Exploring Clinicians' Perspectives on Outcomes of Psychological Interventions for Looked After Children

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Declaration of Originality

I hereby declare that this thesis is an original piece of work, created solely by the author.

The contents of this thesis have not been submitted for any award other than the Doctorate in Clinical Psychology.

Miranda Roberts, May 2010.

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Abstract

Background and Aims: Looked After Children (LAC) have complex mental health needs, as a result of the trauma and inadequate care which they have typically experienced during their early years, and the instability that continues to permeate their lives in many cases. Outcomes of psychological interventions with this group may be particularly difficult to assess, yet little consideration has been given to this issue in the research literature to date. The current study aims to explore the perspectives of clinicians working in specialist Child and Adolescent Mental Health Services (CAMHS) for LAC, on the nature, process and outcomes of the psychological interventions they undertake with clients, and the implications of their observations for measuring outcomes.

Method: Fourteen individual interviews with clinicians were undertaken, each exploring clinicians' experiences and observations of a particular case with which they had undertaken an intervention. Preliminary themes from these interviews, regarding the nature, process and outcomes of clinicians' interventions, were fed back to clinicians during two focus groups; clinicians were asked to reflect on the implications of these themes for measuring outcomes of psychological interventions with LAC.

Results and Conclusions: Thematic analysis of interview and focus group data was conducted. The data was organised into five super ordinate themes, relating to the impact of the external context of the child's life, the nature of presenting problems, the nature of interventions undertaken by clinicians, changes and outcomes observed by the clinician and implications for measuring outcomes. Relationship factors, particularly those in the relationship between the carer and child, were identified as the focus of CAMHS interventions and the changes that clinicians most commonly observed. Measuring these changes in the carer-child relationship, which existing outcome measures do not capture, is crucial. The need to contextualise treatment outcomes within the child's overall life was also highlighted.

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PART ONE:

Literature Review

Effectiveness of Attachment-Based Interventions for Foster/Adoptive Parents: A Systematic Review

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Literature Review

ABSTRACT

Background: Previous reviews of foster carer training have focused exclusively on behavioural/cognitive behavioural interventions. There are no previous reviews of carer interventions based on an attachment theory perspective.

Purpose: To review and critically evaluate the available empirical evidence for the effectiveness of attachment-based interventions for foster and/or adoptive carers.

Method: A systematic search of electronic academic databases was conducted. Titles, abstracts and where necessary, full text articles were screened for their relevance to the review question. Studies which did not report a quantitative evaluation of an attachment-informed intervention with foster and/or adoptive carers, using validated outcome measures, were excluded.

Results: 11 studies were selected for inclusion in the review. The interventions evaluated in these studies fell into two main categories: attachment interventions for carers of infants and group training programmes. A range of methodologies were employed, including randomised controlled trials, cohort studies and uncontrolled small-scale evaluations. Evidence for interventions for carers of infants indicated some beneficial effects on carer attachment behaviour and some child outcomes. Evidence for group training was weaker in comparison, indicating tentative evidence of improvements in carersø parenting, but little impact on child outcomes.

Conclusions: Current evidence suggests that attachment-based interventions with foster/adoptive carers show some potential to improve parenting, and to a lesser extent, child outcomes. Future research should aim to control for some of the confounding variables between studies.

Keywords: Foster carers, adoptive parents, training, attachment

Target Journal: Attachment and Human Development

1. Introduction

1.1 Attachment and Looked After Children

Attachment theory (e.g., Bowlby, 1969) proposes that all children seek to form emotional links with a parent or caregiver who is able to meet their physical and emotional needs. Children who form these secure attachments with at least one caregiver are thought to develop a positive view of themselves and positive expectations for their relationships with others . Bowlby (1969) proposes that these attachment relationships play a crucial role in the childøs social and emotional development.

Children placed under local authority care in the UK (most commonly temporary foster care, which may eventually lead to a permanent adoptive placement) have been shown to have high levels of general mental health morbidity. One national survey identified 45% as suffering from some form of mental health problem (Meltzer et al., 2003), compared with 10% of children in private households (Meltzer, Gatwood, Goodman & Ford, 2003). By definition, these children have been removed from birth families which were unable to provide adequate care, and have typically suffered abuse and/or neglect (Blower et al., 2004). Their early experiences have generally been characterised by a lack of stable and secure relationships with adults who are sensitive and responsive to their needs (e.g., Kenrick, 2000; Golding 2003).

When safe and responsive relationships with caregivers are not available to the child, providing them with opportunity to form a secure attachment to their caregiver, the child may develop a way of relating to others which is characterised by negative views of themselves and/or others, which may result in a fearful, dismissive or dependent style of interacting (Bowlby, 1969). The frequent changes of caregiver commonly experienced by children once they enter the care system may also contribute to attachment difficulties (Rosenfeld et al.,

1997). Indeed, there is evidence indicating higher levels of attachment and relationship

problems in LAC, compared with controls (Millward et al., 2001).

1.2 The role of foster and adoptive carers

Children in the care system clearly have complex needs and require care which is responsive
to these needs. Due to their previous experiences, children are often distrustful of new carers
and are commonly rejecting of them (Golding, 2003), with many children displaying a range
of difficult behaviours, including violence, fire-setting and inappropriate sexual behaviours
(Pilowski, 1995). The role of foster and adoptive carers is therefore a very challenging one,
which requires the capacity to understand and respond to the child's needs in the face of these
difficulties, as well as managing their own emotional reactions in such circumstances.
Schofield and Beek (2005) suggest that the key task of carers is to provide care which
incorporates the qualities associated with providing a secure base during infancy: promoting
trust in availability, promoting reflective self functioning, promoting self-esteem and
promoting autonomy.

Foster and adoptive carers clearly have an important role to play in supporting the
young people in their care and addressing their complex relational needs. In recognition of
this, numerous training programmes have been developed to equip foster carers in particular
with the skills necessary for the role (Dorsey et al., 2008). Furthermore, Hart and Thomas
(2000) suggest that treatment for children with attachment difficulties is more effective when
it is delivered indirectly through work with parents than through direct therapy with the child.

1.3 Previous reviews

Two previous reviews of interventions with foster or adoptive parents were identified during
an initial search of the literature. Dorsey et al. (2008) conducted a broad review
incorporating any foster parent training programme for which a published study of carer or
child outcomes existed in the research literature. The 30 studies reviewed covered various
different interventions, including behavioural approaches, attachment-informed interventions,
and those focused mainly on procedural aspects of fostering. The authors conclude that
although many interventions appear to have some immediate benefit, the quality of most
studies is compromised by inadequate sample size, experimental design and outcome
measurement. Although little comparison is made between the content and theoretical

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underpinnings of different interventions, the trend towards behavioural and cognitive behavioural interventions in recent years is noted (Dorsey et al., 2008).

The recent Cochrane review of training in the management of difficult behaviour for foster carers (Turner, Macdonald & Dennis, 2009) focused exclusively on behavioural and cognitive behavioural (CBT) interventions. Based on the six studies selected for inclusion, most of which were hampered by small sample size, Turner, Macdonald and Dennis (2009) concluded that there is little evidence to support the effectiveness of behavioural and cognitive-behavioural interventions with foster carers in improving outcomes for either children or carers.

Evidence of the effectiveness of CBT approaches to addressing behavioural problems in the general child population (e.g., Scott, 2001) is drawn on by Turner, MacDonald and Dennis (2009) to justify the selection of this approach as the basis for their review. However, an exclusive and narrow focus on such approaches within the Looked After Child population, which doesn't address the unique experiences and difficulties of these children, is unlikely to meet their mental health needs which are so often inseparable from their early experiences. Perry, Pollard, Blakley, Baker and Vigilante (1995) highlight the tendency of adult society to minimize the effects of traumatic early experiences on children, presuming that their young age affords a high level of resilience. Perry et al. (1995) emphasize the vulnerability of the childhood brain to the effects of trauma and delineate the neurodevelopmental processes which may lead to development of sensitised hyperarousal or dissociative patterns. These sensitised responses to threat may be expressed as internalising or externalising behaviour problems; failure to recognise them as such is likely to perpetuate this exaggerated reactivity.

The treatment classification system developed by Saunders, Berliner and Hanson (2004) to evaluate the utility of interventions for children who have suffered abuse highlights the importance of the theoretical and clinical support for an intervention, as well as its empirical support. Attachment theory has been identified in the theoretical and clinical literature as crucial for understanding the needs and difficulties of children who have suffered relational trauma, and informing their treatment (e.g., Becker-Weidman, 2006; Howe & Fearnley, 2003; Hughes 2004). Despite this, neither of the identified reviews of foster carer training give precedence to interventions which are informed by attachment models.

1.4 Attachment-based Interventions: Qualitative Evidence

Qualitative evaluations of attachment-based interventions for foster carers provide evidence of the importance of carersø understanding of the impact of childrenøs histories in enabling them to cope with the emotional impact of fostering and respond in an appropriate way to difficult behaviour. Allen and Vostanis (2005) used pre and post-training focus groups with foster carers to explore their experiences and needs prior to an attachment-based group training programme, and the subsequent impact of this training on their role as foster carers. Themes identified in pre-training focus groups suggested that carers struggled to understand why childrenøs difficulties persisted despite their best attempts to apply parenting skills and management strategies, as well as the emotional impact of this, with carers often feeling a sense of despair and doubt in their own parenting abilities. Following training, carers indicated that the training had provided them with a conceptual framework for understanding childrenøs difficulties and this understanding was helpful in managing the emotional impact of fostering. Similarly, Laybourne, Andersen and Sands (2008) identified themes of carers having developed an understanding of the impact of childrenøs early experiences and attachment histories, which enabled them to respond differently to the child. Again, carers also indicated that the understanding the training provided enabled them to view childrenøs behaviour in a way that lessened its emotional impact, for example recognising that behaviour is not personal against them.

1.5 Aims of the Current Review

To date, no previous review has focused exclusively on attachment-based training interventions for carers of children in the looked after system, despite the importance of such approaches in therapeutic work with children with traumatic histories, as identified in the theoretical and clinical literature. It is essential that this gap in the evidence base is addressed to ensure that research into attachment interventions can be drawn on to inform clinical practice. As previous reviews of interventions for foster/adoptive carers (e.g., Turner, MacDonald & Dennis, 2009) have focused on empirical studies of clinical effectiveness, as measured by quantitative outcome measures, it was decided that a review of attachment interventions should also retain this focus, in order to facilitate comparison with other carer interventions. The current review therefore sought to answer the question õdo attachment-based interventions for foster/adoptive carers improve outcomes for looked after children?ö, through critical evaluation of the empirical evidence.

2. Method

A systematic review of research literature evaluating attachment-based training for foster/adoptive parents was conducted. In anticipation of the dearth of effectiveness studies in this area, a relatively broad review question was formulated, incorporating any interventions which to some extent addressed attachment issues and/or the relational impact of trauma and abuse. Studies based on both foster carers and adoptive parents were included, in acknowledgement of the often similar issues faced by both groups of carers.

2.1 Search Strategy

The following list of search terms were generated to address the current review question and inputted into five electronic academic databases: Medline, Embase, EBSCO PsyInfo and PsyArticles, Scopus and Web of Science:

A) Search terms combined by OR syntax:

õfoster parentö, õfoster carerö, õfoster motherö, õfoster fatherö, õadopt* parentö, õadopt* motherö, õadopt* fatherö, õadopt* carerö

B) Search terms combined by OR syntax:

õtrain*ö, õinterventionö, õtreat*ö, õconsult*ö, õtherap*ö

C) Step A + B combined by AND syntax

The initial search strategy was designed to identify all studies investigating foster and adoptive carer interventions. It was not intended to exclude studies on the basis of the nature of the intervention at this stage, as it was anticipated that closer inspection of potentially relevant studies would be necessary in order to establish whether the content of interventions met the review inclusion criteria.

2.2 Inclusion and exclusion criteria

The main inclusion criteria for studies were as follows:

* Intervention includes consideration of attachment issues and/or impact of childøs history of trauma and its relational impact.
* Quantitative evaluation of child and/or parenting outcomes
* Use of validated outcome measures

The main exclusion criteria were:

- Intervention does not incorporate attachment and/or trauma-related issues
- Intervention is focused on biological, rather than relational, effects of trauma
- Qualitative evaluations
- Lack of validated outcome measures

The inclusion and exclusion criteria of the review were deliberately broad in recognition of the limited number of studies in this area. In particular, interventions were not restricted to those explicitly grounded in attachment theory; any study based on an intervention which incorporated consideration of the impact of trauma and past relationships with caregivers on the child's current difficulties and ways of relating was eligible for inclusion. This decision to include such a range of interventions sought to acknowledge that some interventions are directly aimed at improving carers abilities to meet children's attachment needs (e.g., through developing their understanding of the impact of the child's history on their current relational needs), but do not label this as a formal attachment intervention. In addition, the review incorporated both child and carer-focused outcomes in order to provide scope for evaluation of the direct impact of training on parenting, as well as the indirect impact, through changes in parenting, on the child themselves. Studies were not excluded on the basis of poor experimental design, other than due to failing to use validated, quantitative outcome measures, as it was recognised that even methodologically compromised studies could potentially contribute to the limited evidence base in this area, provided that their limitations are acknowledged.

2.3 Screening

A total of 1140 titles and abstracts, including duplications, were scanned for relevance to the review question. Articles not available in English were excluded. Only empirical studies published in peer-reviewed journals, evaluating interventions for foster and/or adoptive parents that incorporated an attachment-based component were selected. Literature reviews, single case studies, theoretical and discursive papers were discarded during initial screening.

On the basis of titles and abstracts, 24 studies were identified as potentially relevant to the current review and full-text articles were obtained for further evaluation. Reference lists of previous reviews (Turner, Macdonald & Dennis, 2009; Dorsey et al., 2008; Craven & Lee, 2006) were also searched for potentially relevant studies and full-text articles for a further 10 studies were obtained as a result. The 34 identified articles were further screened for relevance to the review question, with particular attention to the description of the intervention under evaluation; only interventions including consideration of attachment and the impact of trauma on the child's relationship with their carer were included.

Interventions in which therapy was provided directly to the child, alongside intervention with carers, were excluded from the current review in order to maintain internal validity, although interventions in which the child was present during, and included in, the parents' training were retained. The aim of the current review was to review the effectiveness of attachment interventions for foster/adoptive carers specifically, in order to provide an alternative to the recent Cochrane review (Turner, Macdonald & Dennis, 2009) of interventions for foster carers, which focused on cognitive behavioural approaches and neglected the importance of attachment-based interventions, despite their frequent use and theoretical justification in therapeutic work with this population. It was judged to be important to retain this focus on carers, rather than incorporate broader interventions aimed directly at the child, in order to ensure comparability with the Turner, Macdonald & Dennis (2009) review, and avoid confounding the effects of work with carers with those arising from direct intervention with the child. Only two studies were actually excluded from the review on the basis of this criterion: Becker-Weidman (2006), which examined the effectiveness of Dyadic Developmental Psychotherapy (a child-focused attachment informed treatment, which includes work with both the child and carers), and Wimmer, Vonk and Bordnick's (2009) evaluation of attachment therapy, again directed at the child and incorporating work with both child and carers.

