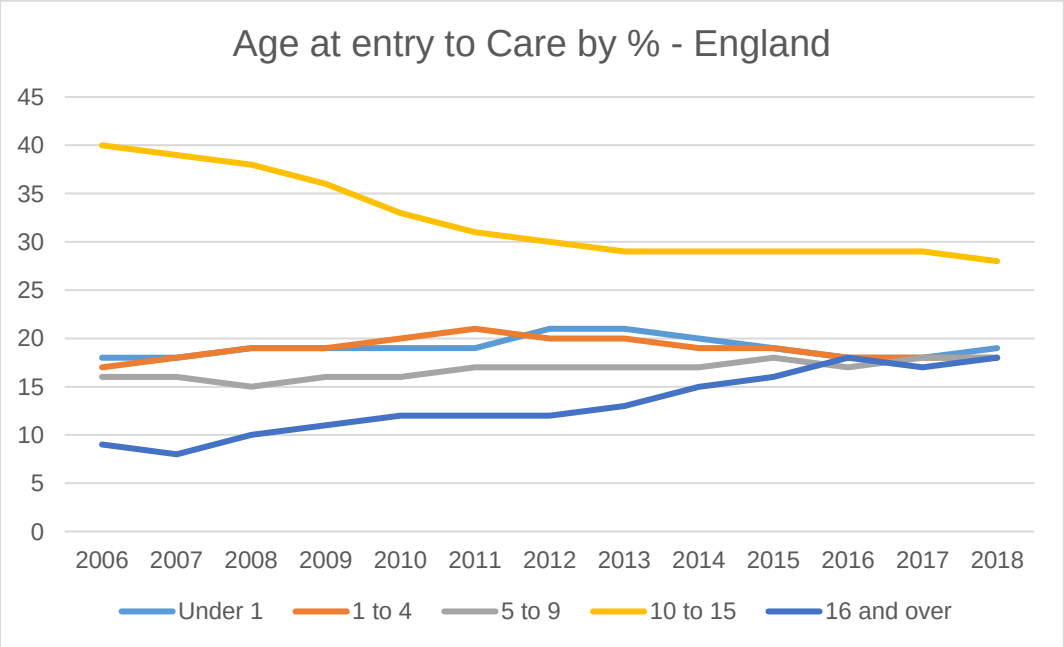
Current Day Statistics

Figure A.1. Variation in reasons given for CLA entry to care, Wales (2003-2018)



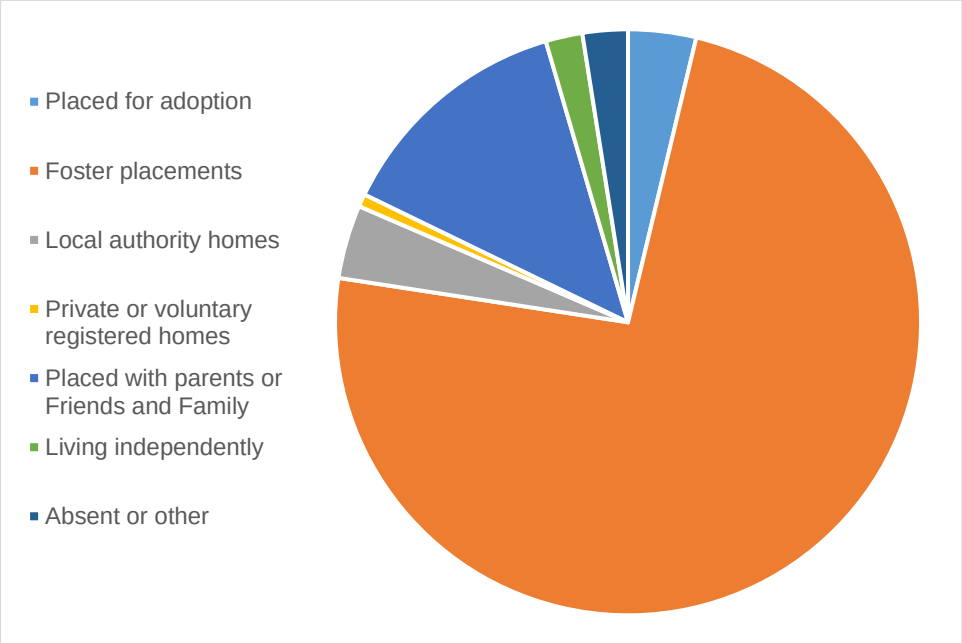
(Data from: Welsh Government, 2019)

Figure A.2. Percentages of age at entry to care, in England (2014-2018)



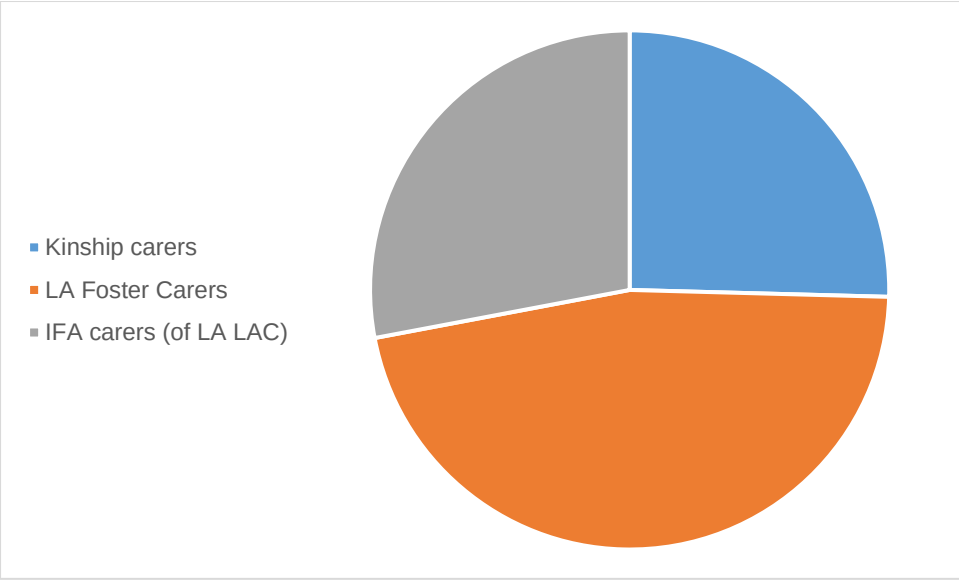
(Data from: Department for Education, 2018)

Figure A.3. Percentages of CLA by accommodation type, in Wales (2018).



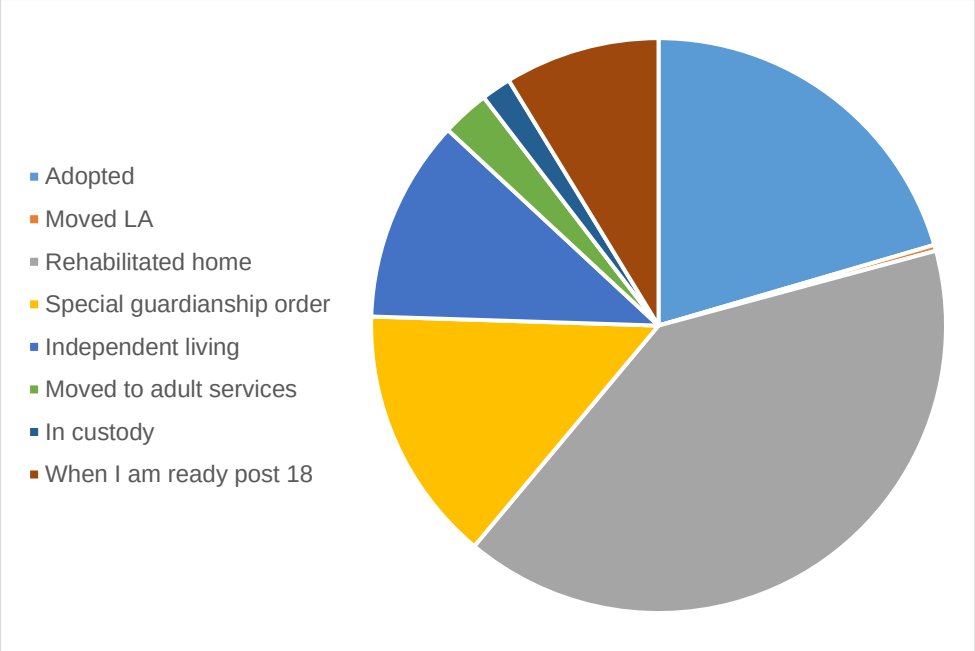
(Data from: Welsh Government, 2019)

Figure A.4. Percentages of CLA in foster or kinship care, in Wales (2018)



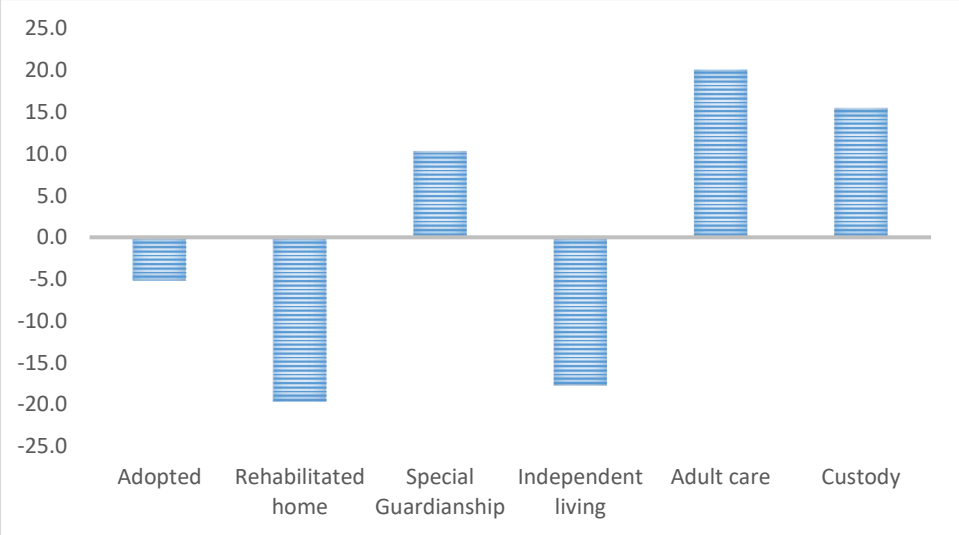
(Data from: Welsh Government, 2019)