3. Results

1140 studies were identified through initial database searches. Of these, 24 were deemed potentially relevant to the current review, with a further 10 studies identified through searching reference lists of relevant reviews. Following in-depth assessment, 11 of these 34 studies were selected as appropriate for inclusion in the current review, based on their methodological characteristics and relevance to the review question. The remaining 23 studies were excluded largely due to lack of relevance to the current review, primarily the use of interventions without an attachment or relational trauma-based focus or component (16 studies). 5 studies were also excluded due to inadequate methodology, namely a lack of validated outcome measures. Full details of excluded studies are provided in Appendix B.

Due to the small number of studies evaluating attachment-based training for foster/adoptive carers, a range of methodologies were accepted for inclusion, including Randomized Controlled Trials (RCTs), cohort studies and uncontrolled practice-based evaluations. Methodological characteristics and outcomes of each study are summarised in Appendix 1.

Overall, 583 foster/adoptive carers were included in the 11 reviewed investigations of the impact of attachment/trauma based training for foster/adoptive carers on parenting, the parent-child relationship and child outcomes. The selected studies covered a range of interventions, all including an attachment or trauma-based component. These interventions fall into two broad groups: attachment interventions for adoptive parents/foster carers of infants and group-based interventions, including attachment/trauma related material, for foster carers.

3.1 Attachment Interventions for Parents of Infants

Attachment and Biobehavioural Catchup (Dozier, Dozier & Manni, 2002)

Three studies (1, 2, 3, see Appendix A) evaluated this intervention and reported positive effects on a range of measures. Attachment and Biobehavioural Catchup is a 10 session, manualised intervention (Dozier, Dozier & Manni, 2002) delivered individually to carer-child dyads with the aim of promoting optimal sensitive parenting behaviour in caregivers, teaching them to persist in providing the child with love and nurture even at times when the child rejects this, whilst managing their own emotional reactions. The intervention was designed to interrupt the reciprocal cycle often observed between children with trauma

histories and their caregivers, in which the child displays avoidant-resistant behaviour towards their carer, who then responds by withdrawing from the child (Stovall & Dozier, 2004).

In a double-blind randomised controlled trial, Dozier et al. (2006) investigated the impact of training 60 foster parents in Attachment and Biobehavioural Catchup on child cortisol levels and parent-reported behaviour problems. In comparison to a control group receiving an educational intervention, children in the treatment group showed significantly lower diurnal salivary cortisol production, as measured 1 month post intervention, suggesting that the training may have been effective in reducing infant stress levels. Behaviour problems as reported on the Parent Daily Report (PDR) 1 month post-intervention were also lower in the intervention group compared to the control group for children aged 18-36 months, but not for infants under 18 months. However, as no reference was made to measurement of these variables in the pre-intervention phase, it is impossible to exclude the possibility that these differences between the groups existed prior to the intervention, rather than being effected by the intervention itself. Dozier et al.øs (2009) evaluation of this interventionøs impact on childrenøs attachment behaviours is compromised by the same methodological flaw: only post-intervention completion of parent attachment diaries is reported. This study of 46 carer-child dyads reports significantly lower levels of avoidant behaviour towards caregivers post-intervention compared to controls, but it is not possible to attribute this to the effects of the intervention as pre-intervention attachment behaviours were not controlled for. No significant differences in secure behaviours were observed following training.

Sprang (2009) conducted a quasi-randomised controlled trial of the Attachment and Biobehavioural Catchup intervention in a naturalistic clinic setting, with 53 foster parents of children (aged younger than 6 years) with maltreatment histories and diagnosis of an attachment-related disorder. Families were recruited into the study following their presentation at the clinic and subsequent referral for a õrelational interventionö before randomisation to treatment or waiting list control group, the latter consisting of a bi-weekly support group. This study overcame the limitation of the previous studies by measuring outcomes at pre and post intervention; carers completed the Child Abuse Potential Inventory (CAPI), Parenting Stress Inventory (PSI) and Child Behaviour Checklist (CBCL). A conservative intention-to-treat analysis demonstrated improved scores on all measures immediately post intervention in the treatment group, relative to controls. The authors draw

links between items on the CAPI and facets of caregiver behaviour involved in development of a secure attachment, suggesting that changes on this measure may be associated with changes in the attachment relationship between the carer and child.

Taken together, the results of these three studies provide promising evidence of the effectiveness of the Attachment and Biobehavioural Catchup intervention for promoting secure attachment relationships between infants and their caregivers, reducing parenting stress and improving child behaviour. However the quality of this evidence is compromised by the cross-sectional nature of two of the studies (Dozier et al., 2006; Dozier et al., 2009).

Book/video-based Attachment Training

Stams et al. (2001) and Juffer et al. (1997) describe a longitudinal study evaluating the impact of a book and video-based attachment training with adoptive families on maternal responsiveness, infant attachment behaviour and child development. However, these studies are based on a particular subset of adopted families, with children adopted internationally (from Sri Lanka or Korea) and before the age of 5 months. This may limit the generalisability of the findings of these studies, as the participants are not representative of the majority of adoptive/foster families, particularly since the children were adopted at a very young age and are therefore likely to have experienced less trauma than most children who are removed from their birth families at a later stage. The intervention used in these studies aimed to support parentsø responsiveness to their child (aged 5-12 months at the time of intervention) in order to facilitate the development of secure infant-parent relationships. Parents were provided either with only written information on sensitive parenting, or written information plus three sessions of video feedback, in which mothers were shown a video of themselves interacting with their child and provided with feedback on their responses to attachment needs and encouragement of exploration behaviour.

Juffer et al. (1997) found that mothers who had received the combined book and video feedback intervention showed significant improvements in responsiveness to their child following the intervention, relative to a no treatment control group, and their children showed significant improvements in exploratory competence as assessed on a contingency analysis task, but not higher levels of exploratory behaviour. The study also found a significant association between receiving the book and video feedback intervention and security of infant attachment aged 12 months (post-intervention). However, as infant attachment style was not

assessed pre-intervention, this was determined by cross-sectional analysis and the possibility that the intervention group consisted of more securely attached infants cannot be excluded.

Stams et al. (2001) conducted a longitudinal study using participants of the Juffer et al. (1997) study, along with an additional sample of children from mixed adoptive/biological families who received the same intervention at a similar time. Children were followed up at age 7 to determine the effects of the intervention on their social development, personality development and behaviour. In all-adoptive families (i.e. foster parents with no birth children), no significant effects of intervention were observed in any of the outcome areas, despite the positive effects observed in early childhood by Juffer et al. (1997). In a smaller sample of mixed adoptive families, internalizing behaviour problems were significantly lower in children whose parents had received the combined book and video feedback intervention, whilst girls, but not boys, in this group also showed higher levels of ego-resiliency and optimal ego-control. Ego-resiliency and ego-control together make up the personality development construct, and are described as the ability to respond flexibly to changing situational demands, and the tendency to contain emotional and motivational impulses respectively. Taken together, the outcomes of Juffer et al. (1997) and Stams et al. (2001) provide tentative evidence for the effectiveness of this intervention in improving maternal attachment behaviours in the short-term. Evidence of longer-term effects is ambiguous, which is interesting to note given that this is the only study in the review with a follow-up period of longer than 1 year.

Overall, there is reasonable evidence to suggest that interventions focused on supporting caregivers to adapt their behaviour towards infants in order to facilitate secure attachments can have a beneficial effect on the attachment relationship between infants and their caregivers, at least in the short-term.

3.2 Group training programmes

Six of the selected studies (4, 5, 6, 7, 10, 11, see Appendix A) comprised evaluations of group training programmes for foster carers; two randomised controlled trials, one cohort study, and three small scale uncontrolled evaluations. MacDonald and Turner (2005) evaluated a cognitive-behavioural programme aimed at supporting foster carers to manage challenging behaviour, with an emphasis on understanding behaviour in the context of children's attachment history and early experiences, as well as the impact of this on their relationship with child. A randomised controlled trial was undertaken with 117 foster parents

randomised to training or waiting-list control groups. Carers' understanding of the behavioural principles taught in the programme was measured pre and immediately post-training using the Knowledge of Behavioural Principles as Applied to Children (KBPACL O'Dell et al., 1979). Carers' rating of children's behavioural problems was rated pre intervention and 6 month post-intervention with the CBCL. Significantly higher levels of knowledge of children's behavioural problems were demonstrated post-intervention, relative to controls, but there was no significant difference in child behaviour problems 6 months after the training ended. Although this indicates that carers had higher levels of knowledge of behavioural principles following training, it is unclear the extent to which this changed their understanding of and responsiveness to children's needs.

Minnis, Pelosi, Knapp & Dunn (2001) also report results from a randomised controlled trial, evaluating a training programme based on the Save the Children manual, 'Communicating with children: helping children in distress' (Richman, 1993), aiming to facilitate carers' communication with their child and understanding of the behaviour, especially in relation to the child's early experiences and emotional needs (Minnis, Devine & Pelosi, 1999). The programme is rooted in attachment theory, in particular the premise that being able to speak fluently and coherently about early experiences is a necessary part of developing secure attachments in adult relationships (Main, Kaplan & Cassidy, 1985). This trial of 121 foster carers showed no significant impact of the training at 9 month follow-up, relative to controls, on measures of general child psychopathology (SDQ), reactive attachment disorder (RAD scale), or child self-esteem (Modified Rosenberg Self-esteem Scale, MRS). Consistent with the results of Macdonald and Turner (2005), this study failed to find any evidence that the training programme had a beneficial impact on child outcomes.

Golding and Picken (2004) and Laybourne, Andersen and Sands (2008) both report a small (7 participants each) in-service evaluation of Golding's (2001) group training programme, 'Fostering attachments'. Based on attachment models such as Crittenden's dynamic maturational model (Crittenden et al., 2001) and Hughes' (1997) parenting model, this training teaches foster carers to apply the principles of attachment theory to understanding their child's behaviour and relational style in the context of their early experiences. Neither study used a control group. Golding and Picken (2004) found significant reductions in children's total SDQ scores, and peer problems and hyperactivity subscale scores following training. This result was not replicated by Laybourne, Andersen and Sands (2008) however, who found no significant change in SDQ scores following

training. Relationship problems, as measured by the Relationship Problems Questionnaire (RPQ) also showed no change, but parenting stress (measured by the Parenting Stress Inventory-Short Form) was significantly lower post training. Of course, the lack of control group and extremely small sample size of these studies severely limit the extent to which these results can be attributed to the effects of the training programme.

Two studies evaluated group-based training for foster parents of children with a history of sexual abuse (studies 10, 11). These studies reported similar content in the training programmes they used, with a focus on understanding the child's history of abuse and the impact of this, particularly in terms of its relevance for understanding behavioural issues. In both studies, parents were also equipped with techniques for managing difficult behaviour and improving communication with their child. Barth, Yeaton & Winterfelt (1994) observed no significant effect of their training intervention on children's general or sexual behaviour. Treacy & Fisher (1994) reported significant increases in parental sense of competence with all the children in their care (i.e. not specific to foster children or those with histories of sexual abuse), but no improvement in parent-child relationship problems, as measured by the Index of Parental Attitudes (IPA). However, the lack of control group undermines the conclusions which can be drawn from this study.

Although the outcomes of studies which evaluated group-based training programmes are conflicting, extremely small sample sizes and inadequate experimental designs undermine the evidence provided by some studies. The methodologically rigorous RCTs undertaken by Macdonald, Turner and Dennis (2005) and Minnis et al. (2001) should be given greatest weight in drawing conclusions. Taking this into account, there is little evidence to suggest that the group-based training programmes reviewed have a positive impact on child-focused outcomes (e.g., behaviour problems). However, there is some tentative evidence to suggest beneficial effects on foster parents' knowledge and ability to care for their children.

3.3 Methodological Issues

In synthesising the evidence provided by the reviewed studies, a number of methodological issues are pertinent.

Nature of Interventions

As previously identified, there is considerable heterogeneity in the nature of interventions evaluated in the studies included in the review, in terms of both content and format of delivery. Although all programmes were informed by attachment and trauma models, the extent and overall theoretical orientation of interventions varied between studies; the training programme in study 5, for example, was based on social learning theory, but within the context of the relational trauma which foster children are likely to have experienced. Interventions also differed in the format of instruction provided, ranging from group-based, primarily educational interventions, to more direct therapeutic work facilitating the caregiverøs interaction with the child, as well as in the duration of the training provided. Clearly, this variation introduces multiple confounding variables when comparing results between studies.

Experimental Design

The main experimental design features of each study are summarised in Appendix A. There was clearly considerable variation in methodological rigour with studies ranging from well-designed randomised controlled trials to extremely small uncontrolled routine evaluations. Eight out of the eleven studies included a control group. The nature of this control group also varied between studies, introducing an additional source of potential bias, with some studies using no treatment controls and others introducing an alternative intervention such as a support or education group. The use of an alternative intervention controls for the possibility that the treatment effects are from õnon-activeö aspects of the intervention, such as being in a supportive atmosphere, as well as possibly controlling for placebo effects if participants are blind to treatment condition (as in study 1/2). Ideally, in order to avoid experimenter-expectancy effects and participant demand characteristics, neither researchers nor participants should be aware of the treatment condition to which participants have been allocated. Clearly, in an interactive intervention such as training, participant blinding is impossible if waiting list/no treatment control groups are used. Even where an alternative intervention is provided to controls, concealment may not be effective. Nevertheless, study 1 and 2 report

double-blinding with use of an educational control group; study 4 reported researcher blinding only; blinding was not reported in any other study.

With the exception of one study (8), which examined 7 year outcomes, follow up of study outcomes was limited to the year immediately following intervention; studies varied as to how soon following the intervention follow-up was conducted, ranging from immediately to 9 months. This is another source of potential bias, as any intervention effects are likely to be influenced by the time elapsed since completion of training. This lack of longer-term follow-up amongst studies of attachment-related training interventions is a significant gap in the literature. Stams et al. (2001) found mixed outcomes at 7 year follow-up, with children from mixed adoptive/biological showing benefits, but not those from all-adoptive families. Longer follow-up periods may well show a very different picture to short-term follow ups; the time elapsed may provide opportunity for changes in carers' parenting to impact on child outcomes, but equally longer-term follow-up of parenting could show that any initial gains from training are not sustained in the long-term.

Outcome Measures

A variety of outcome measures were employed by the reviewed studies and this is a potential source of bias when comparing results of different studies. With one exception (study 10), all studies included child-focused outcomes. Six of the eleven studies reviewed (1, 2, 4, 6, 8, 11, see Appendix A) assessed child outcomes only, with no carer-focused measures. Behaviour was the most commonly used child-focused outcome; other outcomes included general psychopathology and child attachment behaviours. The remaining five studies all incorporated at least one carer-focused measure, assessing parenting-related stress, knowledge, skills, attitudes or attachment behaviours. The majority of outcome measures employed were parent-report questionnaire-based measures (e.g., CBCL, SDQ), but some studies made use of alternative methods such as attachment diaries (study 1), child cortisol levels (study 2), and observations of parent and child attachment behaviours (study 9).

Carer-report measures of child outcomes, such as the CBCL and SDQ, are potentially problematic as such measures are heavily influenced by carers' subjective perceptions of children's presentation, which are likely to be affected by a range of factors, including the training itself. In most studies, there was a discrepancy between the aims or content of the intervention and the outcomes measured. Although the aim of all training programmes was to improve carers' understanding of children's needs and parenting skills, only five studies

included measures to assess this. Without this information, it is impossible to interpret whether a lack of change in child outcomes is due to inadequate changes in parenting or the limited impact of parenting changes on child outcomes.

4 Discussion

4.1 Summary of results

Overall, evidence for effectiveness of attachment-based interventions with foster and adoptive carers was mixed. Two broad categories of intervention were identified as a result of the literature search: interventions aimed at adapting caregiversøattachment behaviour towards infants in order to facilitate secure attachments, and group training programmes incorporating information on attachment and trauma-related issues. Evaluations of attachment-based interventions with carers of infants indicated some evidence of beneficial effects on the attachment relationship between the infant and caregiver. All five studies, which were of reasonable methodological rigour, reported beneficial effects on some outcomes, particularly carer attachment behaviour and some child outcomes, including infant cortisol levels and some aspects of infant attachment behaviour. Evidence pertaining to group-based training programmes was weaker in comparison, with results from those studies of acceptable methodological quality indicating little evidence of positive effects on child outcomes, but some tentative evidence of improvements in carersøknowledge and parenting ability.

4.2 Evaluating the Evidence

In light of the methodological characteristics of the reviewed studies, these results are open to a number of different interpretations. One possible interpretation of the relatively stronger evidence relating to attachment-based interventions with infants is that attachment relationships are more amenable to change, from the perspective of both the child and the carer, during early childhood and the initial stages of the relationship between the child and caregiver, than at a later stage in childhood. Moreover, due to their younger age, the children on which these studies are based may have experienced less trauma and disrupted care than the older children included in the group-based studies, who spent a longer period in the care of abusive/neglectful birth families and/or experienced higher levels of disruption during their time in the care system. This is an important confounding factor, given that the impact

of trauma and disrupted care on the development of attachment relationships is well-documented (e.g., Bowlby, 1969; Crittenden, 1985).

The other main difference between studies evaluating attachment interventions in early childhood and group-based training programmes is the format of training delivery. Early attachment interventions were all delivered through individual therapeutic work with carers and involved the child in the intervention, whereas group-based interventions involved carers only and in a setting that is somewhat removed from their relationship with the child. It may be that delivery of training to individual child-carer dyads, as opposed to a group setting without involvement of the child, facilitated carers' application of the training to their relationship with the child.

A further issue that must be considered when interpreting the results of the review is the considerable diversity in the outcomes assessed by the reviewed studies. The majority of studies focused on child outcomes, especially those related to behavioural problems, and relatively fewer studies assessed carer outcomes, despite this being the immediate aim of carer interventions. Given that any child outcomes resulting from carer interventions must be mediated by parenting changes, it is important that future research incorporates measures of carers' understanding and responsiveness to children's needs, in order that the mechanism of any effects of carer interventions can be delineated.

Future studies must also ensure that they are of sufficient methodological quality to provide an adequate evaluation of effectiveness. In particular, the need for studies with adequate sample size, control groups, and measurement of outcomes pre and post intervention was highlighted in the studies reviewed. A significant omission in the current literature is the use of longer-term follow-up periods; this may be particularly crucial in accurately assessing child outcomes which may be dependent on sustained changes in parenting. However, such long-term outcomes may be difficult to assess due to the often transient nature of care placements, particularly in foster care where children are unlikely to remain with the same carers.

4.3 Review limitations

There are a number of limitations to the current review. Due to the paucity of research evaluating attachment-based interventions for carers, a relatively broad review question was employed, which incorporated both foster and adoptive carers, as well as a broad definition of attachment-based intervention. Furthermore, a wide range of methodologies were accepted

for inclusion. This heterogeneity in the selected studies introduces multiple confounding factors when comparing studies, making it difficult to draw interpretations about the results of studies, particularly where these are conflicting. Moreover, identifying the relevance of studies according to whether the intervention was attachment/relational trauma focused involved a degree of subjective judgement by the author, particularly where descriptions of interventions were less detailed. In ideal circumstances this process could have been undertaken by more than one researcher to increase reliability.

It is also important to consider the impact of study inclusion and exclusion criteria on the findings of the review. The exclusion of studies in which direct work with the child was undertaken in combination with training of carers is particularly pertinent since interventions combining work with carers and direct therapy with children are common in routine clinical practice, particularly with older children who are more able to engage with and benefit from direct work. Two studies were excluded during the initial literature search on the basis of this criterion, both of which were studies of effectiveness of attachment-based interventions which included direct work with the child alongside work with carers (Becker-Weidman, 2006; Wimmer, Vonk & Bordnick, 2009). These studies both met the other main review criterion of using quantitative, standardised outcome measures. The decision to exclude studies involving the child and carer jointly in interventions therefore resulted in the exclusion of two potentially important studies in the evidence base for attachment interventions with foster /adoptive carers. This exclusion criterion may also account for the coverage of individualised interventions with carers of younger children only, as individualised interventions with carers of older children are more likely to include some direct work with the child. However, the focus of the current review was the effectiveness of interventions with carers and inclusion of interventions including direct work with children was beyond itøs scope. Future reviews should address this gap in the evidence base, perhaps covering attachment-based interventions in general in order to allow for comparison of carer-only, child-only and joint carer and child interventions.

4.4 Conclusions

In conclusion, current evidence suggests that attachment-based interventions with foster/adoptive carers show some potential to improve parenting, and to a lesser extent, child outcomes. These equivocal results, as well as the theoretical and clinical support for the utility of attachment approaches to interventions with carers of children with traumatic

histories and potential attachment difficulties (e.g., Becker-Weidman, 2006; Howe & Fearnley, 2003; Hughes, 2004) suggest that further empirical research is justified.

The reviewed studies showed variable results that were open to multiple interpretations. In particular, studies of individualised attachment interventions with carers of younger children, which include direct facilitation of parent-child interaction, showed more positive outcomes than group interventions for foster carers. However, it is unclear whether this is a function of the format of intervention delivery, the age of the child and/or the nature of the carer-child relationship. Variability between studies in the nature of outcomes measured was also a confounding factor; many studies used exclusively child-focused measures despite the fact that the proximal aim of interventions was to impact on parenting. Future research should aim to control for some of these confounding variables, as well as including both carer and child-focused measures, in order to gain further insight into the impact of attachment interventions with carers.

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* Reviewed studies

PART TWO:

Research Report

1. INTRODUCTION

Rates of mental health problems amongst Looked After Children (LAC) are high compared with the general population (Meltzer et al., 2003; Meltzer, Gatwood, Goodman & Ford, 2003). This is unsurprising considering the histories of abuse, neglect and instability which most children have experienced before and after entering the care system (Kenrick, 2000). This high level of mental health need is recognised in the recently revised Department of Health (2009) guidance on promoting the health and well-being of children in the care system, which highlights the need for flexible and responsive mental health services that are able to address the complex needs of this group.

The importance of recognising the impact of trauma and inadequate care, which most LAC have experienced, on the child's development is highlighted by Perry et al. (1995), including the effects on the developing brain. However, in addition to adverse experiences in their birth families, the influence of the child's current social context must also be recognised. Many children continue to experience considerable instability even after entering the care system (Kenrick, 2000). Axford (2008) argued that, although not universally the case, some looked after children are at high-risk of social exclusion due to the multiple disadvantages they face: disrupted relationships with a range of individuals (e.g., carers, teachers, birth families, peers), as well as with institutions (e.g., schools, social services, health services); and lack of agency or control over their circumstances. Thus, traumatic histories and the social contexts in which looked after children currently live are both important influences on their mental health and well-being.

1.1 Attachment theory and interventions

Attachment models highlight the importance of safe and secure attachment relationships between infants and their caregivers (e.g., Bowlby, 1969). Looked after children have invariably

received inadequate parenting during their early lives, lacking the experience of an available and responsive caregiver with whom the child would be able to form a secure attachment relationship. As a result, levels of attachment difficulties amongst children in care are high, with many children showing insecure or disorganised attachment styles (Millward et al., 2001). It is common for a diagnosis of õreactive attachment disorderö to be applied to looked after children to describe their attachment difficulties (Hanson & Spratt, 2000), which is defined in DSM-IV (APA, 1994) as õdisturbed and developmentally inappropriate social relatedness in most contextsö in children with a history of õpathogenic careö (defined as persistent disregard for the childøs basic physical or emotional needs, or lack of opportunity to develop a selective attachment due to repeated changes of caregiver).

The consequences of compromised attachment relationships during early childhood are anticipated to be far-reaching, potentially impacting on childrenøs neurodevelopment (Perry et al., 1995), ability to develop satisfactory social relationships (Hanson & Spratt, 2000), general mental health (Rosenfeld et al., 1997) and behavioural problems (Pilowski, 1995). In light of the prevalence and potential consequences of attachment-related difficulties in looked after children, there is clearly a need for interventions that focused on addressing these issues. A number of different attachment-based interventions are described in the clinical and research literature, which generally aim to facilitate the development of secure attachment relationships between children and their current caregivers (e.g., Hughes, 2004; Dozier et al, 2009; Minnis & Devine, 2001); educating carers about the impact of

trauma on children's attachment styles and developing their skills in providing sensitive and responsive parenting are general key components of these interventions.

1.2 Making new attachments

Dozier, Higley, Albus and Nutter (2002) identified a number of challenges that children with histories of maltreatment and their new caregivers face in establishing an attachment relationship: children alienate new attachment figures as a result of their previously disrupted attachment relationships; even when the child does express a need for comfort, some caregivers may not be responsive to this; and, despite the inadequate care that they may have provided, separation from previous caregivers can cause behavioural and physiological dysregulation. Establishing a new attachment relationship is therefore a very complex task for maltreated children and their caregivers.

Foster and adoptive carers clearly have a challenging and important role. Wilson (2006) suggested that foster carers have the potential to effect positive change in the children they care for, through the provision of responsive parenting. However, carers are not always equipped to provide children with care that meets their needs and facilitates development of a secure attachment relationship (Tyrell & Dozier, 1999). Supporting foster and adoptive carers to develop the understanding and skills which will enable them to build attachment relationships with the children they care for is therefore an essential task for mental health services for looked after children. Indeed, Hart and Thomas (2000) have suggested that attachment interventions are more effective when they focus on indirect work through carers, rather than direct therapy with children.

1.3 Outcome measures for Looked After Children in CAMHS

There is clearly a potential for greater complexity in the presentation of LAC attending Child and Adolescent Mental Health Services (CAMHS), compared with children residing with their birth families. Despite this, the CAMHS Outcome Research Consortium (CORC), which is responsible for coordinating measurement of outcomes in CAMHS nationally, do not currently make specific recommendations for measuring outcomes in this client group. The recent review of outcome measures for CAMHS (Department of Children, School and Families /Department of Health, 2008) recommended the Strengths and Difficulties Questionnaire (SDQ), which is a general measure of child psychopathology, for use in all CAMHS services, combined with other measures to be identified locally by individual services. The research reviewed in this report (Department of Children, School and Families /Department of Health, 2008) was based on general CAMHS services. Given the unique needs of this client group, it is unlikely that this approach can be transferred to LAC without careful consideration of the potential issues with this. In particular, the attachment and trauma issues which are characteristic of this client group, and the impact of this on the nature of interventions undertaken, would need to be considered in order to identify appropriate outcome measures for LAC CAMHS services.

Informal discussions with clinicians working in specialist CAMHS services for LAC have identified some frustration and dissatisfaction with the expectation that generic measures, such as the SDQ, should be used to evaluate outcomes in LAC. Clinicians have raised concerns that such measures do not adequately capture the nature of difficulties typically experienced by LAC. Indeed, the SDQ does not include any items to assess for attachment difficulties. Moreover, clinicians do not feel that the SDQ is sufficiently sensitive to the changes they observe in children during their contact with CAMHS. Clinicians identify a

clear need for further consideration of how to measure outcomes in a way that adequately captures the changes which they observe in their clients.

1.4 Engaging clinicians in outcome measurement

Clinicians' views of their clients' progress have historically been neglected in outcome research. For example, in a review of 276 studies on psychotherapy outcomes in young people, only 7.6% used clinician reports as a source of outcome data (Weisz, Doss & Hawley, 2005). Other evidence suggests that, similar to the informally expressed views of clinicians in LAC teams, clinicians in many services have concerns about the validity of outcome measures and ambivalence about using them as part of their own practice (Garland et al., 2003; Meehan et al., 2006; Gilbody, House & Sheldon, 2002).

On the basis of these studies, it seems that there has been a failure to engage clinicians in the outcome measurement process. This could be one factor contributing to the significant gap between the worlds of research and routine clinical practice that some authors have raised concerns about (e.g., Haine et al., 2007; Goldfried & Wolfe, 1998). The ultimate aim of outcome measures must be to improve the outcome and quality of care (Gilbody, House & Sheldon, 2009), but there is little evidence to suggest that the use of outcome measures has a positive impact on patient care (Gilbody, House & Sheldon, 2001; 2003). Slade et al., (2006) highlight that the primary mechanism for the use of outcome measures to improve the quality of care patients receive is through the impact on clinician behaviour. It is therefore essential that clinicians value and understand outcome measures; increasing their engagement in the outcome measurement process is a crucial step towards this. Moreover, clinicians can offer a valuable perspective on outcome measurement, based on their experience of observing change in their clients, yet their views and experiences are underrepresented in outcomes research.

1.5 The current study: aims and rationale

Looked after children are a unique client group with specific mental health needs, which are often related to their histories of trauma and inadequate caregiving relationships. Measurement of outcomes of CAMHS interventions with this client group must take account of the specific issues facing looked after children, their caregivers and the clinicians working with them, if this is to be done in a way that is valid and clinically useful. Historically, clinicians have not been effectively engaged in the outcome measurement process, yet they are a valuable source of information about therapeutic outcomes.

In order to address these issues, the current study explored qualitatively the perspective of clinicians working in specialist CAMHS services for Looked After Children on the process of change and the impact of therapeutic interventions on their clients. The ultimate aim of the study was to develop an understanding of how therapeutic interventions impact on this client group that is rooted in the reality of clinical practice and cliniciansø direct experience. The study sought to inform the development of appropriate processes for outcome measurement in this client group, in a way that is consistent and resonates with the experiences of clinicians.