Figure A.5. Percentage reasons for exits to care, Wales (2018)



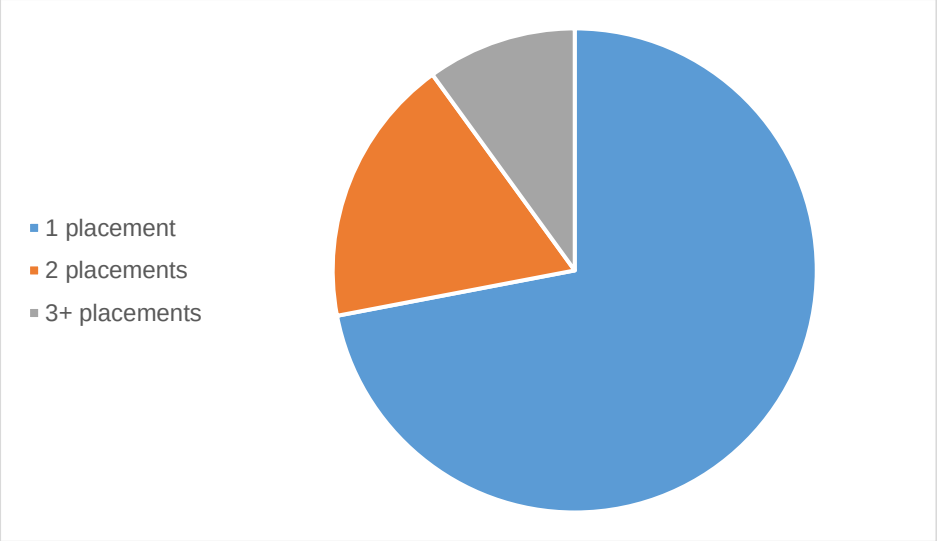
(Data from: Welsh Government, 2019)

Figure A.6. Percentage difference between 2013 and 2018 in reasons for CLA exiting care, in Wales



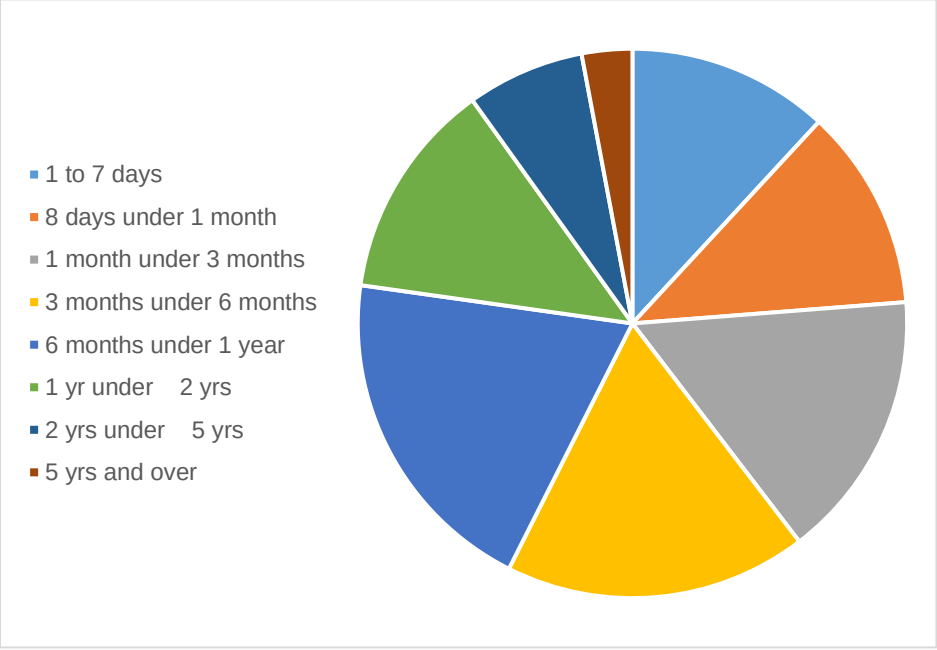
(Data from: Welsh Government, 2019)

Figure A.7. Percentage of CLA experiencing 1, 2 or 3 placement moves, in Wales (2018).



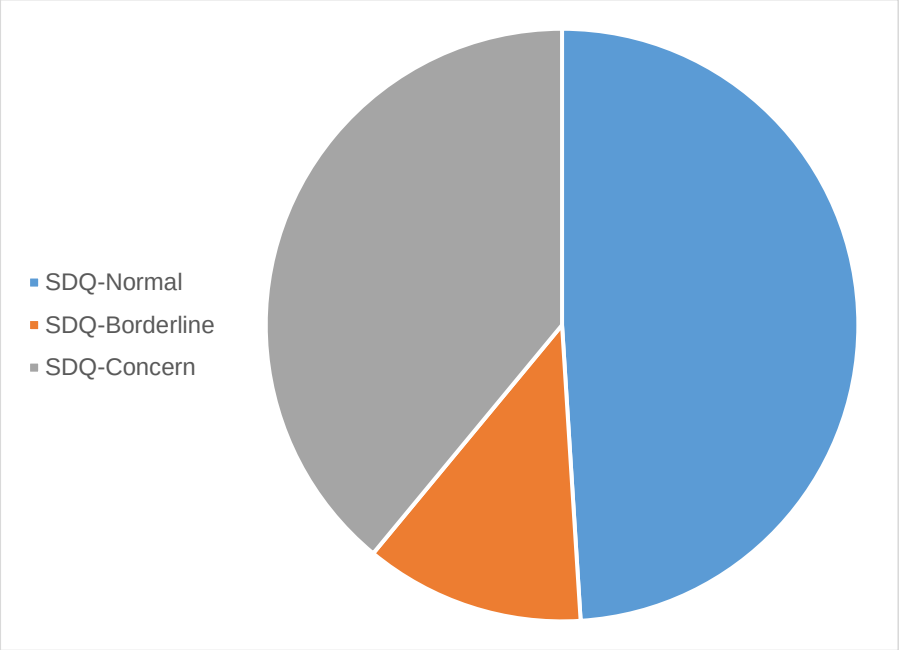
(Data from: Welsh Government, 2019)

Figure A.8. Percentage length of placement duration, in England (2018).



(Data from: Department for Education, 2018)

Figure A.9. Percentage of CLA by SDQ Score, in England (2018)



(Data from: Department for Education, 2018)

APPENDIX B

Local Authority Survey – Participant information and consent

Participant information for the project:

Anglesey Looked After Child, Carer and Training evaluation.

Information about the study

This leaflet describes why the research is being done and what it would involve for you. Please take the time to read it carefully. Talk to others about the study if you wish, such as your supervising social worker or members of your family or friends.

This study is being conducted by Bangor University in conjunction with the Centre for Evidence Based Early Intervention and is funded by a Knowledge Economy Skills Scholarship from the European Union. The study aims to evaluate ways of improving outcomes for looked after children through training provided to foster and kinship carers.

This sheet will give you information about the purpose of the study, what will happen if you take part and information about how the study will be organised. Please ask or contact us if anything is not clear or you would like more information.

Anglesey local authority would like to better understand the needs of both the children looked after and the carers who foster them. They would like to know if the training programme they provide to carers is both useful and helpful to carers to help them manage the needs of the children which they care for. In order to do this, they are asking all carers looking after children placed by Anglesey local authority to complete some questionnaires. To maintain participant confidentiality Bangor University has been asked to undertake the collection and evaluation of this information.

What is the purpose of this study?

To better understand the needs of the carers, such as any stress they may experience along with any difficulties experienced by children looked after by Anglesey local authority, in order to identify any future carer training requirements.

To evaluate the existing training programme offered to carers to find out if carers find the training helpful and useful.

Why have I been asked to participate?

You have been invited to take part in this study because you are a foster or kinship carer and you have a looked after child placed by Anglesey local authority in your care.

Do I have to take part?

No. You have been contacted as you have indicated that you are interested in participating in this study, if you decide to proceed you will be asked to sign a consent form to show you have agreed to participate. You can decide that you do not wish to participate at any time and withdraw from the study, without giving a reason. This will not affect any support or services you receive from your fostering provider.

What will I be expected to do?

If you agree to take part, the researcher will ask you some questions. These will be about you, your experience of looking after the child you care for and any challenges you may have. You have the option to omit a response for any question you do not wish to answer. This will take up to approximately 60 minutes.

What are the possible benefits of taking part?

There may be no direct benefits to anyone taking part in this study. The study is being undertaken to better understand the needs of carers and looked after children. The results will be used to inform the future training programme and this may benefit you and other carers and looked after children in the future.

What are the possible disadvantages and risks of taking part?

You will be asked to spare some time to fill out questionnaires. The questionnaires will ask you to reflect on challenges you may have had with your foster child. However, we do not think that taking part in the study will pose any risks to foster or kinship carers or their looked after children. The study is not designed to replace any services you may be already be accessing for yourself and the child you care for. If you have any concerns about your child's development or behaviour you should contact your supervising social worker.

What are the procedures in place to ensure confidentiality?

All information collected will be handled in confidence and reported anonymously for the participants as a whole, not individually and you will not be identifiable in any report, thesis or publication that arises from this study. Study data will be kept separately from identifiable data such as names and addresses and entered into the databases anonymously. All information relating to participants will be kept securely in line with Bangor University policies and the data protection act 1998. Electronic and paper study data will be stored securely and kept for five years in line with Bangor University research policies. If during any visits there is any concern that you, or your looked after child may be at risk, we will contact the relevant authorities, as normal safeguarding practice.

What will happen if I decide I don't want to carry on with this research study?
Participation in this research is entirely voluntary and you are entitled to withdraw at any time.

What will happen to the results of this research study?
A report of the research study will be prepared and given to Anglesey social services. It will also be included as part of a doctoral thesis. Results will be published in scientific journals and presented at scientific meetings and conferences. You or your child will not be identifiable in any report, publication or presentation.

What next?
If you agree to participate in this research project, then you will be asked sign a consent form and complete the questionnaires.

Ethical approval for the study
This study has been reviewed and approved by Bangor University ethics committee. Research application reference: 18/12

Who do I contact for more information about the study?
If you have any queries about this research please contact:

Sue Layland
Email:
Phone:
Children's Early Intervention Trust, Nantlle Building, Normal Site. Bangor University. Bangor. LL57 2PX

Professor Judy Hutchings
Email:
Phone:
Children's Early Intervention Trust, Nantlle Building, Normal Site. Bangor University. Bangor. LL57 2PX

Who do I contact with any concerns about his study?
If you have any concerns or complaints regarding this research, please contact Professor Judy Hutchings, 01248 383758.

Thank you for considering taking part in this study.

Foster / Kinship Carer Consent form for the Project:

Anglesey Looked After Child, Carer and Training evaluation

Please read and **initial each statement** to show you agree or consent:

I confirm that I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

I understand that my participation is voluntary and I am free to withdraw at any time without giving any reason. ☐

I understand that I will be asked to complete questionnaires up to approximately one year after agreeing to take part in the study. I understand members of the research team will contact me to complete the questionnaires. ☐

I understand that the data collected about me will be treated confidentially.

I agree to take part in the above study. ☐

I can be contacted on the following number or email address:

_____

_____	_____	_____
Name of participant	Date	Signature
_____	_____	_____
Name of person taking consent	Date	Signature

Researcher: Mrs S. Layland
Centre for Evidence Based Early Intervention
Nantlle Building, Normal Site
Bangor University, Bangor
LL57 2PX

Research Application Ref: 18/12

APPENDIX C

Local Authority Survey – Training questionnaire

Anglesey Training Survey 2017

Please complete this questionnaire by circling yes for training you have attended, scoring the training delivery and usefulness to you, and indicating if you would like to attend this training in the next year. Thank you.

1-poor
2-ok
3-excellent

1-not useful
2-a bit useful
3-very useful

Training offered during 2016-17	I have attended this training	The quality of this training was:			The usefulness of this training to me has been:			I would like to attend this training
Introduction to the Social Services and wellbeing act (Wales) 2014	**Yes / No**	**1**	**2**	**3**	**1**	**2**	**3**	**Yes / No**
CLA reviews	**Yes / No**	**1**	**2**	**3**	**1**	**2**	**3**	**Yes / No**
Managing allegations	**Yes / No**	**1**	**2**	**3**	**1**	**2**	**3**	**Yes / No**
Recording refresher	**Yes / No**	**1**	**2**	**3**	**1**	**2**	**3**	**Yes / No**
Safeguarding	**Yes / No**	**1**	**2**	**3**	**1**	**2**	**3**	**Yes / No**
Skills to foster	**Yes / No**	**1**	**2**	**3**	**1**	**2**	**3**	**Yes / No**
Attachment	**Yes / No**	**1**	**2**	**3**	**1**	**2**	**3**	**Yes / No**
Behaviour (Pathways)	**Yes / No**	**1**	**2**	**3**	**1**	**2**	**3**	**Yes / No**
Blood Borne Viruses	**Yes / No**	**1**	**2**	**3**	**1**	**2**	**3**	**Yes / No**
Contact (Pathways)	**Yes / No**	**1**	**2**	**3**	**1**	**2**	**3**	**Yes / No**
Education (Pathways)	**Yes / No**	**1**	**2**	**3**	**1**	**2**	**3**	**Yes / No**
First aid	**Yes / No**	**1**	**2**	**3**	**1**	**2**	**3**	**Yes / No**
First aid (Paediatric)	**Yes / No**	**1**	**2**	**3**	**1**	**2**	**3**	**Yes / No**
Health (Pathways)	**Yes / No**	**1**	**2**	**3**	**1**	**2**	**3**	**Yes / No**
Recording	**Yes / No**	**1**	**2**	**3**	**1**	**2**	**3**	**Yes / No**
Safe & positive Behaviour Induction	**Yes / No**	**1**	**2**	**3**	**1**	**2**	**3**	**Yes / No**
Safe Caring	**Yes / No**	**1**	**2**	**3**	**1**	**2**	**3**	**Yes / No**
Safe & Positive Behaviour Refresher	**Yes / No**	**1**	**2**	**3**	**1**	**2**	**3**	**Yes / No**

Safe Care Level 2	**Yes / No**	**1**	**2**	**3**	**1**	**2**	**3**	**Yes / No**
Safe Caring Refresher	**Yes / No**	**1**	**2**	**3**	**1**	**2**	**3**	**Yes / No**
Attachment based parenting	**Yes / No**	**1**	**2**	**3**	**1**	**2**	**3**	**Yes / No**
Caring for children in the long term	**Yes / No**	**1**	**2**	**3**	**1**	**2**	**3**	**Yes / No**
Child Development	**Yes / No**	**1**	**2**	**3**	**1**	**2**	**3**	**Yes / No**
Contact in permanent foster placements	**Yes / No**	**1**	**2**	**3**	**1**	**2**	**3**	**Yes / No**
Dealing with drugs in foster care	**Yes / No**	**1**	**2**	**3**	**1**	**2**	**3**	**Yes / No**
Diabetes	**Yes / No**	**1**	**2**	**3**	**1**	**2**	**3**	**Yes / No**
Five to Thrive	**Yes / No**	**1**	**2**	**3**	**1**	**2**	**3**	**Yes / No**
Foetal Alcohol Syndrome	**Yes / No**	**1**	**2**	**3**	**1**	**2**	**3**	**Yes / No**
Fostering Teenagers	**Yes / No**	**1**	**2**	**3**	**1**	**2**	**3**	**Yes / No**
Life Story Work	**Yes / No**	**1**	**2**	**3**	**1**	**2**	**3**	**Yes / No**
Managing Risky Behaviour	**Yes / No**	**1**	**2**	**3**	**1**	**2**	**3**	**Yes / No**
Nutrition	**Yes / No**	**1**	**2**	**3**	**1**	**2**	**3**	**Yes / No**
Nutrition 3 days	**Yes / No**	**1**	**2**	**3**	**1**	**2**	**3**	**Yes / No**
Online safety workshop	**Yes / No**	**1**	**2**	**3**	**1**	**2**	**3**	**Yes / No**
Parenting teenagers	**Yes / No**	**1**	**2**	**3**	**1**	**2**	**3**	**Yes / No**
Secure Base	**Yes / No**	**1**	**2**	**3**	**1**	**2**	**3**	**Yes / No**
Sexually harmful behaviour	**Yes / No**	**1**	**2**	**3**	**1**	**2**	**3**	**Yes / No**
Siblings together or apart	**Yes / No**	**1**	**2**	**3**	**1**	**2**	**3**	**Yes / No**
Social Media and the internet	**Yes / No**	**1**	**2**	**3**	**1**	**2**	**3**	**Yes / No**
The Child's World (Scott King)	**Yes / No**	**1**	**2**	**3**	**1**	**2**	**3**	**Yes / No**

When I'm Ready	**Yes / No**	**1**	**2**	**3**	**1**	**2**	**3**	**Yes / No**
Working with birth families	**Yes / No**	**1**	**2**	**3**	**1**	**2**	**3**	**Yes / No**
Youth Mental Health First aid	**Yes / No**	**1**	**2**	**3**	**1**	**2**	**3**	**Yes / No**

APPENDIX D

IY Evaluation – Participant expression of interest

Incredible Years® Training Programme Evaluation.

We are frequently asked by carers for more training so Ynys Mon Social services, in conjunction with North West Wales CAMHS service are offering an Incredible Years® (IY) training programme for carers in the summer term of 2017 and again in the autumn term. The IY programme is supported by over 30 years of research demonstrating its effectiveness in preventing and reducing children's behavioural problems and promoting their social, emotional, and academic competence.

The programme aims to strengthen carer-child interactions and attachment, and a foster or kinship carer's ability to promote children's social, emotional and academic development. The programme covers three main topic areas:

- Promoting positive behaviours in school age children
- Reducing inappropriate behaviours in school age children
- Supporting your child's education

The programme will run for two hours a week for 12 weeks and the first group will be run on Thursday mornings from 10.30 – 12.30 in Llangefni starting on 27th April The programme uses video clips of real-life situational scenarios to encourage group discussions, problem solving and practice exercises. More information on the programme series is available at: http://incredibleyears.com/

The programme will be evaluated by Bangor University to find out if it:

- Adds to the skills of foster and kinship carers in supporting looked after children
- Influences the relationship between looked after children's and their carers
- Reduces carer stress associated with challenging child behaviour
- Improves children's behaviour

Carers will need to have a child aged between 4-12 years placed with them and to expect to have the child remain with them until the summer of 2017.

If you would like to participate, we will need your consent to pass your details to the researchers at Bangor University for them to contact you regarding the evaluation. Please complete and sign the attached form and return it to your supervising social worker.

Expression of Interest for the Project:

Incredible Years® Training Programme Evaluation

If you have discussed the training programme and research project with your supervising social worker or support worker and are willing to learn more about this exciting research opportunity, please complete and sign this form and hand it to back to the staff member.

Carer's details			
First Name:		Surname:	
Address:			
Postcode:			
Telephone (Landline):			

Telephone (Mobile):	
First Language:	
Best Time to Contact:	

I consent for Ynys Mon Social Services to forward my contact details to the research team at Bangor University. I understand that I will be contacted and provided with additional information about the study and the possibility of participating in the project, at which time I will have the opportunity to decide whether or not to participate.

Signature:	Date:

APPENDIX E

IY Evaluation – Participant information and consent form

Participant information for the project:

Incredible Years® Training Programme Evaluation.

Information about the study

We would like to invite you to take part in this research study. This leaflet describes why the research is being done and what it would involve for you. Please take the time to read it carefully. Talk to others about the study if you wish, such as your supervising social worker or members of your family or friends. This study is being conducted by Bangor University in conjunction with the Centre for Evidence Based Early Intervention and is funded by a Knowledge Economy Skills Scholarship from the European Union. The study aims to evaluate ways of improving outcomes for looked after children through training provided to foster and kinship carers. The Incredible Years® series has been developed by Professor Carolyn Webster-Stratton and is supported by over 30 years of research. It is effective in preventing and reducing children's behavioural problems and promoting their social, emotional, and academic competence.