2. METHOD

2.1 Design Overview

A qualitative design was employed, using a combination of semi-structured interviews and focus groups to explore clinic, perceptions of change in their clients and their views on how this could best be measured. Study 1 used semi-structured interviews with individual clinicians to explore their perceptions of change and the impact of CAMHS interventions for particular clients. Important themes arising during these interviews were then fed back to the participating teams in focus group discussions (Study 2), in order to validate the results and analysis of Study 1. The focus groups also aimed to explore teams, views about how these results can be used to inform clinical and research developments in outcome measurement. The focus groups were a formal part of the study, with qualitative data collected, analysed and integrated into the results of the study. This iterative process was intended to maximise the relevance and utility of the study for clinical practice. Focus groups were identified as a particularly useful way to facilitate teams to express their views and generate ideas through the process of interaction with one another (McLafferty, 2004).

2.2 Ethical Approval

An application for Research Ethics Approval was made to Leicestershire, Northamptonshire and Rutland Research Ethics Committee, which was granted a favourable opinion in January 2010 (see Appendices C and D). Research Governance approval was provided by the sponsoring trust and both local research sites.

2.3 Researcher's Epistemological Position

The researcher was not allied to a particular single epistemological stance during the research process, but rather sought to take a pragmatic approach to addressing the research question and the important clinical issues underpinning this (Freeman, 2006). Nevertheless, the researcher was aware that some of the assumptions underpinning the research were consistent with critical realist and contextual constructionist approaches, which suggest that knowledge and perceptions of the world are subjective and influenced by individuals' own beliefs and experiences, as well as being context-dependent (Madill, Jordan & Shirley, 2000). Qualitative research from such perspectives is firmly grounded within the data obtained from the research process, but awareness of the subjectivity of this data, which is influenced by the researcher as well as participants, is retained.

Consistent with this stance, the researcher was mindful of her own experiences and beliefs, which have inevitably had some bearing throughout the research process and indirectly shaped its outcomes. Through training and clinical experience as a clinical psychologist, the researcher has come to view psychological problems as the product of human experiences, with individuals' current and past relational and social contexts as crucial contributors. Diagnostic conceptualisations of distress are therefore viewed with some scepticism, as potentially reductionist explanations that risk minimising the importance of an individual's experiences. In keeping with a contextual constructionist epistemology, it was assumed that the researcher's views inevitably impacted on the research process. Indeed transparency, such as reflection on the researcher's perspective and experiences and their impact on the data, is an essential feature of rigorous qualitative research according to Yardley (2000).

2.4 Selection of Methodology

As the aim of the current research was to explore clinicians' perceptions of change in their clients and their views of the issues associated with measuring this change, qualitative methods were considered most suitable. A number of possible qualitative approaches were considered. The focus of the research question was to explore clinicians' experiences and perspectives on change in their client, and to link this to the outcome measurement process, thus it was not the intention of this research to explore clinicians' individual lived experiences of their work; phenomenological approaches such as Interpretive Phenomenological Analysis (IPA, see Smith et al., 2009) were therefore discounted at an early stage. Grounded Theory (see Glaser & Strauss, 1967) was considered as a potentially useful approach, that would involve inductively building a theoretical account of the process of change for children and families during psychological interventions, from the perspective of clinicians. However, it was decided that such a structured and prescribed approach would be too restrictive to allow for shifting from understanding change within individual children and families to applying this understanding to inform outcome measurement, which was a key aim of the research. Thematic analysis was therefore identified as the most appropriate method of analysis to meet the aim of the research, allowing sufficient flexibility and depth to explore clinicians' views and experiences in a way that could be used to inform thinking about outcome measurement in this client group. Braun and Clarke (2006) defined thematic analysis as "the searching *across* a data set to find repeated patterns of meaning". This is one important demarcation between thematic analysis and phenomenological approaches, with the latter emphasising within-subject analysis as crucial. This feature of thematic analysis was also well suited to the research question, which aimed to identify patterns across

different cases in order to establish an understanding which was transferable to the specialist CAMHS services for looked after children generally.

2.5 Study 1: Clinicians' perspectives on change following therapeutic interventions with looked after children

Sample

The sample consisted of clinicians from two Child and Adolescent Mental Health Services for Looked After Children in the East Midlands area of the UK. These are multidisciplinary services for children aged 0-18 who are under local authority care, including foster care, residential care and pre/post adoptive placements. Clinicians from both services were invited to participate in the study. Inclusion and exclusion criteria were as follows:

Inclusion criteria:

- Clinicians working in the service for a minimum of 6 months

- Clinicians from any health/social care professional background

- Clinicians who undertake psychological therapy or therapeutic work of some form – they must have undertaken psychological/therapeutic intervention with the clients selected for discussion. This may include indirect work with parents/carers, provided the clinician has also had sufficient contact with the child to be able to make detailed comments on the impact of the intervention on the child. As the aim of the study is to explore the outcomes of routine interventions provided by LAC services, participation will not be restricted to clinicians undertaking more formal psychological therapy.

- Clinicians who are able to select cases which they have closed within the last 6 weeks.

Exclusion criteria:

- Clinicians working in the service for less than 6 months

- Clinicians who do not undertake psychological therapy with clients, e.g., their main role is medical prescribing

- Clinicians who are not able to select cases for discussion which they have closed within the last 6 weeks

In total, 14 interviews, each based on a clinician's description of a different client, were undertaken. Twelve clinicians participated in these interviews. In one service, seven clinicians participated in one interview each. In the other service, 3 clinicians undertook one interview, whilst a further 2 clinicians participated in two interviews, each based on a different client. Professional roles and length of employment within the service for the 12 participating clinicians are detailed in Table 1 below. Clinicians also cited a variety of theoretical and therapeutic approaches as informing their work: attachment models were the most commonly mentioned, but a range of other therapeutic approaches were also cited, including systemic, cognitive-behavioural, theraplay, and dyadic developmental psychotherapy.

Taking account of the scope of the interviews and anticipated depth of data, the target sample size was a minimum of 12 interviews (each based on a different client). Although not a formal requirement for thematic analysis, as would be the case for a grounded theory study, Guest, Bruce and Johnson (2006) highlight the importance of data saturation in determining sample size requirements in qualitative research. They contrast data saturation

with the grounded theory requirement for *theoretical saturation,* which refers to the stage at which the theory emerging from the data is a complete and exhaustive account of the phenomenon in question. Data saturation as applied to thematic analysis is defined as the point at which new data no longer leads to the emergence of new themes or changes to the thematic structure. Based on empirical evidence, Guest, Bunce and Johnston (2006) estimated that, for studies with a relatively homogenous population and narrow focus, 12 interviews are likely to be sufficient to achieve data saturation within a thematic analysis. Fourteen interviews were ultimately undertaken, the (pre-focus group) thematic structure was well-established following analysis of the first 6 interviews and interviews 10-14 did not produce any new themes; data saturation was therefore assessed as having been achieved.

Table 1: Interview participant professional characteristics

Professional Characteristics	Number of Participants
Role: Primary Mental Health Worker	2
Nurse Practitioner	2
Family Therapist	2
Clinical Psychologist	2
Social Worker	2
Psychiatrist	2
Total	**12** (14 interviews)
Time in Service: 6 months - 1 year	1
1 - 3 years	3
3 ó 5 years	2
5 ó 10 years	6

Materials

A structured interview schedule was developed (see Appendix F) covering cliniciansø

perspectives on the nature, process and impact of the intervention undertaken with each

client. The schedule was developed with reference to literature on mental health problems in

Looked After Children and through consultation with clinicians working in the area. In

anticipation of the range of cases and interventions that clinicians might choose to discuss,

particularly since staff from a range of disciplines would be invited to participate, interview

questions were deliberately broad to allow clinicians sufficient freedom to provide a coherent

account of their chosen case. The schedule aimed to provide enough structure to ensure all

relevant aspects of a case and intervention were explored, including presenting problems,

details of current family, birth family experiences, aims of intervention, and the impact of the

intervention on the child and the systems around them. However, the sequencing of the

questions was flexible and the researcher retained the discretion to omit or add questions in

response to the account provided by the clinician, guided by the overall aim of exploring the

impact and outcome of the intervention from the clinicianøs perspective. A digital tape

recorder was used to record the interviews.

Procedure

Clinicians were invited to volunteer to participate in the study by the researcher, who verbally

informed clinicians about the research through attendance at team meetings and by email.

Potential candidates contacted the researcher by email, telephone or in person to volunteer

their participation; provided the clinician met the inclusion criteria, a mutually convenient

time to conduct the interview was then arranged. Each interview focused on a particular

client with whom the clinician had undertaken a therapeutic intervention, with each clinician

taking part in a maximum of two interviews. Clinicians were asked to select a case that they

had either closed within the last 6 weeks, or were due to close shortly, and that they felt able to discuss in detail. Prior to each interview, participating clinicians were asked to review the clinical records for the client in question to ensure they were able to recall the details of the case during the interview. Interviews were conducted in quiet, private rooms at the base of the respective service. At the start of each interview, clinicians were provided with a participant information sheet (see Appendix H) explaining the purpose and format of the study, as well as the terms of their participation. Written informed consent was obtained from all participants at this stage (see Appendix I). Participating clinicians were asked to use a pseudonym to refer to the client during the interview, in order to preserve anonymity. They were also asked to avoid using other potential identifiers, such as relatives names, names of schools or residential homes.

Interviews were based on the interview schedule detailed in Appendix F and were tape recorded. Verbatim transcribing of all interviews was undertaken by the researcher.

2.6 Study 2: Team perspectives on evaluating outcomes of therapeutic interventions in looked after children

Sample

Two focus groups were conducted, one within each of the Looked After Childrenøs services that participated in study 1. In line with recommendations from the research literature (e.g., McLafferty, 2004) and in order to ensure sufficient richness of data, a sample size of a minimum of 4 and a maximum of 8 participants per focus group was planned. In actuality, the focus groups comprised 8 and 5 participants respectively. Both focus groups contained a mixture of clinicians who had previously undertaken interviews and those who had not. Each

focus group comprised clinicians of various professional roles and levels of experience, as detailed in Table 2.

Table 2: Focus group participant professional characteristics

Professional Characteristic	Number of Participants
Role: Social Worker	3
Psychiatrist	3
Clinical Psychologist	2
Family Therapist	2
Nurse Practitioner	1
Psychotherapist	1
Primary Mental Health Worker	1
Total	**13**
Time in Service: < 1 year	4
1 ó 3 years	2
3 ó 5 years	1
5 ó 10 years	6

In the same way as for Study 1, clinicians were informed of the research through the researcherøs attendance at team meetings and via email. A focus group was then scheduled with each service through liaison with the team leader or another lead clinician, who subsequently informed clinicians of the details of this, to allow them to choose whether or not they wished to attend. Inclusion and exclusion criteria for focus group participants are detailed below.

Inclusion criteria:

- Working in the service for a minimum of 6 months

- Role within the team involves provision of psychological interventions or therapeutic work of some form to looked after children and their carers/families (see criteria specified in Study 1). As the aim of the study was to explore the outcomes of routine interventions provided by LAC services, participation was not restricted to clinicians undertaking more formal psychological therapy.

Exclusion criteria:

- Working in the service for less than 6 months

- Role does not include undertaking some form of psychological work.

Materials

Focus groups began with presentation of some of the main themes identified from the individual interviews conducted in Study 1, followed by a discussion exploring each teamsø reactions to and interpretation of these, as well as their thoughts about how the data can be used to inform thinking about measuring outcomes in this client group. A semi-structured focus group schedule was developed (see Appendix G), including an outline of important themes to be fed back from Study 1 and questions designed to evoke discussion of these themes and the issues they raised for measuring outcomes in this client group. A digital tape recorder was used to record focus groups.

Procedure

Participants were initially informed about the research, including details of focus groups, through the researcher's attendance at team meetings and by an email sent to all clinicians. Focus groups were arranged with each service through the team manager or a lead clinician, who then informed team members of when the focus group would be taking place so that they could choose whether or not they wished to attend. Participants were provided with information about the research (see Participant Information Sheet, Appendix H) and informed of the terms of their participation. Informed consent was obtained from each member by the researcher prior to the start of the focus group (see Appendix I for consent form). Focus groups were held in private rooms at the base of the respective service. Prior to the start of each focus group, some basic ground rules (e.g., allowing each participant their turn to speak, confidentiality of discussions during focus group etc) were established with the group. Tape-recording started once ground rules were agreed.

Focus groups were facilitated by the researcher. The first part of each focus group included presentation of results of Study 1, detailing key themes that were identified from the individual interviews. A discussion of these results and their relevance to measuring outcomes in this client group then took place, based loosely on the schedule in Appendix G. All focus group recordings were transcribed by the researcher.

2.7 Analysis

Transcription

Transcription is viewed by many researchers as an important part of the analytic process (e.g., Lapadat & Lindsay, 1999) and the researcher viewed the transcribing process as the first step in gaining familiarity with the data. As the focus of the thematic analysis was at the

level of verbal units, interviews were transcribed verbatim, but with little reference to intonation, pauses or other nonverbal units, as this level of detail was not necessary for the purposes of the analysis (Braun & Clarke, 2006). Any patient or staff identifiable information accidentally disclosed by participants during interviews was not recorded in transcripts, but were instead replaced which the pseudonym or other term which the clinician had chosen to refer to the client. Speakers in focus groups were identified by their professional roles where possible, i.e., psychiatrist, psychologist, nurse, as this may provide important context to the speakerøs comments. However, in order to prevent inadvertent identification of individual clinicians, speakers were not identified in this way if they were the only person with that particular role in the service; in these cases, the speaker was referred to as just õclinicianö.

Thematic Analysis

The analysis was conducted in two phases. Interviews from Study 1 were transcribed and analysed prior to focus groups taking place, in order for the findings to be fed back and form the basis for the focus group discussions. This first phase of the analysis was conducted in a number of broad stages, as suggested by Braun and Clarke (2006). Initial analysis involved familiarisation with the data, followed by initial coding to produce a preliminary descriptive summary of the data. This initial coding was undertaken systematically across the data set. Once the whole data set had been analysed at this superficial level, the focus shifted to looking for broader themes across initial codes and subsequently to consideration of relationships between themes. Themes were ultimately organised into a hierarchical thematic framework. This was reviewed and refined to ensure that the emerging framework accurately represented the data in a coherent and meaningful way. Each transcript was electronically coded using a software package, QSR NUD*IST, in order to support the process of collating

and organising data during the analysis. The analysis was data-driven, but firmly guided by the research aim of exploring cliniciansøexperiences and views of change in their clients and their systemic context. An example coding extract is provided in Appendix J.

Focus group data was then analysed in a second analytic phase. Again, analysis was undertaken in a series of broad stages as recommended by Braun and Clarke (2006). This part of the analysis was integrated into the thematic framework generated by Study 1, with additional codes established where necessary to incorporate the greater depth of data on cliniciansøviews of outcome measurement which the focus groups sought to elicit. Again, the analysis was data-driven, but with the overarching aims of gaining feedback on the themes identified in Study 1 and exploring cliniciansø views of the issues associated with outcome measurement in this client group.