This sheet will give you information about the purpose of the study, what will happen if you take part and information about how the study will be organised. Please ask or contact us if anything is not clear or you would like more information.

What is the purpose of this study?

To find out if the Incredible Years® parent programme:

- Adds to the skills of foster and kinship carers in supporting looked after children
- Influences the relationship between looked after children's and their carers
- Reduces carer stress associated with challenging child behaviour
- Improves children's behaviour

Why have I been asked to participate?

You have been invited to take part in this study because you are an approved foster or kinship carer and you have a looked after child in your care aged between 4 and 12 years old, that you expect to be with you for at least six months.

Do I have to take part?

No. You have been contacted as you have indicated that you are interested in participating in this study, if you decide to proceed you will be asked to sign a consent form to show you have agreed to participate. You can decide that you do not wish to participate at any time and withdraw from the study, without giving a reason. This will not affect any support or services you receive from your fostering provider.

What will I be expected to do?

If you agree to take part, the researcher will ask you some questions. These will be about you, your experience of looking after the child you care for and any challenges you may have. You have the option to omit a response for any question you do not wish to answer. This will take up to approximately 90 minutes. We will then arrange a time with you to observe you and the child you are caring for undertaking a short play session together of up to 30 minutes, which will be recorded using video equipment. We will also arrange a time to conduct a short, recorded interview with the child you nominate for this study, this will take between 30 minutes and 1 hour. You will be asked to attend the Incredible Years® parent programme which will run weekly for two hours for up to 12 weeks, starting after Easter 2017. Everyone who is taking part will be contacted after the course has finished by the researcher to arrange a time to complete questionnaires, an observed play session and a second interview with the child.

The Incredible Years® Programme (School age basic).

The Incredible Years® programme aims to strengthen carer-child interactions and attachment, and a foster or kinship carer's ability to promote children's social, emotional and academic development. The programme covers three main topic areas:

- Promoting positive behaviours in school age children
- Reducing inappropriate behaviours in school age children
- Supporting your child's education

The programme runs for two hours a week for up to 12 weeks and the sessions will be conducted between 10.30 and 12.30 on a Thursday. The programme uses video clips of real-life situational scenarios to encourage group discussions, problem solving and practice exercises.
More information on the programme series is available at: http://incredibleyears.com/

What are the possible benefits of taking part?
There may be no direct benefits to anyone taking part in this study. The study is being undertaken to find out whether foster and kinship carers find the programme helpful for themselves and the children they look after. The programme has considerable evidence to show that it is helpful to parents and children and some evidence to show that it is helpful to foster carers and children. By taking part, you will be helping to answer the question of whether it is helpful to you. The results may benefit other carers and looked after children in the future.

What are the possible disadvantages and risks of taking part?
You will be asked to spare some time to fill out questionnaires, attend a play session with the child you care for and to attend the Incredible Years® programme. The questionnaires will ask you to reflect on challenges you may have had with your foster child. However, we do not think that taking part in the study will pose any risks to foster or kinship carers or their looked after children. The programme is not designed to replace any services you may be already be accessing for yourself and the child you care for. If you have any concerns about your child's development or behaviour you should contact your supervising social worker. Should you have any concerns regarding the programme, please contact the researchers on the contact numbers below.

What are the procedures in place to ensure confidentiality?
All information collected will be handled in confidence and reported anonymously for the participants as a whole, not individually and you will not be identifiable in any report, thesis or publication that arises from this study. Study data will be kept separately from identifiable data such as names and addresses and entered into the databases anonymously. All information relating to participants will be kept securely in line with Bangor University policies and the data protection act 1998. Study data will be kept in line with Bangor University research policies.
If during your meetings there is any concern that you, or your looked after child may be at risk, we will contact the relevant authorities, as normal safeguarding practice.

What will happen if I decide I don't want to carry on with this research study?
Participation in this research is entirely voluntary and you are entitled to withdraw at any time.

What will happen to the results of this research study?
A report of the research study will be prepared and included as part of a doctoral thesis. Results will be published in scientific journals and presented at scientific meetings and conferences. You or your child will not be identifiable in any report, publication or presentation.

Expenses and payments
As a thank you for your time in helping us, we will provide you with a £10 high street voucher each time you complete the questionnaires and play session as a thank you for your time.

What next?
If you would like to participate in this research project, then you will be asked sign a consent form and complete the questionnaires. A separate appointment will be made for the observed play session and child interview. You will then be enrolled onto the Incredible Years® programme starting after Easter 2017 and sent a voucher in the post. On completing the programme you will be asked to complete a programme evaluation. At the end of the programme you will be contacted to arrange to complete another set of questionnaires, a play session and child interview. When these are completed, you will be sent a second voucher in the post.

Ethical approval for the study
This study has been reviewed and approved by the Bangor University Psychology Department ethics committee. Research application reference: 2016-

Who do I contact for more information about the study?
If you have any queries about this research please contact:

Sue Layland
Email:
Phone:
Children's Early Intervention Trust, Nantlle Building, Normal Site, School of Psychology. Bangor University. Bangor. LL57 2PX

Professor Judy Hutchings
Email:
Phone:
Children's Early Intervention Trust, Nantlle Building, Normal Site, School of Psychology. Bangor University. Bangor. LL57 2PX

Who do I contact with any concerns about his study?
If you have any concerns or complaints regarding this research, please contact Mr Hefin Francis, School of Psychology, Bangor University, Bangor, LL57 2AS.

Thank you for considering taking part in this study.

Foster / Kinship Carer Consent form for the Project:

Incredible Years® Training Programme Evaluation

Please read and **initial each statement** to show you agree or consent.

I confirm that I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
I understand that my participation is voluntary and I am free to withdraw at any time without giving any reason.	☐
I understand that I will be asked to complete questionnaires up to approximately one year after agreeing to take part in the study. I understand members of the research team will contact me to complete the questionnaires.	☐
I consent to being recorded during a play session with a child I care for, both before and after the training programme has been completed.	☐
I understand that I am agreeing to take part in a parent programme of up to 12 weeks duration.	☐
I consent to my child being interviewed and recorded by the researcher, both before and after the training programme has been completed.	☐
I agree to take part in the above study.	☐

_____	_____	_____
Name of participant	Date	Signature

_____	_____	_____
Name of person taking consent	Date	Signature

Researcher: Mrs S. Layland
Centre for Evidence Based Early Intervention
Nantlle Building, Normal Site
School of Psychology
Bangor University, Bangor
LL57 2PX

APPENDIX F

IY Evaluation – Parent information and consent form

Parental Consent form for the Project:

Incredible Years® Training Programme Evaluation

The foster / kinship carer your child is fostered with is being invited to participate in a research project which will provide training to the carer. As a part of the research, we would like to observe and record two short play based sessions between the carer and your child, one before the training and one after the training programme has been completed. The sessions will be recorded for later evaluation by trained researchers and once the research project is completed the recordings will be deleted.
We would also like to complete a session with your child where we ask them a series of questions about their relationship with the foster carer. This session will take up to around an hour and will also be recorded for later evaluation by trained researchers, once the project is completed the recordings will be deleted.
The recordings will only be used for the purpose of the research and will be viewed by members of the research team. Your child will not be identifiable in the completed research in any way.

Please read and **initial each statement** to show you agree or consent.

I confirm that I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
I consent to my child participating in the above research project.	☐
I consent to my child being recorded during a play session with their carer, both before and after the training programme has been completed.	☐
I consent to my child being interviewed and recorded by the researcher, both before and after the training programme has been completed.	☐

_____	_____	_____
Name of parent	Date	Signature of parent

_____
Name of child

_____	_____	_____
Name of person taking consent	Date	Signature

Centre for Evidence Based Early Intervention
Nantlle Building, Normal Site
School of Psychology
Bangor University, Bangor
LL57 2PX

APPENDIX G

IY Evaluation – Demographic questionnaire

Pre training Questionnaire for the project:

Incredible Years® Training Programme Evaluation

We would like to ask you some questions about yourself and the children living with you.

1. About you.

a. What is your gender?

☐ Female ☐ Male ☐ Rather not say

b. In what year were you born? _____

c. How long have you been a foster or kinship carer for?

☐ Years ☐ Months

d. Have you ever been on a parenting course? Yes / No (please delete)

If yes, please specify:

_____

2. About your children and relationships.

a. How many children do you have currently living with you??

	Number of:
Biological children	
Step children	
Fostered children	
Other (please describe)	

b. How old were you when you had your first child? _____

c. What is your marital status? *(Please select the one appropriate for you now.)*

	✓
Single, never married	
Married	
Widowed	
Separated	
Divorced	

In a relationship but living apart	
In a relationship but living together	

3. About your Education and employment.

a. How old were you when you left school? _____

b. Did you receive any qualifications at school? (If so, please specify)

Yes / No (please delete)

_____

c. Did you receive any further education after you left school? (If so, please specify)

Yes / No (please delete)

_____

d. What is your current employment status? (Tick as many as apply)

	✓
Employed for wages	
Self-employed	
Full time foster or kinship carer	
Out of work	
Student	
Retired	
Other – please describe	

4. About your income and your household.

a. What is your income made up of?

	✓
State benefits	
Benefits that subsidise wages	
Child maintenance payments	
Foster or kinship carer allowances or fees	

Wages	
Other (please describe)	
Rather not say.	

b. Which category best describes your total weekly income after the excluded costs below have been taken deducted?

(Please EXCLUDE the following: any income tax payments, national insurance contributions, council tax, pension scheme contributions (including voluntary contributions), maintenance and support payments (deducted from the income of the person making the payment), parental contributions to students living away from home and student loan repayments.