Quality Measures

Braun and Clarke (2006) identify 15 quality criteria for ensuring a good thematic analysis. This checklist is reproduced below, along with details of the efforts made to meet each criterion during the analytic process for the current study. In addition, a selection of transcripts were read by the research supervisor, which informed discussions about the analysis during supervision and provided an additional check of validity and reliability.

Transcription

- *The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for 'accuracy':* Each interview/focus group was transcribed verbatim and checked against the recording by the researcher.

Coding

- *Each data item has been given equal attention in the coding process:* The same
  coding procedure was conducted for each transcript, beginning with preliminary
  reading and initial descriptive coding, through to deeper analysis and consideration of
  relationship between themes.

- *Themes have not been generated from a few specific vivid examples, but instead the
  coding process has been thorough, inclusive and comprehensive:* All transcripts were
  analysed and codes generated systematically, aided by an analytic software package,
  QSR NUD*IST.

- *All relevant extracts for each theme have been collated:* QSR NUD*IST used to
  collate data extracts for each theme.

- *Themes have been checked against each other and back to the original data set:*
  Transcripts re-read following development of thematic framework to ensure analysis
  captures overall data. Complete thematic framework reviewed for coherence.

- *Themes are internally coherent, consistent, and distinctive:* Data extracts for each
  theme reviewed to ensure coherence and consistency; themes compared and
  contrasted against each other to ensure distinctiveness.

Analysis

- *Data have been analysed – interpreted, made sense of –rather than just paraphrased
  or described:* Once initial descriptive analysis had been undertaken, initial themes
  were synthesised in order to identify broader themes, and relationships between codes
  and themes were explored.

- *Analysis and data match each other – the extracts illustrate the analytic claims:* Data extracts were collated and checked against the description for each respective theme.

- *Analysis tells a convincing and well-organized story about the data and topic:* Analysis was driven by aim of understanding process and outcomes of interventions from clinicians' perspectives, with the intention of developing a coherent understanding of clinicians' views and observations.

- *A good balance between analytic narrative and illustrative extracts is provided:* Each theme was supported by a range of extracts from the data to reflect both descriptive and analytic aspects of the theme.

Overall

- *Enough time has been allocated to complete all phases of the analysis adequately without rushing a phase or giving it a once-over-lightly:* Each phase of analysis was conducted thoroughly.

Written Report

- *The assumptions about, and specific approach to, thematic analysis are clearly explicated:* Epistemological assumptions and position are explicitly stated. The specific approach employed to thematic analysis in the current study is elaborated.

- *There is a good fit between what you claim to do, and what you show you have done – i.e., described method and reported analysis are consistent:* Report aims to provide an accurate and transparent description of the analytic process.

- *The language and concepts used in the report are consistent with the epistemological position of the analysis:* Use of tentative language, highlighting the subjectivity of the

data. An awareness of the subjective and context-dependent nature of individualsø

perceptions and reports also informed the entire analytic process.

- *The researcher is positioned as active in the research process:* The impact of the

  researcher on the research and analytic process is highlighted in the õEpistemological

  Positionö and õAnalysisö sections of the main research report, as well as in the critical

  appraisal.

3. Results and Analysis

3.1 Organisation and Presentation of Analysis

A detailed account of the super-ordinate and sub-themes identified through the analysis is provided in this section, organized according to the structure provided by the thematic framework outlined in figure 1, with each of the five super-ordinate themes (Context, Presenting Problems, Interventions, Outcomes, Measuring Outcomes) providing numbered sub-headings. Sub-themes are also clearly delineated, underlined and in bold text; any further division within sub-themes is marked with underlined sub-headings in standard text.

The analysis of interview and focus group data is combined, according to the relevance of the data obtained. The first four themes (Context, Presenting Problems, Interventions, Outcomes) are mainly based on interview data only, with any relevant data from focus groups in relation to specific themes incorporated as an adjunct to support, question or elaborate on established themes as appropriate, as focus groups did not provide new data relating to this theme, but rather were an opportunity to gain validation of the themes established from interview data. The fifth theme, õmeasuring outcomesö , is based on relevant data from interviews and focus groups alike, as data relating to this theme was elicited in both of these forums.

Each theme is illustrated using quotes from participants. All quotes are anonymous, with participants identified only by the number of their interview transcript. Where it is possible to identify the professional role of the participant without this being a threat to their anonymity, this is provided in order to contextualise the quote. However, in cases where the participantsø role could enable them to be identified, e.g., if they are the only person with that

role within a team, they are referred to as simply õclinicianö, along with their interview

transcript number for reference.

CONTEXT

- Traumatic histories
- Experiences in care
- Birth family relationships
- School

PRESENTING PROBLEMS

- Behavioural issues
- Emotional distress
- Carer-child relationship issues
- Difficulties in peer relationships

INTERVENTIONS

- Multiple components
- Intervention with carers
- Direct therapy with child
- Consultation with school

OUTCOMES

- Improvement in carer-child relationship
- Behavioural changes in child
- Changes in child's understanding of emotions and experiences

MEASURING OUTCOMES

- Limited relevance of current measures
- Potential benefits of outcome data
- Discrepancy between intervention aims and measured outcomes
- External expectations
- Interpreting outcome data
- Linking context to outcome

Figure 1. Thematic Structure

3.2 Details of Themes and Supporting Evidence

Theme 1: Context

Clinicians consistently reported that the histories of the children seen by the service were characterised by trauma, chaos and instability, both in terms of their early experiences with their birth families and their experiences since entering the care system. Moreover, the children whom clinicians spoke about often continued to live with considerable uncertainty and instability in their lives. Changes in the child's circumstances during the course of an intervention were common and clinicians identified a range of contextual issues that they felt had impacted on the child, and the process and outcome of the intervention.

Traumatic Histories

The early environments within the birth family homes of children seen by the participating services were typically described as chaotic and unstable, with inadequate care provided to the child by the birth family. Experiences of physical, sexual or emotional abuse and neglect were common in the cases clinicians discussed.

"She had a history of neglect, physical abuse and sexual abuse... that was quite severe really, we're talking about whipping...cigarette burns, lack of food..."
(Primary Mental Health Worker, Interview 3; 39-43)

õmum has a significant drug and alcohol problem and worked as a prostitute so he was exposed to a fair amount of sexual activity as well...and there was a fair amount of violence as well..."
(Psychologist, Interview 4; 22-25)

Experiences in Care

In many of the cases discussed, the child had experienced multiple foster or adoptive placements prior to their current placement. For some children, previous placement breakdowns had happened in very difficult circumstances, which had a lasting impact on the child. Instability in the current placement was also an issue in some of the cases and this was a source of considerable uncertainty and anxiety for the child.

"He's had a very chaotic time in foster care. I can't remember exactly how many placements he's had, but it's more than 12, 13...so he's moved very very frequently"
(Psychologist, Interview 4; 30-32)

"During our sessions she would become overwhelmed really with distress because what happened was that her adoptive parents took her to the social services office and...then they left her there, in a way abandoned her....and she was just never....able to resolve that level of anger she felt and distress..."
(Social Worker, Interview 10; 144-151)

Birth Family Relationships

For some of the young people discussed by clinicians, relationships and contact, or lack thereof, with birth family members was an ongoing issue for the child and their carers to manage. In some cases, clinicians noted changes or issues in birth family relationships during the course of an intervention, which they felt had impacted on the child's progress or the process of therapy in some way.

"There was a big issue about John not being able to have any contact with his birth sister at all....it would have been really difficult just to then leave her behind"

(Primary Mental Health Worker, Interview 2; 151-157)

"I guess the biggest one was the death of his mum, which was obviously very difficult, but in some ways did seem to be one of these kind of stepping stones in the therapeutic process..."

(Psychologist, Interview 4; 342-344)

School

Difficulties in the school environment, particularly in interactions with peers, were frequently experienced by the children clinicians spoke about. These difficulties were a significant source of distress in the child's life and clinicians highlighted the impact of this on the process and outcome of the intervention.

"he just can't cope with it (the secondary school setting)*...it appears to be his relationships with his peers that cause him the most distress....he does get called names, people aren't his friend"*

(Psychologist, Interview 7; 579-583)

"She found it extremely distressing...she hates going to school.....we couldn't do anything to stop the bullying..."

(Clinician, Interview 12; 219-225)

Theme 2: Presenting Problems

Clinicians described a range of clinical problems in the cases they discussed, including behavioural issues, emotional difficulties such as anxiety or low mood, neurodevelopmental disorder and issues relating to eating. However, clinicians typically identified difficulties in

the child's relationships with others as the central issue. Indeed, many clinicians highlighted the importance of this relational and systemic context in understanding difficulties which others might have located exclusively within the child.

Behavioural Issues

Clinicians commonly reported concerns about the child's behaviour as the main reason for referral to the service. Difficulties in managing the child's behaviour were often reported by the child's carers/parents or school. Clinicians commonly highlighted the importance of understanding the child's emotional distress and needs underlying their behaviour, which sometimes did not appear to be apparent to carers/parents and referrers.

"the foster carers and social worker...were talking about a boy who they felt was a little boy whose rages were very controlled, with very little distress underneath them, they thought it was...a real function and that he was deliberately behaving in ways to break the placement down so he could move....he presented as a very very anxious little boy to me."
(Psychologist, Interview 4; 127-146)

Emotional Distress

Clinicians identified high levels of emotional distress in the majority of cases discussed. Significant difficulties with anxiety were particularly common, which was often linked to real issues within the young person's life.

"When I first met him, he presented as very quiet and very serious, but he was a very anxious child and anxious about kind of a whole range of things"
(Clinician, Interview 5; 94-97)

"He basically within that first assessment session came up with a whole host of worries....and a lot of those worries very realistic about, you know, his mum's drinking and is she going to die, those types of things..."

(Psychologist, Interview 4; 144-148)

Carer–Child Relationship Issues

Difficulties within the relationship between the child and their foster carers or adoptive parents were commonly identified by clinicians. In many cases, the context of the carer/parent-child relationship was highlighted as a key part of understanding the presented difficulties.

"Mum would have kind of spoke very much about kind of the Asperger's taking over control of everything, but I think there was also the attachment aspect of things as well – there was the difficulty in the relationship between her and mum, which was probably the predominant problem, but might not have been identified as the predominant problem..."

(Clinician, Interview 12; 60-68)

"Adoptive mum had acknowledged not feeling the same capacity of love for the child that she had assumed she would feel, and that she also had experienced with...her own birth daughter..."

(Clinician, Interview 9; 88-91)

Reflection on this theme in a focus group prompted discussion of the complexities inherent in carer-child relationships that are formed as a result of the adoption/fostering process.

Clinicians emphasised that carers' experiences prior to and during this process are often equally as relevant as those of the child.

"For adopters coming into this process, there's something about their skills as parents being scrutinised...it (attending CAMHS) *means...that they haven't done what they're supposed to as parents, and it's that sense of perceived blame I think"*

 (Psychologist, Focus Group 1; 151-161)

Some clinicians suggested that negotiating the parent-child relationship may potentially be particularly difficult in adoptive families, due to the permanence of such arrangements, as well as the hopes and expectations which adoptive parents are likely to hold.

"...there's a difference for me in adoption and the fostered children...something about how difficult it is for adopters to claim the child as their own...something about what the adoptive parents were expecting...how that child would become a feature of who they are...when that doesn't kind of show itself in the way that adoptive parents were hopeful for, then there's this kind of mismatch..."

(Clinician, Focus Group 1; 128-139)

Difficulties in Peer Relationships

Many of the children discussed were reported to struggle with negotiating peer relationships. Clinicians often commented on the relationship of this to the child's attachment and relationship issues generally, as well as the reciprocal impact of difficulties with peers on the child's self-esteem and social style.

"In terms of peers, he found it very difficult to keep any friendships, he didn't really understand how to play....it really impacted on his self-esteem further, and when...the peers rejected him, which just increased his aggressive behaviour"

(Clinician, Interview 5;)

"He does find it (peer relationships) *very difficult, in that he misjudges it, it's all or nothing, so you're either my friend or you're not, he cannot bear the triangulation within friendships, so a three is a disaster. I think...he's got the capacity to build a friendship at that kind of initial stage, but actually maintaining it becomes very difficult because actually he expects too much, wants too much, which I think is his emptiness really, you know, please be my friend, stick with me..."*

(Psychologist, Interview 7; 601-609)

Theme 3: Interventions

<u>Multiple Components</u>

Many of the interventions described by clinicians consisted of several components. Consultation work with carers and/or the school, alongside individual work with the child was typical. In some cases, a number of different approaches were applied sequentially, as the case formulation evolved. Different components of an intervention were often delivered by different members of the team.

*"I think it's a classic example of how one therapeutic intervention doesn't fit for many looked after cases, and the need to draw on lots of different models, different approaches, and being really flexible throughout the work too...*ö

(Psychologist, Interview 7; 939-943)

"Another person in the team got involved, started to...offer her some play therapy. My work with mum and dad still carries on...and the play then moves on to including mum in the process..."

(Clinician, Interview 9; 248-250)

Intervention with Carers

In the majority of cases discussed, carers/adoptive parents were a key part of the interventions undertaken. The focus of work with carers was generally increasing their understanding of the ongoing impact of the child's history, as well as their awareness of the child's emotional and developmental needs. With this understanding carers could be supported to adapt their parenting to become more responsive to the child's needs.

Various approaches to this work with carers were described, including group work with foster carers/adoptive parents, Theraplay and work based on attachment and Dyadic Developmental Psychotherapy models.

"helping his mum and dad to really have an understanding of the impact of his history, but also all of those early experiences that he missed out on and what he really needed in terms of helping him to recreate those experiences and have the opportunity to do that..."

(Clinician, Interview 6; 344-350)

"it was very much about strategies that they could employ that might hold and contain and support, with a focus on the child's needs rather than the behaviours..."

(Psychologist, Interview 7; 386-389)

Many clinicians also emphasized the importance of engaging and supporting carers, with containment of their anxiety viewed as the central aim of some interventions.

"some of it was about containing foster carers' emotions....reassurance for them that some of the things that she did, that there would be would be movement, but it wouldn't necessarily be quick."

(Primary Mental Health Worker, Interview 3; 290-295)

Feedback of this emergent theme of carer/parent interventions as the central focus of the work of the participating services prompted discussion in one focus group of the discrepancy between the nature of interventions provided by the service and carersøexpectations of what will be offered.

"There is this idea that...do therapy with the child and that will cure the child, when the reality is you need to...change how the system works with the child and what the child experiences in the system..."

(Social Worker, Focus Group 1; 113-118)

Direct Therapy with Child

In half of the cases discussed, individual therapeutic work with the child was described as a significant part of the intervention. With the exception of work with older teenagers, carer interventions would always be undertaken alongside this, to some extent, and were seen as an essential complement to any child-focused therapy.

Many clinicians described the focus of individual therapeutic work as helping children/young people to make sense of their emotions and experiences.

"some of his worries were around memories that he had....of being at home with his mum and the violence....he wanted to talk about that and think about those...."

72

(Psychologist, Interview 4; 234-241)

"I think also trying to help him start to make more sense of some of that jumble that was in his head, because he just talked about having this big, wobbly mess in his head, this big jelly he drew it as..."

(Clinician, Interview 6; 204-208)

For some children, developing emotional literacy and communication skills was a key part of the intervention, providing a language to talk about and express emotions, as well as supporting children to communicate these effectively within their relationships with carers/parents.

"I wanted to spend some time thinking about...feelings that he assigns to those, how he recognises them, how he felt other people saw them and how he communicated them..."

(Psychologist, Interview 4; 178-181)

"It was really around helping him to increase and enhance his emotional communication, so rather than having to say to people that...he wanted to kill himself, to be able to start thinking about expressing the emotions more appropriately."

(Clinician, Interview 6; 199-204)

Finally, developing constructive ways of managing emotions was also an identified focus of the work in some cases.

"We talked about...which ones are worries that everybody has...which ones are worries that grown- ups should be dealing with...who he felt comfortable talking to, and then we did some of the anxiety management techniques...he was really good at relaxation..."

(Psychologist, Interview 4; 221-226)

Feedback on themes arising from descriptions of individual therapeutic work with children led some clinicians in the one focus group to reflect on the basic nature of these skills in emotional literacy and management which formed the focus for their work, which seems paradoxical in light of the complexity of the lives and difficulties of the children with whom it is undertaken.

"See it is that thing about children with very complex histories trying to manage very complex feelings with very limited ability to do it, so you are switching between containing that and providing really basic skills at the same time..."

(Psychologist, Focus Group 2; 186-190)

Some clinicians in one focus group also highlighted the potential value of the therapeutic relationship for the child, feeling that experiences within this relationship could be beneficially transferred to other relationships outside the therapy context.

"Sometimes they can test out that relationship. So they can be as angry as they want to and they know they can come back. They can just keep testing the boundaries of, will they still be there for me, or not be there for me....and then that can be used outside..."

(Therapist, Focus Group 1; 459-463)

Finally, feedback on themes arising from descriptions of individual therapeutic work with children led some clinicians in a focus group to highlight the need for individual therapeutic work to be explicitly connected with the important relationships in the child's life.

"That's my struggle with thinking about individual work, because actually I think the focus of our work is about relationships..."

(Psychologist, Focus Group 1; 305-307)

"I always say the child will be working, but....the family are still working as much as the child...that child is part of a network and they need those links to work together..."

(Therapist, Focus Group 1; 374-385)

Consultation with School

Work with the child's school was commonly identified as a component of the clinician's intervention. The focus of this work was typically described as developing school's understanding of the child's history and current needs, in order to enable the school to better meet these needs.

"lots of liaison with school turned out to be one of the main issues....it was really important for school to realise they had a role to play if the self-harm was being generated by the stress within school..."

(Primary Mental Health Worker, Interview 2; 225-236)

"This meeting of 20 people (at the school) *and I'm talking about this very scared, vulnerable little boy, and some of them have actually changed their view completely, because actually they saw an angry.... aggressive boy, who needed to be excluded for everyone's safety...they've been able to change their view because actually they can see the distinction between how he was and how he is now."*

(Psychologist, Interview 7; 828-834)

Theme 4: Outcomes

Improvements in Relationship Between Child and Carers

Clinician's identified three ways in which the relationship between the child and their carers improved during and following an intervention: carers becoming more understanding of and responsive to the child's needs; carers obtaining support and containment from the service,

enabling them to feel more confident in their ability to care for the child; the child becoming more able to communicate their needs to their carers and having their needs better met as a result.

Increase in carer's understanding of and responsiveness to child's needs

Improvement in carer/adoptive parents' understanding of the ongoing impact of the child's history and their emotional and developmental needs in light of this, resulting in a parenting style more responsive to these needs, was commonly cited as the most significant change observed by clinicians. Changes in carers' perceptions of the child and their behaviour were often identified as an important vehicle for changes in their relationship with the child.

"It was how mum coped with Sarah as well that changed. I think through understanding what Sarah was doing, (mum) could cope with it better, because she didn't just see it as naughtiness....she saw it as this is because she's distressed about something, and this is what she does when she's distressed."

(Clinician, Interview 12; 273-278)

"Certainly parents are more aware of the little boy's....emotional need for care, nurture and support is certainly more significant than most young lads his age, but mum and dad are able to provide it when they know that that's what's needed."

(Clinician, Interview 5; 757-762)

"I think there was something quite powerful about them seeing him as an anxious little boy rather than an angry little boy....their language about him seemed to change....so that kind of re-labelling seemed to help...I think he was given a more appropriate way to be able to communicate that."

(Psychologist, Interview 4; 296-304)

However, in some cases, clinicians felt that changes in this area were more limited and interventions aimed an increasing carersøunderstanding had not had the impact they had hoped for.

"there had been some of the parents seeing the benefits, so in theory saying that they really understood and it made a lot of sense to them; in practice, still getting incredibly frustrated and annoyed with the effect on them when...simple requests don't happen.."
(Clinician, Interview 9; 211-216)

<u>Support and Containment for Carers</u>

In many cases, clinicians referred to foster carers/adoptive parents having obtained a sense of support from the service, which had helped to reduce their anxiety and increase their ability to cope with caring for the child. This was identified as an important function of the intervention, which they felt was a significant contributor to the overall outcome.

"As soon as the (foster) *mum was calmer....if foster mum is less anxious, the boy will be less anxious; if foster mum is able to cope with the temper tantrums, the boy will be much quieter."*
(Psychiatrist, Interview 11; 239-243)

(In groups) *"...kind of sense of relief about being in a room, saying something about your child's behaviour and presentations and other parents' nodding, you don't have to explain, so there's a real sense of understanding...."*
(Clinician, Interview 5; 511-515)

Increase in Child's Ability to Seek Support from Carers

Some clinicians remarked on changes in the child's ability to communicate their feelings in a constructive way to their carers/parents and seek their comfort or support, which in turn provided opportunity for carers to be responsive to the child's need and the child to benefit from the experience of having their needs met. Clinicians described this change in the child's emotional expression being brought about by direct work with the child focusing on emotional literacy and communication, as well as through work with carers encouraging them to promote and reinforce the child's emotional communication.

"I think that experience of talking and talking being ok, and actually the stuff we fed back to mum being acted on, helped them to remove the need for the middle person. It was...more possible to talk to mum and dad, without kind of coming through me."
(Clinician, Interview 5; 537-542)
"He would be more able to say when he needed time with mum and dad....he'd go and say to them that he...needed to be with them...or...sometimes he wouldn't necessarily say anything, he would just go and join them..."
(Clinician, Interview 6; 475-480)

The idea that changes in carers' understanding and responsiveness to the child's difficulties and needs would result in changes in the overall relationship between the child and the carer, and in the child as an individual, was implicit in many clinicians' accounts. One clinician summarised this more explicitly:
"I wonder if that's where the long-term changes come from, because the children sense that that relationship (with the carer/parent) *is different...they can then be kind of different in the*

relationship and you get over time better kind of behaviours, they feel more secure, they feel

more loved and so things can change"

(Clinician, Focus Group 1; 804-809)

Behavioural Changes in the Child

Some clinicians commented that there had been improvements or changes in the childøs

behaviour, which were clearly linked to changes in carersøunderstanding and management.

It was generally acknowledged that such changes were precarious and dependent on the

parent-child relationship and other contextual factors.

" she's more confident, she feels more valued and accepted, that they feel there is more pride

around for them as a family. There's less tensions or atmospheres in the home, she's having

less tantrums..."

(Clinician, Interview 9; 309-313)

"I know there was some change in her behaviours, but I think the biggest change was in

mum's understanding of her behaviours...the behaviours would still be there and they'd

probably fluctuate; when she's more stressed, there would be more behaviours..."

(Clinician, Interview 12; 327-332)

Changes in Child's Understanding of Emotions and Experiences

For some children and young people who engaged in individual therapeutic work, clinicians

noticed changes in the childøs ability to make sense of their emotions in the context of their

lives and experiences, which in some instances was linked to alleviation of distress or

changes in their management of emotions. The limitations and undeveloped nature of such

changes were emphasized.

"She....started to understand a lot about the...feelings of loss and separation...she could...say well, if that happened to me, that's why I'm feeling like this... making sense of it really....and I think it....did alleviate something for her."

(Social Worker, Interview 10; 488-504)

"...areas are still difficult for him, his self-esteem is still very fragile and peer relationships are still hard, but I think he's had the opportunity to be able to start making links with some of the reasons why he finds those things difficult..."

(Clinician, Interview 6; 462-466)

Theme 5: Measuring Outcomes

<u>Limited Relevance of Current Measures</u>

For most clinicians who took part in the interviews and focus groups, outcome measures were viewed as having limited relevance to their clinical practice. Many clinicians commented that the measures currently employed by the service, e.g., the SDQ, fail to capture the changes that they view as important, in particular, the relationship between the child and their carers/parents.

"the things I suppose I'm more interested in, that I feel will pick up more of the changes about how well do you feel you understand your child, why they behave as they do, how confident are you in being able to care for them – you think for a child's life day to day, those are the kind of things that really matter."

(Clinician, Interview 5; 814-819)

"they're (outcome measures) *all about clinical diagnosis, and I find that rather unhelpful, because we don't want to diagnose, we understand the formulation..."*

(Psychologist, Interview 7; 884-886)

Potential Benefits of Outcome Data

Some discussions emerging from focus groups indicated that staff do recognise the potential for outcome data to benefit the service, provided that the data accurately reflects the work that the service does and the impact of this on children and their families.

"yet you can see the value...if you could get good data, it would reinforce why the work is often slow, long-term....if you could capture the right information, you'd think it would be really helpful in justifying why we work as we work..."

(Clinician, Focus Group 2; 793-797)

Other discussions emphasised the political and economic context of outcome measurement, which demands that services demonstrate their clinical and cost-effectiveness through the collection of routine outcome data, in order to justify their funding. The tension between this function of outcome data and use of the data to actually improve clinical practice was stressed.

"I think the context is, not necessarily wrong, but it's...defensive to justify existence – using the words commissioners want. They're imposed, rather than, I don't know, we use them to improve how we work. So if the relationships don't shift then we question our model, that would be useful, but not quite there....the outcomes are not sort of child-centred, they're financially driven."

(Psychiatrist, Focus Group 2; 812-817)

Discrepancy between Intervention Aims and Measured Outcomes

A key issue highlighted by many clinicians was the disparity between the aims and nature of interventions they undertake, and the constructs on which many routinely used outcome measures are based. Participants highlighted the importance of the quality of the carer-child

relationship, with the carers' understanding and responsiveness to the child's needs as a key facet of this, indicating that this should be a major focus of outcome measures employed with this client group.

"we're looking to build...playfulness, empathy, curiosity, acceptance and attunement and the interventions that we use are about doing that, but the measures that we use are about behaviour and they're about psychiatric diagnosis, and that has got nothing to do with playfulness, empathy, curiosity, attunement..."

(Psychologist, Focus Group 1; 563-569)

õthe measures...like SDQ...they kind of miss it a bit for me...so I think there is something more about the relationship and the carers' and parents' perceptions and how confident...they feel to manage things."

(Psychologist, Focus Group 2; 460-465)

External Expectations

Some clinicians identified external expectations (stakeholders such as carers, referrers and NHS managers) that the service will be able to demonstrate uniformly positive outcomes as a source of pressure for services, which is inconsistent with the reality of clinical work.

"It's very difficult for people to think about outcome measures, because as someone else said, some get better, some don't get better, and some get worse, and it's very difficult to think about having a service that actually could make people worse."

(Psychiatrist, Focus Group 1; 1041-1045)

Interpreting Outcome Measure Data

The complexity of interpreting outcome measure data was a key issue identified by clinicians. Some of the assumptions implicit in the outcome measurement process were questioned, for example, the notion that a particular outcome, such as lower scores on a certain measure, is preferable in all cases. Some clinicians suggested that the use of some frequently used measures with this client group would be less concerning if they felt more considered interpretations of data would be made.

"if we can have a more complex understanding and a formulation around the measures that we're collecting then that would be helpful, but this whole idea of actually this is what you score now and this is what you score then, and aiming for reductions, is just nonsense when it comes to this particular group of young people."

(Psychologist, Focus Group 1; 714-719)

"I guess even if we did have SDQ data which didn't show much shift and then perhaps relationships questionnaires which did....we've got a very clear rationale and model for why we would expect that to happen. So it doesn't particularly matter if the SDQ isn't shifting that much, but other things are..."

(Psychologist, Focus Group 2; 800-807)

"I think we need as well to think about the word "better" – better for one child is actually them being really angry because they couldn't do it before, but then that would make the figures look quite bad, because they're not actually getting "better"..."

(Therapist, Focus Group 1; 874-879)

Many clinicians also identified some of the potential flaws associated with self or carer-report data in this client group, which must also be taken into account in the interpretation of

outcome data. The impact of carers' increased awareness and understanding of the child's behaviour and history on their ratings on outcome measures was considered, as well as some carers' need for validation, which may lead to over-scoring.

"with that increased understanding, there's almost an increased awareness of how tricky it can be to parent children with these histories"

(Clinician, Interview 6; 734-736)

Problems with the use of child self-report were also identified, in terms of the limitations of the child's emotional literacy, as well as instability and reactivity of emotions.

"I don't think she has the language really, to be able to give that much information about how she is feeling....if you got her to do a rating scale, she would either be 0 or 10, there would be no in between"

(Clinician, Interview 12; 263-267)

Some clinicians debated whether alternative methodologies, such as observation or semi-structures interviews, would better capture the complexities of change within the client group. However, the expense and labour-intensiveness of such methods were recognised as barriers to their routine implementation within the NHS.

"I think qualitative stuff gives you much more information than them ticking a box about what they thought of the service or how they're feeling..."

(Clinician, Focus Group 2; 564-566)

"Outcome measures are notoriously difficult to get completed....bringing them back particularly for an outcome interview is very labour intensive, expensive, not a necessary thing to do..."

(Psychiatrist, Focus Group 1; 886-892)

Linking Context to Outcome

External influences on the child's well-being, such as placement breakdown and school difficulties, were identified as a major potential confounding factor when measuring the outcome of any intervention. Clinicians reflected on the difficulty of incorporating the child's context into assessments of outcome.

"There's been this really major regression now, where all those behaviours are back in full force, on the basis that the kid's been told that they're going to be leaving, so it's kind of gone full circle, and that would be interesting on outcome measures..."

(Clinician, Focus Group 1; 1014-1018)

"....you're missing bits, I liked the bit when you (another focus group member) *said you miss the spice, because you do, I don't think any of the forms capture particularly well the context and life events..."*

(Psychologist, Focus Group 2; 558-561)

I guess outcome measures don't really measure how well she's coping with how much is happening in life....

(Clinician, Interview 13; 223-225).