Please also EXCLUDE housing costs from your weekly income – these include; rent (gross of housing benefit), ground rent and service charges, water rates or charges, mortgage interest payments, buildings insurance)

One adult household	✓	**Two adult household**	✓
£160 or below		£245 or below	
£161 - £239		£246 - £325	
£240 - £319		£326 - £400	
£320 - £395		£401 - £480	
£396 - £474		£481 - £555	
£475 - £550		£556 - £634	
£551 - £650		£635 - £749	
£651 or above		£750 or above	
Rather not say.		Rather not say.	

c. What is your housing situation, are you a:

	✓
Social / council tenant	
Own home / Own with a mortgage	
Housing association tenant	
Private tenant	
Other (please specify)	

d. How many bedrooms does your house have? _____

5. About the children living with you.

a. How many looked after children do you generally have living with you on a full time basis? ☐

One child you are looking after will become the nominated child for this study. The child will be between the ages of 6-12 years old and you will be expecting them to be with you for at least six months.

b. What is your relationship to this child?

	✓
Biological relative (Other than parent, please describe)	
Foster carer	
Adoptive parent	
Step parent	
Biological parent	
Other (please describe)	

6. Please answer these questions for the child you have nominated.

a. What is the nominated child's gender?

☐ Female ☐ Male

b. What is the nominated child's date of birth? ☐☐ ☐☐ ☐☐ (Day, Month, Year)

c. How long has the child lived with you? ☐☐ ☐☐ (Years, Months)

d. Approximately how long do you expect this child to be placed with you?

_____
_____

e. How many placements did this child have prior to being placed with you?

_____

f. What year did this child first come into care? _____

g. What is the long term plan for this child?

	✓
Move to long term foster care	
Remain in long term foster care	
Return to parents	

Be placed for adoption	
Other or not known (please detail)	

h. Does this child receive any therapeutic or educational support from outside agencies e.g. CAMHS?

☐ Yes ☐ No

i. If yes, please list which agencies and the support given:

_____
_____

Participant Name: _____

Date of completion: _____

APPENDIX H

IY Evaluation – Post training questionnaire

Post training follow up Questionnaire for the project:

Incredible Years® Training Programme Evaluation

1. Is the nominated looked after child still living with you?

   ☐ Yes ☐ No

2. If no, where did this child move to?

   ☐ Placed with another foster carer

   ☐ Returned to parents

   ☐ Adopted

   ☐ Other (please detail)

   _____

3. Have you been on any training, as part of your role as being a foster carer or kinship carer since you completed the Incredible Years programme?

   ☐ Yes ☐ No

4. If yes, please list the names of the course/s and the topic/s covered:

5. Did you feel you benefited from attending the Incredible Years course?

   ☐ Yes ☐ No

Participant Name: _____

Date of completion: _____

APPENDIX I

EPaS Evaluation – Participant information and consent form

Programme Trainee Consent form for the Project:

Enhancing Parenting Skills (EPaS) Evaluation

You are being asked to consent to the collection of information about your participation in an EPaS training programme, which is being collected for the purposes of scientific research. This research will evaluate the Enhancing Parenting Skills Programme (EPaS) training and if the training is effective in achieving its aims.

The research will be undertaken during 2018/9 and data collected during the evaluation will be processed and used as part of a PhD dissertation. Data may also be published.

All data will be anonymised when it is collected, by the use of a reference code allocated to the trainee. These reference codes will be used on the forms used to collect the data and in all databases or spreadsheets used to analyse the data. Participants will be anonymised and any use of names in the recording will be anonymised during transcription. The recording will be transcribed by an agency external to Bangor University; the data will be stored on encrypted drives and will be deleted after transcription. All efforts to anonymise the content will be made, however the participant should understand that due to the qualitative nature of the evaluation and for example, the use of direct quotes, it may be possible for people who know the participant well to identify the participant in the end report.

Contact details and the system used to record and allocate the reference codes will be destroyed or deleted at the end of the project or by 31st December 2019, whichever is the sooner. After this point, reverse anonymization of participant data will not be possible.

The data processor will be the researcher, Sue Layland and the data controller will be Bangor University who will provide ethical approval for this project and supervision of the research. The supervisory authority is the UK designated authority, the information commissioner's office (ICO) https://ico.org.uk

You have the right to:

- Request the removal of your data from the research project
- Request access to data held about you
- Request correction to data held about you
- The right to lodge a complaint with a supervisory authority.

Upon receipt of a request to remove your data from the research, all data that can be identified as being yours, will be deleted or destroyed.

In case of any complaint, the contact at Bangor University is:

Huw Ellis
College Manager, Psychology.
Bangor University, Penrallt Road, Bangor. Gwynedd. LL57 2AS.
01248 383229
Huw.Ellis@bangor.ac.uk

Please read and **initial** each statement to show you agree and consent.

- I confirm that I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

- I understand that my participation is voluntary and I am free to withdraw and have my data destroyed at any time without giving any reason. ☐

- I understand that I will be asked to complete questionnaires up to approximately one year after agreeing to take part in the study. I understand members of the research team will contact me to complete the questionnaires. ☐
- I agree to take part in the EPaS research. ☐
- I consent to taking part in a semi-structured interview about my experience of the EPaS training programme. ☐
- I consent to the audio recording and transcription of the semi-structured interview. ☐
- I understand it may be possible for people who know me well to identify my comments in the completed report. ☐

Researcher: Mrs S. Layland
Centre for Evidence Based Early Intervention
Nantlle Building, Normal Site
School of Psychology
Bangor University, Bangor
LL57 2PX

Research Application Ref: 2018-16314

_____	_____	_____
Name of person taking consent	Date	Signature

Participant Reference: _____

This section to be removed and destroyed before archiving.

_____	_____	_____
Name of participant	Date	Signature

APPENDIX J

EPaS Evaluation – Training summary and interview questions

EPaS training summary

The content for each training day are as follows:

1. **Assessment procedures (3 sessions)**

The programme describes a standardised assessment procedure that includes a range of assessment tools including interview schedules, questionnaires, and observation tools. Assessment tools are used to collect information about the family, their current circumstances, the specific child problem behaviours, the child's skills and strengths, and their goals.

1. Personal Development and Health Questionnaire (PDHQ)
2. Three problem rating scale
3. Parent-Child Constructional questionnaire
4. Parent / carer completed questionnaires:
    - Strengths and difficulties questionnaire
    - Arnold O'Leary Parenting scale
    - Warwick-Edinburgh Mental well-being scales
5. Typical day interview
6. Parent / carer records:
    - ABC charts
7. Observation of parent – child interactions
8. Developmental assessments of the child:
    - Ages and stages questionnaire
9. External sources of data – health, education.

Working collaboratively to establish new behaviours.

2. **Case analysis (1 session)**

The programme teaches how to produce a case analysis using the information collected in the assessment sessions. It involves using the information to develop an understanding of the problem, its history and current function, the assets available in the situation that will support change, and some potential short and longer-term goals. The case analysis is shared with the family and an intervention contract is agreed.
Developing the case analysis:

Step 1: Background information from the assessment phase
Step 2: The problem
Step 3: The function - an understanding of why the problem may be occurring
Step 4: Targets and intervention goals – the alternative behaviour
Step 5: Sharing the case analysis and agreeing a contract

3. Intervention strategies (6-8 sessions)

The programme introduces intervention strategies that parents could use to achieve their short and longer-term goals.
Parents/carers are asked to undertake assignments and keep records about their efforts to achieve weekly goals that clarify whether the intervention strategies are effective. Intervention strategies focus on teaching replacement behaviours. Example intervention strategies include praising behaviour that the parent wants to see more of, ignoring unwanted behaviours, setting limits for the child, rewards and consequences.

Semi-structured Interview Questions:

The interview will be a chat about the usefulness of the training to you. I will use the following questions to structure the session:

1. What aspects of the training on the assessment did you like and what did you find difficult?
2. What aspects of the training on the case analysis did you like and what did you find difficult?
3. What aspects of the training on the intervention did you like and what did you find difficult?

These questions to expand on the three areas:

A. Did you learn any strategies for engaging people you work with, or for assessing people you work with?
B. Did you learn any strategies or skills for question formulation or analysing information?
C. How has the training influenced how you relate to families / carers now?
D. What aspects could / would you use to deliver to foster/kinship families?
E. How could it be used to support you doing their jobs – for example the assessments?
F. Have you noticed any new ways of looking at situations / assessing problems?

Finally:

How likely would you be to recommend this training and/or intervention to a friend or colleague and why?

APPENDIX K

EPaS Evaluation – Behavioural questionnaire

Enhancing Parenting Skills (EPaS) 2019 Programme

Questionnaire

An earlier version of this questionnaire was developed for the Hutchings and Nash 1998* study of health visitors knowledge and skills.

It is a useful checklist for evaluating your own skills and knowledge in relation to use of behavioural intervention skills.

The questionnaire has two sections and asks about:

your current frequency of use of specific behavioural intervention techniques and strategies in your work with children and families.

your views about the use of a behavioural approach in work with children and families and your confidence in your knowledge and ability to apply this approach.

* Hutchings, J., & Nash, S. (1998) Behaviour therapy: what do health visitors know? Community Practitioner 71. 364-367.

Section A

In your work with children and families, how often do you:

1. Record what is happening at the time whilst observing the child and parent or carer(s)?

Always	often	about half the time	only sometimes	never

2. Design record sheets for parent or carer(s) and ask them to keep records of their child's behaviour?

Always	often	about half the time	only sometimes	never

3. Agree and provide a written summary of specific homework tasks for parent or carer(s)?

Always	often	about half the time	only sometimes	never

4. Set homework tasks for parent or carer(s) in reading about behaviour problems and child management?

Always	often	about half the time	only sometimes	never

5. Provide parent or carer(s) with written agreements of specific goals?

Always	often	about half the time	only sometimes	never

6. Provide star charts and record sheets for parent or carer(s) and children to record successes?

Always	often	about half the time	only sometimes	never

7. Use your observations and records to determine precisely what works best as reinforcement or punishment for a particular child?

Always	often	about half the time	only sometimes	never

8. Provide specific feedback to parent or carer(s) on their child management skills based on their records and/or your observations of their behaviour?

Always	often	about half the time	only sometimes	never

9. Teach parent or carer(s) how to reinforce behaviours that are alternative to, or incompatible, with problem behaviour?

Always	often	about half the time	only sometimes	never

10. Discuss with parent or carer(s) specific factors in the home environment which appear to be reinforcing problematic behaviour?