4. DISCUSSION

Outcomes of psychological interventions must be assessed in order to evaluate the quality of care provided by mental health services and ensure that they are effectively meeting the needs of clients. Berger (1996) highlights the complexity of this task, however: *"outcomes of psychological interventions are the amalgam of a complex of factors...attempts to assess such outcomes need to take account of the complexity"* (p23). Outcomes of psychological interventions are multiply determined, in the same way that psychological interventions can impact on clients and the systems around them in a variety of ways (Berger, 1996). The current study aimed to explore the complex issues involved in measuring outcomes in CAMHS services for Looked After Children (LAC).

Children who are in foster or adoptive care have unique and complex needs. Yet the same outcome measures recommended for general CAMHS services (Department of Children, Schools and Families/DoH, 2008) are currently applied in specialist LAC services, with little consideration having been given in the literature as to the appropriateness of this. The current study sought to address this gap in the literature through the use of interviews and focus groups with clinicians working in LAC CAMHS services, exploring their perspectives on the impact of their interventions and the implications of this for measuring outcomes. Thematic analysis of the data identified a number of important themes in clinicians' accounts of cases, their observations of outcomes of interventions and views on how best to measure these. The following discussion does not closely adhere to the structure of the thematic framework, but instead focuses on drawing out the aspects of the analysis judged to be of greatest relevance to clinical practice, with emphasis on the study's aim of understanding the impact of therapeutic interventions for LAC and the implications of this for measuring

outcomes. Three areas are explored in greater depth, with reference to the research literature and clinical implications: the importance of the context in which children live and services function; the focus in CAMHS services for LAC on improving relationships and the systems around the child as the main therapeutic goal; and clinician's views on how to best evaluate mental health interventions/services for LAC.

4.1 The importance of context

The importance of the external context in which looked after children live, interventions are conducted, and outcomes are assessed was an overarching theme. Clinicians highlighted the traumatic histories and ongoing stressors of the children they work with. Contextual factors, such as the stability of the child's placement or relationships with birth family members, were identified as major influences on the process and outcomes of interventions. The confounding influence of this on any assessment of outcome was also recognised by some clinicians. The assumption that outcomes generally can be directly attributed to the impact of psychological interventions, without due consideration of the many other potential influences, has already been identified as problematic (Berger, 2006). This is clearly an even more crucial issue in LAC, as is evidenced by the accounts given by clinicians in the current study, due to the instability that is characteristic of the lives of many of these young people.

This finding has clinical implications beyond measuring outcomes, in terms of broader service delivery, as well as for health service and social policies. As indicated by the multifaceted interventions described by participants in the current study, psychological interventions cannot be delivered in isolation; due attention must be given to addressing the contextual factors that are impacting on children's lives. For health services, this is likely to mean increased collaboration with other agencies that are part of, or could potentially be part of, the systemic context in which the child is embedded, e.g., schools, social services,

voluntary sector organisations. Beyond health services, this issue needs to be addressed more adequately by wider government policies; Friedli (2009, pIV) argues that *"while there is much that can be done to improve mental health, doing so will depend less on specific interventions...and more on a policy sea change, in which policy makers across all sectors think in terms of "mental health impact".* Policy changes in areas such as social welfare and education are particularly relevant for improving the lives of looked after children.

4.2 Changing Relationships

Clinicians reported that children were often referred to the service due to concerns about behavioural issues, yet emotional distress and issues in the relationship between the child and carers were often identified as underlying this. This is consistent with Beck's (2006) survey of young people in care and their carers, which found that carers were likely to focus on behaviour problems, whereas young people most commonly reported emotional and relationship problems. This suggests that carers are most likely to notice externally visible problems, perhaps lacking the awareness of young people's internal emotional states, which is crucial if they are to provide the sensitive and responsive parenting necessary for them to act as a secure base for the child (Schofield & Beek, 2005). Indeed, Tyrell and Dozier (1999) have demonstrated that despite their complex task of forming attachment relationships with children who are likely to behave in rejecting ways towards new carers, foster carers do not show increased understanding of attachment strategies or higher levels of sensitivity in their parenting compared with biological parents. There is therefore a clear need for mental health services to support carers in providing parenting that is able to meet the complex needs of the children they care for. Indeed, indirect intervention with carers/parents was identified through the current study as a crucial function of LAC services and there is some tentative

emerging empirical evidence of the effectiveness of such interventions (e.g., Dozier, Dozier & Manni, 2002; Sprang 2009; MacDonald & Turner, 2005).

Improvements in the relationships between children and their carers were indicated by clinicians to be the most significant outcomes of the interventions they undertook. In particular, changes in carers' understanding and perceptions of children and their emotional needs, as well as carers' responsiveness to these were noted. Carers feeling more emotionally supported and children being more able to express their needs to carers were also cited by clinicians as important and potentially measurable changes in the relationship between the child and carer.

Some clinicians did observe positive changes in children's behaviour and emotional management. These changes were generally recognised as very limited and unstable however, with their maintenance being linked to the ongoing relationship between the child and their carer and to other wider contextual factors. This finding was an important one, given that existing outcome measures such as the SDQ focus on changes within the child rather than the systems surrounding them, yet clinicians are suggesting that the important and noticeable changes from their perspective are those which occur in the relationship between the carer and child. One possible interpretation of this finding is that changes in the child-focused outcomes are mediated by changes in the relationship between the carer and the child; following this reasoning, changes in the child are likely to occur gradually over time, through the child's experience of consistently sensitive and responsive parenting, which would require much longer term follow-up to capture.

4.3 Measuring outcomes

Clinicians clearly identified that the outcome they viewed as most important to capture is the quality of the relationship between the child and their carers; this is the outcome which they view their interventions as being directed towards. Some clinicians remarked that current

measures recommended for use in CAMHS, such as the Strengths and Difficulties

Questionnaire, do not evaluate this important aspect of their work. In recent years, there has

been some research directed towards attempts to capture some of the more specific

difficulties associated with looked after children. For example, a scale has been developed to

measure children's attachment problems (Relationship Problems Questionnaire (RPQ);

Minnis, Rabe-Hesketh & Wolkind, 2002) and clinicians within some LAC services have

started to use this with their clients, as they feel it has greater face validity than generic

measures such as the SDQ. However, the RPQ is based on diagnostic criteria for attachment

disorder and therefore contains exclusively child-focused items, such as *"is demanding or

attention-seeking"*, rather than items to assess the quality of the *relationship* between the

child and carer.

Some participants of the current study indicated that they recognised some potential

benefits for the service of collecting outcome data, in terms of justifying the nature of the

work they undertake and the opportunity to improve the way in which they work. Clinicians

felt that such benefits were not being achieved however, due to the poor validity and clinical

relevance of existing outcome measures. These views are consistent with studies across a

range of mental health services, which have shown that clinicians doubt the validity and

clinical relevance of outcome measures (e.g., Garland, Cruse & Aarons, 2003; Meehan et al.,

2006), with some clinicians expressing reluctance to incorporate them into routine clinical

practice (e.g., Gilbody, House & Sheldon, 2002).

Aside from concerns about the validity and appropriateness of particular outcome

measures, many clinicians indicated that they felt a more concerning issue relates to the

interpretation of the data obtained from generic outcome measures, such as the SDQ.

Participants of the current study challenged some of the assumptions often made in the

interpretation of outcome data, for example that a certain change in scores on an outcome

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measure can be assumed to reflect a particular clinical change. As Berger (1996) highlighted, *"any outcome index is essentially neutral. It is a description or an index of a state...the value attached to that state will depend on the judge".* This suggests that measuring outcomes in a way that is valid and clinically relevant is about more than just selecting appropriate outcome measures; it is the interpretation of these measures which is crucial. If clinicians, managers and commissioners involved in the analysis and interpretation of outcome data are able to contextualise outcome measures in a broader understanding of the nature and complexity of the issues facing this client group and the services working with them, then identification of measures which accurately capture this complexity becomes less important. Outcome measures themselves are not problematic, provided that it is clear what they do and do not measure, and that the data they provide is interpreted against a background understanding of the complex clinical situations of which they reflect only a single, isolated aspect.

4.4 Methodological Issues

Clinicians' Perspectives

There are limitations to the indirect methodology employed in the current study, which relies on cliniciansø observations and second-hand reports of children and their familiesø experiences, and cliniciansø subjective evaluations of client progress. However, clinicians have a valuable and unique perspective on the progress of their clients, which has historically been neglected in outcomes research (Weisz, Doss & Hawley, 2005). The lack of research exploring the complexity of outcomes in LAC justified a qualitative approach in order to capture the relevant issues. Clinicians are only one source of information about outcomes however; future research should explore the views of other sources, such as children themselves, their carers and families, teachers and referrers, to ensure a more complete

understanding which can inform processes for outcome measurement in a reliable and valid way.

Selection of cases

Clinicians who participated in interviews were each asked to select a case for which they had undertaken a psychological intervention, had recently closed, and felt able to discuss the process and outcome of the intervention in depth during the interview. No other guidance was given to clinicians regarding which case to select. In addition, as described in the õmethodö section of the research report, the interview schedule was deliberately designed to be broad and flexible to allow clinicians sufficient freedom to give an adequate account of their chosen case. The sample consisted of clinicians with various different roles and professional backgrounds; it was anticipated in advance that the nature of cases and interventions clinicians described during interviews would be diverse, and that the interview schedule would need to be broad and flexible in order to accommodate this.

A consequence of this flexibility in the selection and discussion of cases was that some of the interventions described by clinicians would perhaps fall into the category of case management rather than psychological intervention. As psychological outcome measures are intended to assess outcomes of psychological interventions, rather than more general case management, understanding the outcomes of these cases is less relevant to consideration of appropriate outcome measures than cases in which a more specific intervention has been undertaken. With more time and resources available, it would have been preferable to impose stricter criteria on participantsø selection of cases to ensure that only accounts of clear psychological interventions were recorded.

Another consequence of cliniciansø freedom to choose cases for discussion is that the cases selected are not necessarily representative of all cases in LAC CAMHS services. Yardley (2000) suggests õtheoreticalö sampling as a strategy for ensuring a broad sample

without the need for large numbers of participants. Although a technique often reserved for grounded theory investigations (e.g., Glaser & Strauss, 1967), a theoretical sampling strategy could equally have been employed within the flexible framework of thematic analysis. In the current study, this could have involved specifying that different participants select cases with particular characteristics; for example, cases that are viewed as successful as well as cases that are viewed as unsuccessful, or straightforward cases versus complex cases. Within the time and resource limits of the current study however, such an approach was not deemed to be feasible: many participants already struggled to select cases which they had recently closed and judged to be appropriate for discussion, thus further restriction of cliniciansø choice may have caused recruitment problems.

Generalisability

Unlike most quantitative research studies, findings from qualitative research cannot be extrapolated from study samples to the general population. The current study explored the observations and views of a selection of clinicians, on a selection of cases, from two LAC CAMHS services; it cannot be assumed that the results of the current study will necessarily apply to other LAC CAMHS services, nor to all clinicians or cases even within these services. However, this is not to say that the findings do not have relevance beyond the sample from which the data was collected, only that the findings should be interpreted with this caveat in mind.

4.5 Conclusions and Future Research

The results of the current study highlight the impact of the wider context of the childøs life on outcomes of CAMHS interventions: children in care commonly experience high levels of instability and disadvantage in their lives, which has a significant impact on their well-being.

The potential for isolated CAMHS interventions to be beneficial for the child in this context is very limited, thus interventions which address these contextual factors, and the systems around the child, are crucial. Indeed, clinicians indicated that the most significant changes they observed in their clients were in the relationship between the carer(s) and the child, whilst child-focused changes were much more limited. Moreover, many clinicians highlighted that any assessment of outcome is likely to be confounded by the changes which may, and often do, occur in looked after children's lives during the course of an intervention. As highlighted by Berger (1996) therefore, no measured outcome can be causally linked to an intervention; rather, outcome measures assess various aspects of a child's life at a particular point in time and are influenced by a variety of factors, of which CAMHS interventions are but one.

Existing outcome measures commonly used in CAMHS services, e.g., the SDQ, aim to measure changes within children, rather than in the system around them. The findings of the current study indicate that it is the changes in the carer-child relationship, or carers' ability to provide a secure base to children who are often rejecting of their efforts to provide sensitive and responsive care (Schofield & Beek, 2005), which are felt by clinicians to be the areas most likely to show change, as well as the most important areas to show change. Although clinicians identified the carer-child relationship as the focus of much of their work, child-focused outcomes of psychological interventions are still potentially appropriate and useful to assess. Afterall, the ultimate aim for services is to bring about improvements in the child's wellbeing, and it is important that this continues to be captured to some extent in services' assessments of outcomes. However, to assess the direct product of the majority of CAMHS interventions for LAC, there must also be some assessment of the parenting and/or the carer-child relationship. Indeed, as it is the carer-child and relationship that is most commonly cited as the vehicle for changes in the child, some evaluation of this is essential to

the interpretation of child-focused measures. Furthermore, clinicians highlighted that any assessment of outcome of CAMHS interventions for LAC needs to be interpreted with an understanding of the often unstable context in which looked after children live and services work.

Future research should focus on developing appropriate outcome measures for this population, which focus on the relationship between the carer and child, or the parenting provided by the carer, rather than individual psychopathology or other child-focused outcomes. Existing measures which were designed primarily for use in general populations, but which focus on this area, such as the Parenting Stress Inventory (Abidin, 1983), might be a place to start. However, it is important that outcome measures are validated with this population specifically, and that they include consideration of issues which may be unique to looked after children, such as trauma and attachment issues.

Finally, it must be remembered that a key purpose of outcome measurement is to provide data regarding the effectiveness of mental health services, in order to inform decisions about allocation of funding and resources. It is therefore essential that the complexity of measuring outcomes of psychological interventions, and the contextual factors that are likely to impact on this process, are communicated to managers and commissioners who have responsibility for such decisions. Managers and clinicians should be able to incorporate an understanding of this complexity into their interpretations of the data provided and use it to inform their decisions about service provision.

PART THREE:

Critical Appraisal

5. Critical Appraisal

1. Project conception and design

At the start of my training as a clinical psychologist, I was asked to select a research project to be conducted over the following three years, which would eventually form the basis of the thesis which I would be required to submit at the end of my training. This seemed like an overwhelming task; the project would need to be something that I was able to sustain an interest in throughout the three years, yet I was at a time in my career when I was unsure of where my interests lay, excited about the opportunities I would have over the course of my training to explore and develop my interests. Choosing a single topic to invest so much in at this stage felt limiting and restrictive. Having completed an undergraduate degree which was exclusively focused on quantitative approaches to psychological research, and having had limited experience of qualitative methods, I felt that my strength as a researcher lay in quantitative research. I therefore sought a project which would capitalise and build on these existing skills. With hindsight, this bias towards quantitative methods limited my choice of project and led me to explore options which would suit this methodology but ultimately failed to capture my enthusiasm.