Always	often	about half the time	only sometimes	never

Section B

1. How confident are you that the behavioural approach is helpful for the families of children with whom you work?

very confident	confident	neutral	unconfident	very unconfident

2. How confident are you that you have sufficient knowledge to work behaviourally with children with developmental difficulties?

very confident	confident	neutral	unconfident	very unconfident

3. How confident do you feel about implementing behavioural programmes with these families?

very confident	confident	neutral	unconfident	very unconfident

APPENDIX L

Copies of measures used

Strengths and Difficulties Questionnaire P 4-17

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of the child's behaviour over the last six months.

Child's Name ..... Male/Female

Date of Birth.....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	☐	☐	☐
Restless, overactive, cannot stay still for long	☐	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐	☐
Shares readily with other children (treats, toys, pencils etc.)	☐	☐	☐
Often has temper tantrums or hot tempers	☐	☐	☐
Rather solitary, tends to play alone	☐	☐	☐
Generally obedient, usually does what adults request	☐	☐	☐
Many worries, often seems worried	☐	☐	☐
Helpful if someone is hurt, upset or feeling ill	☐	☐	☐
Constantly fidgeting or squirming	☐	☐	☐
Has at least one good friend	☐	☐	☐
Often fights with other children or bullies them	☐	☐	☐
Often unhappy, down-hearted or tearful	☐	☐	☐
Generally liked by other children	☐	☐	☐
Easily distracted, concentration wanders	☐	☐	☐
Nervous or clingy in new situations, easily loses confidence	☐	☐	☐
Kind to younger children	☐	☐	☐
Often lies or cheats	☐	☐	☐
Picked on or bullied by other children	☐	☐	☐
Often volunteers to help others (parents, teachers, other children)	☐	☐	☐
Thinks things out before acting	☐	☐	☐
Steals from home, school or elsewhere	☐	☐	☐
Gets on better with adults than with other children	☐	☐	☐
Many fears, easily scared	☐	☐	☐
Sees tasks through to the end, good attention span	☐	☐	☐

Do you have any other comments or concerns?

Please turn over - there are a few more questions on the other side

Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

No	Yes- minor difficulties	Yes- definite difficulties	Yes- severe difficulties
☐	☐	☐	☐

If you have answered "Yes", please answer the following questions about these difficulties:

- How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
☐	☐	☐	☐

- Do the difficulties upset or distress your child?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

- Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
HOME LIFE	☐	☐	☐	☐
FRIENDSHIPS	☐	☐	☐	☐
CLASSROOM LEARNING	☐	☐	☐	☐
LEISURE ACTIVITIES	☐	☐	☐	☐

- Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

Signature ..... Date .....

Mother/Father/Other (please specify:)

Thank you very much for your help

Please print **CHILD BEHAVIOR CHECKLIST FOR AGES 6-18** For office use only ID #

CHILD'S FULL NAME First Middle Last

CHILD'S GENDER ☐ Boy ☐ Girl | CHILD'S AGE | CHILD'S ETHNIC GROUP OR RACE

TODAY'S DATE Mo. ____ Day ____ Year ____ | CHILD'S BIRTHDATE Mo. ____ Day ____ Year ____

GRADE IN SCHOOL _____

NOT ATTENDING SCHOOL ☐

Please fill out this form to reflect *your* view of the child's behavior even if other people might not agree. Feel free to print additional comments beside each item and in the space provided on page 2. ***Be sure to answer all items.***

PARENTS' USUAL TYPE OF WORK, even if not working now.
(Please be specific — for example, auto mechanic, high school teacher, homemaker, laborer, lathe operator, shoe salesman, army sergeant.)
PARENT 1 (or FATHER)
TYPE OF WORK _____
PARENT 2 (or MOTHER)
TYPE OF WORK _____

THIS FORM FILLED OUT BY: (print your full name)

_____

Your gender: ☐ Male ☐ Female

Your relation to the child:
☐ Biological Parent ☐ Step Parent ☐ Grandparent
☐ Adoptive Parent ☐ Foster Parent ☐ Other (specify)

I. Please list the sports your child most likes to take part in. For example: swimming, baseball, skating, skate boarding, bike riding, fishing, etc.

☐ None

	Compared to others of the same age, about how much time does he/she spend in each?				Compared to others of the same age, how well does he/she do each one?			
	Less Than Average	Average	More Than Average	Don't Know	Below Average	Average	Above Average	Don't Know
a. _____	☐	☐	☐	☐	☐	☐	☐	☐
b. _____	☐	☐	☐	☐	☐	☐	☐	☐
c. _____	☐	☐	☐	☐	☐	☐	☐	☐

II. Please list your child's favorite hobbies, activities, and games, other than sports. For example: video games, dolls, reading, piano, crafts, cars, computers, singing, etc. (Do ***not*** include listening to radio, TV, or other media.)

☐ None

	Compared to others of the same age, about how much time does he/she spend in each?				Compared to others of the same age, how well does he/she do each one?			
	Less Than Average	Average	More Than Average	Don't Know	Below Average	Average	Above Average	Don't Know
a. _____	☐	☐	☐	☐	☐	☐	☐	☐
b. _____	☐	☐	☐	☐	☐	☐	☐	☐
c. _____	☐	☐	☐	☐	☐	☐	☐	☐

III. Please list any organizations, clubs, teams, or groups your child belongs to.

☐ None

	Compared to others of the same age, how active is he/she in each?			
	Less Active	Average	More Active	Don't Know
a. _____	☐	☐	☐	☐
b. _____	☐	☐	☐	☐
c. _____	☐	☐	☐	☐

IV. Please list any jobs or chores your child has. For example: doing dishes, babysitting, making bed, working in store, etc. (Include both paid and unpaid jobs and chores.)

☐ None

	Compared to others of the same age, how well does he/she carry them out?			
	Below Average	Average	Above Average	Don't Know
a. _____	☐	☐	☐	☐
b. _____	☐	☐	☐	☐
c. _____	☐	☐	☐	☐

Be sure you answered all items. Then see other side.

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Please print. Be sure to answer all items.

V. 1. About how many close friends does your child have? (Do *not* include brothers & sisters)
☐None ☐1 ☐2 or 3 ☐4 or more

2. About how many times a week does your child do things with any friends outside of regular school hours? (Do *not* include brothers & sisters) ☐Less than 1 ☐1 or 2 ☐3 or more

VI. Compared to others of his/her age, how well does your child:

	Worse	Average	Better	
a. Get along with his/her brothers & sisters?	☐	☐	☐	☐ Has no brothers or sisters
b. Get along with other kids?	☐	☐	☐	
c. Behave with his/her parents?	☐	☐	☐	
d. Play and work alone?	☐	☐	☐	

VII. 1. Performance in academic subjects. ☐Does not attend school because _____

	Check a box for each subject that child takes	Failing	Below Average	Average	Above Average
	a. Reading, English, or Language Arts	☐	☐	☐	☐
Other academic subjects–for example: computer courses, foreign language, business. Do *not* include gym, shop, driver's ed., or other nonacademic subjects.	b. History or Social Studies	☐	☐	☐	☐
	c. Arithmetic or Math	☐	☐	☐	☐
	d. Science	☐	☐	☐	☐
	e. _____	☐	☐	☐	☐
	f. _____	☐	☐	☐	☐
	g. _____	☐	☐	☐	☐

2. Does your child receive special education or remedial services or attend a special class or special school?
☐No ☐Yes—kind of services, class, or school:

3. Has your child repeated any grades? ☐No ☐Yes—grades and reasons:

4. Has your child had any academic or other problems in school? ☐No ☐Yes—please describe:

When did these problems start?

Have these problems ended? ☐No ☐Yes–when?

Does your child have any illness or disability (either physical or mental)? ☐No ☐Yes—please describe:

What concerns you most about your child?

Please describe the best things about your child.

Be sure you answered all items.

Please print. Be sure to answer all items.

Below is a list of items that describe children and youths. For each item that describes your child ***now or within the past 6 months***, please circle the ***2*** if the item is ***very true or often true*** of your child. Circle the ***1*** if the item is ***somewhat or sometimes true*** of your child. If the item is ***not true*** of your child, circle the ***0***. Please answer all items as well as you can, even if some do not seem to apply to your child.

0 = Not True (as far as you know) **1 = Somewhat or Sometimes True** **2 = Very True or Often True**

0 1 2 1. Acts too young for his/her age
0 1 2 2. Drinks alcohol without parents' approval (describe): _____
_____
0 1 2 3. Argues a lot
0 1 2 4. Fails to finish things he/she starts
0 1 2 5. There is very little he/she enjoys
0 1 2 6. Bowel movements outside toilet
0 1 2 7. Bragging, boasting
0 1 2 8. Can't concentrate, can't pay attention for long
0 1 2 9. Can't get his/her mind off certain thoughts; obsessions (describe): _____
_____
0 1 2 10. Can't sit still, restless, or hyperactive
0 1 2 11. Clings to adults or too dependent
0 1 2 12. Complains of loneliness
0 1 2 13. Confused or seems to be in a fog
0 1 2 14. Cries a lot
0 1 2 15. Cruel to animals
0 1 2 16. Cruelty, bullying, or meanness to others
0 1 2 17. Daydreams or gets lost in his/her thoughts
0 1 2 18. Deliberately harms self or attempts suicide
0 1 2 19. Demands a lot of attention
0 1 2 20. Destroys his/her own things
0 1 2 21. Destroys things belonging to his/her family or others
0 1 2 22. Disobedient at home
0 1 2 23. Disobedient at school
0 1 2 24. Doesn't eat well
0 1 2 25. Doesn't get along with other kids
0 1 2 26. Doesn't seem to feel guilty after misbehaving
0 1 2 27. Easily jealous
0 1 2 28. Breaks rules at home, school, or elsewhere
0 1 2 29. Fears certain animals, situations, or places, other than school (describe): _____
_____
0 1 2 30. Fears going to school
0 1 2 31. Fears he/she might think or do something bad
0 1 2 32. Feels he/she has to be perfect
0 1 2 33. Feels or complains that no one loves him/her
0 1 2 34. Feels others are out to get him/her
0 1 2 35. Feels worthless or inferior
0 1 2 36. Gets hurt a lot, accident-prone
0 1 2 37. Gets in many fights
0 1 2 38. Gets teased a lot
0 1 2 39. Hangs around with others who get in trouble
0 1 2 40. Hears sound or voices that aren't there (describe): _____
_____
0 1 2 41. Impulsive or acts without thinking
0 1 2 42. Would rather be alone than with others
0 1 2 43. Lying or cheating
0 1 2 44. Bites fingernails
0 1 2 45. Nervous, highstrung, or tense
0 1 2 46. Nervous movements or twitching (describe):
_____
_____
0 1 2 47. Nightmares
0 1 2 48. Not liked by other kids
0 1 2 49. Constipated, doesn't move bowels
0 1 2 50. Too fearful or anxious
0 1 2 51. Feels dizzy or lightheaded
0 1 2 52. Feels too guilty
0 1 2 53. Overeating
0 1 2 54. Overtired without good reason
0 1 2 55. Overweight
56. Physical problems ***without known medical cause:***
0 1 2 a. Aches or pains (***not*** stomach or headaches)
0 1 2 b. Headaches
0 1 2 c. Nausea, feels sick
0 1 2 d. Problems with eyes (***not*** if corrected by glasses) (describe): _____
0 1 2 e. Rashes or other skin problems
0 1 2 f. Stomachaches
0 1 2 g. Vomiting, throwing up
0 1 2 h. Other (describe): _____
_____

PAGE 3 ***Be sure you answered all items. Then see other side.***

Please print. Be sure to answer all items.

0 = Not True (as far as you know) **1 = Somewhat or Sometimes True** **2 = Very True or Often True**

0 1 2 57. Physically attacks people
0 1 2 58. Picks nose, skin, or other parts of body (describe): _____
_____
0 1 2 59. Plays with own sex parts in public
0 1 2 60. Plays with own sex parts too much
0 1 2 61. Poor school work
0 1 2 62. Poorly coordinated or clumsy
0 1 2 63. Prefers being with older kids
0 1 2 64. Prefers being with younger kids
0 1 2 65. Refuses to talk
0 1 2 66. Repeats certain acts over and over; compulsions (describe): _____
_____
0 1 2 67. Runs away from home
0 1 2 68. Screams a lot
0 1 2 69. Secretive, keeps things to self
0 1 2 70. Sees things that aren't there (describe): _____
_____
_____
0 1 2 71. Self-conscious or easily embarrassed
0 1 2 72. Sets fires
0 1 2 73. Sexual problems (describe): _____
_____
_____
0 1 2 74. Showing off or clowning
0 1 2 75. Too shy or timid
0 1 2 76. Sleeps less than most kids
0 1 2 77. Sleeps more than most kids during day and/or night (describe): _____
_____
0 1 2 78. Inattentive or easily distracted
0 1 2 79. Speech problem (describe): _____
_____
0 1 2 80. Stares blankly
0 1 2 81. Steals at home
0 1 2 82. Steals outside the home
0 1 2 83. Stores up too many things he/she doesn't need (describe): _____
_____
_____
0 1 2 84. Strange behavior (describe): _____
_____
0 1 2 85. Strange ideas (describe): _____
_____
0 1 2 86. Stubborn, sullen, or irritable
0 1 2 87. Sudden changes in mood or feelings
0 1 2 88. Sulks a lot
0 1 2 89. Suspicious
0 1 2 90. Swearing or obscene language
0 1 2 91. Talks about killing self
0 1 2 92. Talks or walks in sleep (describe): _____
_____
0 1 2 93. Talks too much
0 1 2 94. Teases a lot
0 1 2 95. Temper tantrums or hot temper
0 1 2 96. Thinks about sex too much
0 1 2 97. Threatens people
0 1 2 98. Thumb-sucking
0 1 2 99. Smokes, chews, or sniffs tobacco
0 1 2 100. Trouble sleeping (describe): _____
_____
0 1 2 101. Truancy, skips school
0 1 2 102. Underactive, slow moving, or lacks energy
0 1 2 103. Unhappy, sad, or depressed
0 1 2 104. Unusually loud
0 1 2 105. Uses drugs for nonmedical purposes (***don't*** include alcohol or tobacco) (describe): _____
_____
_____
0 1 2 106. Vandalism
0 1 2 107. Wets self during the day
0 1 2 108. Wets the bed
0 1 2 109. Whining
0 1 2 110. Wishes to be of opposite sex
0 1 2 111. Withdrawn, doesn't get involved with others
0 1 2 112. Worries
113. Please write in any problems your child has that were not listed above:
0 1 2 _____
0 1 2 _____
0 1 2 _____

Please be sure you answered all items.

ACC Assessment Checklist for Children

GIRLS FORM

PART 1

Here are some statements that describe children's behaviour and feelings.
For each statement, please circle the number that best describes your child in the **last 4 to 6 months**.

→ circle **0** if the statement is **not true** for your child in the last 4 to 6 months.
→ circle **1** if the statement is **partly true** for your child in the last 4 to 6 months.
→ circle **2** if the statement is **mostly true** for your child in the last 4 to 6 months.

Please do not check your answers with your child, as they may cause distress or embarrassment.

0	1	2	1.	Adjusts slowly to changes
0	1	2	2.	Attention-seeking behaviour
0	1	2	3.	Avoids eye contact, except if in 'trouble'
0	1	2	4.	Believes she is no good at anything
0	1	2	5.	Can't concentrate, short attention span
0	1	2	6.	Changes friends quickly
0	1	2	7.	Clingy
0	1	2	8.	Complains of not being likeable
0	1	2	9.	Craves affection
0	1	2	10.	Dislikes herself
0	1	2	11.	Distrusts adults
0	1	2	12.	Does not cry
0	1	2	13.	Does not share with friends
0	1	2	14.	Does not show affection
0	1	2	15.	Does not speak up for herself
0	1	2	16.	Easily discouraged at home
0	1	2	17.	Easily discouraged at school
0	1	2	18.	Easily influenced by other children
0	1	2	19.	Eats from garbage
0	1	2	20.	Eats things that are not food
0	1	2	21.	Eats too much
0	1	2	22.	Fearful of men in general
0	1	2	23.	Fearful or nervous at bedtime
0	1	2	24.	Fears she might be molested
0	1	2	25.	Fears she might do something bad
0	1	2	26.	Fears you will reject her
0	1	2	27.	Feels ashamed
0	1	2	28.	Feels worthless or inferior
0	1	2	29.	Finds it hard to make decisions
0	1	2	30.	Gets hurt a lot, "accident prone"
0	1	2	31.	Gives up too easily
0	1	2	32.	Gorges food
0	1	2	33.	Has a low opinion of herself
0	1	2	34.	Has an imaginary friend
0	1	2	35.	Has nightmares
0	1	2	36.	Hides feelings
0	1	2	37.	Hides or stores food
0	1	2	38.	Hugs men, other than relative or male carer
0	1	2	39.	Is convinced that friends will reject her
0	1	2	40.	Is fearful of being harmed
0	1	2	41.	Lacks confidence
0	1	2	42.	Lacks guilt or empathy
0	1	2	43.	Laughs when injured or hurt
0	1	2	44.	Lives in a fantasy world
0	1	2	45.	Low self-esteem
0	1	2	46.	Manipulates or 'uses' friends
0	1	2	47.	Play includes violent or frightening themes
0	1	2	48.	Possessive, can't share friends
0	1	2	49.	Precocious (talks or behaves like an adult)
0	1	2	50.	Prefers to be with adults, rather than children
0	1	2	51.	Prefers to mix with older children
0	1	2	52.	Refuses to talk
0	1	2	53.	Relates to strangers 'as if they were family'
0	1	2	54.	Resists being comforted when hurt
0	1	2	55.	Risks physical safety, fearless
0	1	2	56.	Says friends are against her
0	1	2	57.	Says she is "bad", or "no good"
0	1	2	58.	Secretive
0	1	2	59.	Seems insecure
0	1	2	60.	Startles easily
0	1	2	61.	Steals food
0	1	2	62.	Suspicious
0	1	2	63.	Thinks she is someone or something else
0	1	2	64.	Thinks other children are better than her
0	1	2	65.	Too compliant (over-conforms)
0	1	2	66.	Too dramatic (false emotions)
0	1	2	67.	Too friendly with strangers
0	1	2	68.	Too independent
0	1	2	69.	Too jealous
0	1	2	70.	Treats you as though you were the child, and she was the parent
0	1	2	71.	Tries too hard to please other children
0	1	2	72.	Tries too hard to please you
0	1	2	73.	Turns friends against each other
0	1	2	74.	Uncaring (shows little concern for others)
0	1	2	75.	Very forgetful
0	1	2	76.	Wants to be treated like a baby, or a toddler
0	1	2	77.	Wary or vigilant
0	1	2	78.	Withdrawn
0	1	2	79.	Won't attempt new activities
0	1	2	80.	Won't communicate with other children
0	1	2	81.	Worries that something bad will happen to you

Please turn over to complete part 2

ACC Assessment Checklist for Children

GIRLS FORM

PART 2 Please note that the instructions are different on this page.

On this page only

→ circle **0** if the behaviour **did not occur** in the last 4 to 6 months.
→ circle **1** if the behaviour **occurred once** in the last 4 to 6 months.
→ circle **2** if the behaviour **occurred more than once** in the last 4 to 6 months.

0	1	2	82.	Asks to be physically punished
0	1	2	83.	Attempts suicide
0	1	2	84.	Bites herself
0	1	2	85.	Causes herself to vomit
0	1	2	86.	Causes injury to herself (describe):_____ _____
0	1	2	87.	Cuts or pulls out her hair (describe):_____
0	1	2	88.	Cuts or rips her clothes (describe):_____ _____
0	1	2	89.	Describes how she would kill herself
0	1	2	90.	Describes or imitates sexual behaviour
0	1	2	91.	Distressed by traumatic memories
0	1	2	92.	Does not show pain if physically hurt
0	1	2	93.	Extreme reaction to losing a friend, or being excluded by other children (describe):_____ _____
0	1	2	94.	'Flirts' with strangers
0	1	2	95.	Forces or pressures children into sexual acts
0	1	2	96.	Has blackouts or periods of amnesia
0	1	2	97.	Has panic attacks (when?)_____
0	1	2	98.	Hits head, head-banging
0	1	2	99.	Intentionally harms herself with knives or implements (describe):_____ _____
0	1	2	100.	Intentionally swallows dangerous substance to harm herself (e.g. medication, poison) (describe):_____
0	1	2	101.	Kisses with open mouth
0	1	2	102.	Masturbates at home in view of others
0	1	2	103.	Masturbates at school, or in public
0	1	2	104.	Picks at sores or injuries
0	1	2	105.	Requests to be harmed
0	1	2	106.	Rocks back and forth (describe):_____
0	1	2	107.	Says her life is not worth living
0	1	2	108.	Sexual behaviour not appropriate for her age (describe):_____ _____
0	1	2	109.	Sexual intercourse with another young person
0	1	2	110.	Sexual relations with an adult (describe):_____ _____
0	1	2	111.	Shows sex parts to children (other than siblings)
0	1	2	112.	Starts rude conversations, tells jokes about sex
0	1	2	113.	Talks about suicide
0	1	2	114.	Threatens to injure herself
0	1	2	115.	Threatens to kill herself
0	1	2	116.	Throws herself against walls, onto floors, etc (describe):_____ _____
0	1	2	117.	Touches or puts mouth on other person's sex parts
0	1	2	118.	Tries to involve others in sexual behaviour (describe):_____ _____
0	1	2	119.	Unhealthy drinking (e.g. from discarded drink bottle, from toilet bowl) (describe):_____
0	1	2	120.	Won't say when physically hurt

Please make sure you have answered each question on both sides of the page

ID:

Child's name:

Child's age:

Your name:

Your relationship to the child: (e.g. mother, father, aunt, foster mother, grandfather)

PSI Short Form

Instructions

This questionnaire contains 36 statements. Read each statement carefully. For each statement, please focus on the child you are most concerned about, and circle the response that best represents your opinion.

Circle the SA if you strongly agree with the statement.

Circle the A if you agree with the statement.

Circle the NS if you are not sure.

Circle the D if you disagree with the statement.

Circle the SD if you strongly disagree with the statement.

For example, if you sometimes enjoy going to the movies, you would circle A in response to the following statement:

I enjoy going to the movies. SA (A) NS D SD

While you may not find a response that exactly states your feelings, please circle the response that comes closest to describing how you feel. YOUR FIRST REACTION TO EACH QUESTION SHOULD BE YOUR ANSWER.

Circle only one response for each statement, and respond to all statements. **DO NOT ERASE!** If you need to change an answer, make an "X" through the incorrect answer and circle the correct response. For example:

I enjoy going to the movies. SA A NS (X) (SD)

Before responding to the statements, write your name, gender, date of birth, ethnic group, marital status, child's name, child's gender, child's date of birth, and today's date in the spaces at the top of the questionnaire.

SA = Strongly Agree A = Agree NS = Not Sure D = Disagree SD = Strongly Disagree

1.	I often have the feeling that I cannot handle things very well.	SA	A	NS	D	SD
2.	I find myself giving up more of my life to meet my children's needs than I ever expected.	SA	A	NS	D	SD
3.	I feel trapped by my responsibilities as a parent.	SA	A	NS	D	SD
4.	Since having this child, I have been unable to do new and different things.	SA	A	NS	D	SD
5.	Since having a child, I feel that I am almost never able to do things that I like to do.	SA	A	NS	D	SD
6.	I am unhappy with the last purchase of clothing I made for myself.	SA	A	NS	D	SD
7.	There are quite a few things that bother me about my life.	SA	A	NS	D	SD
8.	Having a child has caused more problems than I expected in my relationship with my spouse (or male/female friend).	SA	A	NS	D	SD
9.	I feel alone and without friends.	SA	A	NS	D	SD
0.	When I go to a party, I usually expect not to enjoy myself.	SA	A	NS	D	SD
1.	I am not as interested in people as I used to be.	SA	A	NS	D	SD
2.	I don't enjoy things as I used to.	SA	A	NS	D	SD
3.	My child rarely does things for me that make me feel good.	SA	A	NS	D	SD
4.	Sometimes I feel my child doesn't like me and doesn't want to be close to me.	SA	A	NS	D	SD
5.	My child smiles at me much less than I expected.	SA	A	NS	D	SD
6.	When I do things for my child, I get the feeling that my efforts are not appreciated very much.	SA	A	NS	D	SD
7.	When playing, my child doesn't often giggle or laugh.	SA	A	NS	D	SD
8.	My child doesn't seem to learn as quickly as most children.	SA	A	NS	D	SD
9.	My child doesn't seem to smile as much as most children.	SA	A	NS	D	SD
0.	My child is not able to do as much as I expected.	SA	A	NS	D	SD
1.	It takes a long time and it is very hard for my child to get used to new things.	SA	A	NS	D	SD

or the next statement, choose your response from the choices "1" to "5" below.

2.	I feel that I am: 1. not very good at being a parent 2. a person who has some trouble being a parent 3. an average parent 4. a better than average parent 5. a very good parent	1	2	3	4	5
3.	I expected to have closer and warmer feelings for my child than I do and this bothers me.	SA	A	NS	D	SD
4.	Sometimes my child does things that bother me just to be mean.	SA	A	NS	D	SD
5.	My child seems to cry or fuss more often than most children.	SA	A	NS	D	SD
6.	My child generally wakes up in a bad mood.	SA	A	NS	D	SD
7.	I feel that my child is very moody and easily upset.	SA	A	NS	D	SD
8.	My child does a few things which bother me a great deal.	SA	A	NS	D	SD
9.	My child reacts very strongly when something happens that my child doesn't like.	SA	A	NS	D	SD
0.	My child gets upset easily over the smallest thing.	SA	A	NS	D	SD
1.	My child's sleeping or eating schedule was much harder to establish than I expected.	SA	A	NS	D	SD

or the next statement, choose your response from the choices "1" to "5" below.

2.	I have found that getting my child to do something or stop doing something is: 1. much harder than I expected 2. somewhat harder than I expected 3. about as hard as I expected 4. somewhat easier than I expected 5. much easier than I expected	1	2	3	4	5

or the next statement, choose your response from the choices "10+" to "1-3."

33.	Think carefully and count the number of things which your child does that bother you. For example: dawdles, refuses to listen, overactive, cries, interrupts, fights, whines, etc.	10+	8-9	6-7	4-5	1-3
34.	There are some things my child does that really bother me a lot.	SA	A	NS	D	SD
35.	My child turned out to be more of a problem than I had expected.	SA	A	NS	D	SD
36.	My child makes more demands on me than most children.	SA	A	NS	D	SD

DPICs Coding Sheet

Time: BL / FU Video/Family ID: Time start: End: Coder:
RV.SO Prim/Sec

Parent Behaviours					
Critical Statements: Critical			Critical Statements: Negative Command		
Unlabelled Praise			Labelled Praise		
Des. Comment / Encouragement			Des. Question/ Encouragement		
Statement			Problem solve (DC)		
Question			Acknowledge		
Reflective Question			Reflective Statement		
Indirect Command:			Direct Command:		
No opportunity			No opportunity		
Compliance			Compliance		
Non Compliance			Non Compliance		
Child Behaviours					
Physical Negative			Destructive		
Smart Talk					

Reliability: A= DA= Total= Reliability=

(PDR) Carer Daily Report Checklist (Chamberlain, P., Reid, J. B. (1987))

Week beginning:
(Mon - Date)

Child Initials:			**Child DOB:**				
	Mon	**Tue**	**Wed**	**Thur**	**Fri**	**Sat**	**Sun**
Aggressiveness							
Arguing							
Bedwetting							
Competitiveness							
Complaining							
Crying							
Defiance							
Destructiveness							
Fearfulness							
Fighting with siblings							
Fire setting							
Hitting others							
Hyper-activeness							
Irritableness							
Lying							
Negativism							
Noisiness							
Noncomplying							
Not eating meals							
Pants wetting							
Pouting							
Running around							
Running away							
Sadness							

Soiling							
Stealing							
Talking back - adult							
Teasing							
Temper tantrum							
Whining							
Yelling							
Police contact							
School contact							

Instructions for completing:

Please enter a tick in a box if the behaviour has occurred at least once in the last 24 hours.

(QUARQ) HOW MY FOSTER CHILD AND I GET ON TOGETHER

This is about your relationship with your foster child. For each of the items below, please indicate how frequently they happen by ticking one of the boxes on the right.

ATT		Never	Hardly ever	Sometimes	Often	Very often
1	My foster child comes to me if he/she is not feeling well…	☐	☐	☐	☐	☐
2	My foster child likes to spend time with me…	☐	☐	☐	☐	☐
3	My foster child will talk to me about things that are on their mind…	☐	☐	☐	☐	☐
4	My foster child lets me look after him/her (e.g. brushing hair or choosing clothes)…	☐	☐	☐	☐	☐
5	My foster child tells me that they appreciate what I do for them…	☐	☐	☐	☐	☐
6	My foster child shows me affection…	☐	☐	☐	☐	☐
7	I am able to comfort my foster child when he/she is upset…	☐	☐	☐	☐	☐
8	I understand and accept my foster child's feelings…	☐	☐	☐	☐	☐
9	My foster child tells me if something bad happens to them at school or elsewhere (e.g. being bullied or punished)…	☐	☐	☐	☐	☐
10	My foster child enjoys being close to me…	☐	☐	☐	☐	☐
11	My foster child tells me about things that have made them happy…	☐	☐	☐	☐	☐

12	My foster child trusts me…	☐	☐	☐	☐	☐
13	My foster child likes it when I say something nice about them…	☐	☐	☐	☐	☐
14	My foster child lets me give him/her a hug…	☐	☐	☐	☐	☐
15	I am able to show affection to my foster child…	☐	☐	☐	☐	☐
16	I am able to help my foster child to manage their difficult feelings…	☐	☐	☐	☐	☐
Pre	*Office use only, code:*	*[0]*	*[1]*	*[2]*	*[3]*	*[4]*