I eventually stumbled upon the idea for the current project through discussions with some clinicians in a CAMHS service for Looked After Children, who were struggling with the issue of measuring outcomes in the children and families with whom they worked. Like most mental health services, they were under pressure from managers and commissioners to provide empirical evidence of their effectiveness, but felt the tools currently available to do this, e.g., the Strengths and Difficulties Questionnaire, lacked validity and sensitivity for measuring outcomes in this particular group of clients. In particular, the clinicians expressed concerns that the work they did, and the changes they noticed and felt to be important in their

clients, would go unrecognised due to the lack of appropriate outcome measures. The challenge for me as a researcher was to translate this broad clinical issue into a researchable question and devise an appropriate methodology with which to answer it. The issue presented was intriguing to me for a few reasons. Firstly, it offered the opportunity to explore a clinical area which was relatively new to me, yet which already held some appeal, both intuitively and as a result of some limited contact with looked after children prior to training. In addition, I was attracted to the challenge of developing a research project which would address a real clinical issue and produce findings of direct relevance to clinical services.

2. The challenge of research in the NHS

At various stages of the research process, I was struck by the complexity of undertaking research in the context of the NHS. At times, I was perplexed by the numerous obstacles and ongoing struggles that I was faced with. Yet other aspects of my experience reinvigorated my enthusiasm for research, particularly where it is inspired by real clinical issues, conducted in close collaboration with enthusiastic clinicians, and aims to make a real and meaningful difference to the clinical care which services provide.

Establishing links with services which were prepared to participate in the research was one of the first challenges I experienced. Clearly, collaboration with relevant services at an early stage is crucial in order to assess the feasibility of the research and establish a source of participants. Similar to my experience at many subsequent stages of the research process, I found myself becoming frustrated at the extent to which servicesø agreement was out of my control, despite being able to appreciate the many reasons why services might not be willing or able to commit to collaboration in a research project, e.g. lack of resources, lack of motivation, alienation from research generally. However, the process of liaising with

potential research sites made me aware of the importance of trying to understand the potential views and perceptions which services might have about research projects, in order to both address their concerns and highlight the potential benefits of the research for the service.

My experience of obtaining approval from various sources ó a CAMHS research committee, the research ethics committee, and the research governance department within each participating trust ó was another lesson in managing frustration and anxiety. Rather than particular issues with gaining approval itself, the frustration I experienced was related to the many different forms of approval I was required to obtain, the numerous processes involved in gaining each form of approval, and various unanticipated delays at different stages of these processes. At times, I felt disheartened, wondering whether I would ever be able to actually start my research project and make progress towards my imminent deadline. I learnt to take an assertive and tenacious approach to liaison with the personnel involved in the approval processes; I feel that I would be able to be more confident about negotiating these processes as a result of this experience.

3. Interviews and Focus Groups

The roles of research interviewer and facilitator of focus groups were new to me, yet I was surprised at how easily I slipped into them. This led me to compare these roles to some of the tasks that I undertake in my role as a clinical psychologist, such as clinical interviewing and facilitating therapy groups or team discussions, which require similar skills such as active listening, clarification, and management of group dynamics. However, I was also aware of the inherent differences between clinical and research roles, in particular the need to maintain greater detachment from the material during research interviews in order to avoid undue influence of the researcher on the process and provide the most helpful forum for participants to discuss their experiences and express their views. I was especially conscious

of my own views and experiences of the issues participants discussed, at times feeling

tempted to offer some of these, in the same way that I would in an informal discussion with

colleagues or during a consultation session, but I endeavoured to exercise restraint in order to

maintain a relatively neutral position as a researcher. However, reading the interview and

focus group transcripts with hindsight, I wonder if there were times when I allowed my own

views to unduly influence the interview process. Although, from a contextual constructionist

position, perhaps this active influence of the researcher on the construction of the

participantsø account is inevitable and not necessarily undesirable, provided that the

researcher is transparent about their position.

I was especially surprised by the extent to which participants seemed to enjoy and

benefit from the interviews and focus groups, with some clinicians reflecting that they

provided useful forums for them to reflect on cases or particular service issues. This made

me reflect on the many different benefits of research, particularly when it is well-integrated

into services. I also felt that I gained something as a clinician and psychologist generally

from undertaking the interviews; I found cliniciansø accounts interesting and at times,

inspiring. The issues that they faced in their work led me to reflect on similar issues that I

have faced as a clinician, or could potentially face in the future.

4. Different perspectives

Another issue related to epistemology concerned the balance and integration of different

views and positions. The participants in the current study were clinicians from CAMHS

services for looked after children, from a range of professional backgrounds, including

psychiatry, social work, psychology and nursing. I was mindful of the impact that

participantsø clinical training and roles, as well as personal beliefs, might have on their

perspectives on client outcomes. In particular, clinicians from different professional

disciplines, and even within the same discipline, often hold different conceptualisations of distress. In many respects, this can be viewed as a strength of the research, in that it captures a range of professional perspectives, and through the use of focus groups, sought to establish some form of consensus or integration of these. However, at times during the research process, I felt that there were tensions between different perspectives, not least between my own position and that of some of the participants. The majority of participants described perspectives compatible with the broad contextual constructionist/critical realist position which I adopted during the research, but a minority of clinicians gave accounts that were more consistent with more positivist epistemologies, focused on diagnostic frameworks of understanding for example. I remember feeling frustrated with some of these accounts, which I felt offered reductionist explanations of clientsø difficulties and neglected relational and contextual factors. This reminded me of the tension that I often feel in my clinical role during multidisciplinary team work, which requires respect for different professionals whilst also retaining some unique identity as a psychologist. I aimed to employ a similar attitude to the process of understanding and integrating different perspectives within the current research. However, it is possible that these minority perspectives were marginalised in the analysis as a result of my bias, as well as the general bias in the data towards more contextual epistemologies.

5. Power dynamics

Yardley (2000) highlights the potential for power dynamics between researchers and participants to influence the accounts obtained from interviews. In the current study, I was conscious that the subject matter of outcome measurement can be experienced as threatening by some clinicians (Meehan et al., 2006), with the potential for the purpose of the study to be misinterpreted as evaluating cliniciansø performance rather than the childøs process of

change. Although the rationale for the research was carefully explained to participants, and was derived from clinicansøown concerns about outcome measures in this client group, concerns about performance evaluation may have impacted on the accounts clinicians gave of their interventions. Power dynamics may have impacted to an even greater extent in focus groups, which included clinicians in different hierarchical positions; this may have impacted on the nature of discussion and the extent to which clinicians felt able to express their opinions.

6. Validity of Analysis

The analysis of both interview and focus group data was undertaken by me, with some input from the research supervisor through discussions and feedback at various points. The criteria specified for a good thematic analysis by Braun and Clarke (2006) were used as a guide in order to maintain rigour in the analytic process. Nevertheless, it could be argued, that analysis conducted mainly by a single researcher in isolation is limited in its validity, compared to analyses derived from consensus interpretations of a number of researchers. However, Yardley (2000) argues that the concept of objectivity of analyses is incompatible with qualitative research which rejects positivist assumptions and by definition offers a subjective interpretation of a particular dataset. In keeping with the broad contextual constructionist/critical realist position adopted, I was mindful of the impact of my own views and experiences on the interpretation of the data. The themes in the data fitted well with my existing views and understanding of outcomes, which led me to wonder how the analysis might have been different if it had been undertaken by someone else. However, I was also conscious that the process of conducting the research and analysis had had some impact on my thinking about outcomes, making it difficult to disentangle the two.

7. Moving forward in my future career

The difficulties I encountered during this project, particularly in terms of bureaucratic processes, prompted me to reflect on the issues that clinical psychologists attempting to undertake research as part of their full-time jobs in the NHS might be faced with, in terms of time, resources, and motivation. Looking ahead to my own future as a qualified clinical psychologist, I feel very ambivalent about undertaking further research projects. On the one hand, feeling passionate about the potential value of both the process and product of research, particularly that which is embedded in the real clinical world; yet on the other hand, feeling somewhat disillusioned about the bureaucratic processes involved and unsure of my motivation and capacity for coping with these in the context of the demands of a full-time clinical role. I anticipate that undertaking research as part of my clinical role, rather than to fulfil academic requirements, might be a rather different experience however. For example, research questions arising naturally from clinical practice, rather than needing to seek a topic out. Moreover, it may be necessary to adopt a more pragmatic approach in order to balance clinical and research demands, perhaps undertaking õservice evaluationö, which has fewer bureaucratic demands than formal research.

In addition to these external influences on the research process, I must also acknowledge the impact of some of my own personal difficulties with organisation and time management, which inevitably led to additional delays at various stages of my project. This is an ongoing issue which I have found it useful to reflect on with clinical supervisors and colleagues who know me well. Perhaps because, in some ways, my tendency to complete work very close to deadlines is reflective of my ability to work well under pressure, which is a valuable strength in many aspects of my job, I have always struggled to make changes in this area, despite my recognition of the disadvantages of working in this way. However, my experiences of completing this project, whilst managing many other competing demands, has

highlighted to me the importance and benefits of making some changes to the way in which I manage my workload. To some extent, I also feel that it would be beneficial to recognise and accept this aspect of my style of working and seek to capitalise on my ability to work under pressure.

8. Overall learning points

Over the course of this project, I feel that I have changed somewhat in my attitudes towards research. In particular, I have developed a greater appreciation for qualitative research methods and feel more confident in my ability to undertake qualitative research. Importantly, the project has developed my passion for research which has real clinical relevance and genuinely engages with clinical services; this is something I hope to take forward and build on in my future career. Finally, I feel I have learnt something significant about the area of looked after children's mental health generally, about the challenges that face these children and their carers, as well as the clinicians and other systems supporting them.

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APPENDICES

Appendix A: Summary of studies included in Literature Review

Study ID, 1st Author and Year	Intervention	Sampling	Methodology	Analysis/Results
1. Dozier (2009)	Attachment & Biobehavioural Catchup (Dozier et al., 2002)	46 foster carers of children aged 3-39 months, referred to project at initial placement	RCT, with Parent Attachment Diaries as outcome measure, completed at T2 only; no pre-intervention measures reported. Diaries coded for avoidant and secure attachment behaviours. Randomisation to treatment or control group (Developmental Educational Intervention).	ANOVAs applied to evaluate impact of intervention on avoidance/security. Avoidance scores significantly lower in intervention group at T2 (F(1,44)=5.02, p<.05); no significant difference in security scores.
2. Dozier (2009)	Attachment & Biobehavioural catchup	60 foster carers of children aged 3-39 months, referred to project at initial placement.	RCT, with child diurnal salivary cortisol production and Parentøs Daily Report (problem behaviour inventory) as outcome measures at T2 only; no pre-intervention measures reported.	ANOVAs applied to evaluate impact of intervention on cortisol levels and reported behaviour problems. Significantly higher cortisol levels in control vs intervention group at T2 (F(1,46)=4.55, p=.04). Significant age x intervention group interaction for behaviour problems, with lower levels at T2 for in intervention vs

				control group in toddlers, but not infants.
3. Sprang (2009)	Attachment & Biobehavioural catchup	53 foster carers of children under 6 who have history of severe maltreatment and attachment-related diagnosis. Referred after presenting for treatment.	RCT in naturalistic clinic setting. Randomisation to intervention or waiting list control group (offered biweekly support group focused on problem solving issues relating to dealing with the child welfare system). CAPI, CBCL & PSI completed pre and post intervention.	t-tests applied to compare treatment to control group at T1 and T2, and to compare variance in group scores from T1-T2. Intention to treat analysis conducted. Significantly lower T2 scores in treatment group on CAPI, CBCL and PSI and T1-T2 variance. Results replicated in intent to treat analysis.
4. Minnis (2001)	Group-based training aimed at facilitating carersø communication with child, especially in relation to early experiences and emotional needs.	121 children aged 5-16 and their foster families (all foster families in local authority invited to participate if child like to be in placement for a further year or more)	Single blind RCT with SDQ, MRS, RAD-scale and Costs of Foster Care Questionnaire completed pre and 9 months post-training. RAD-scale also completed immediately post-training. Randomisation to intervention or control group (standard services).	ANCOVA applied to compare treatment and control groups on all measures in an intention to treat analysis. No significant differences in pre and post training scores were observed on any measure.

5. MacDonald (2005)	Cognitive-behavioural group training based on social learning theory, but with explicit consideration of child's history and impact of that on current behaviour and relationship with carer	117 foster carers who responded to invitation sent to all carers in local authorities.	RCT. Carers randomised to intervention or waiting list control (standard services). KBPAC and CBCL completed pre and post training. Foster carer satisfaction questionnaire and number of unplanned placement breakdown also used as outcome measures.	ANOVA showed significant group x time interaction for KBPAC scores $(F(1,84=14.26, p<.0001)$, with significant improvement in the intervention, but not control, group at T2. No significant changes on CBCL or placement breakdowns.
6. Golding (2004)	Fostering Attachments Group Training (Golding, 2001)	7 foster carers	Mixed quantitative/qualitative evaluation. Pretest-posttest design using SDQ.	Statistical methods not reported. Quantitative results: significant reductions in total SDQ score and peer problems and hyperactivity SDQ subscales.
7. Laybourne (2008)	Fostering Attachments Group Training (Golding, 2001)	7 foster carers referred to the study due to identified placement difficulties/ attachment difficulties in	Mixed quantitative/qualitative evaluation. Pretest-posttest design using PSI-SF, SDQ, RPQ	Quantitative evaluation: t-tests applied to pre and post-training scores showed significantly reduced scores on PSI-SF (total scores and parental distress, but not difficult child subscale); no statistically significant differences in pre and post-training scores were observed on SDQ/RPQ.

		child.		Thematic analysis of interviews identified 3 main themes: õcarers developed an understanding of the issues for their foster childrenö, õpersonal growth and development and self-reported reduced stress in carersö and õcourse delivery and future trainingö.
8. Stams (2001)	Video/book-based training, providing adoptive parents with information on sensitive parenting and, in one condition, video-based feedback on the parentøs responsiveness to the childøs needs.	35 mixed adoptive/ biological families; 90 all adoptive families. All children were internationally adopted (Asian children adopted into white Dutch families) before the age of 5 months. Child was aged between 5 and 12 months at the time of the intervention	Longitudinal follow-up study of Juffer (1997), examining the effects of the attachment intervention delivered in infancy on childrenøs social development(subscales from California Child Q Set, (CCQS) School Behaviour Assessment Checklist (SCHOAL) and CBCL/Teacherøs Report Form (TRF)), personality development (CCQS) and behaviour (CBCL/TRF) aged 7. Other sources of outcome data also incorporated, e.g., subjective peer ratings of popularity.	Composite scores for personality development, social development and behaviour produced by combining various subscales of standardised measures and other sources of outcome data, e.g., popularity with peers. Mixed adoptive/biological families: significant effects of book+video feedback intervention on personality development (ego-resiliency and optimal ego-control) for girls but not boys. Significant effect of intervention on internalizing behaviour problems in boys and girls. No other significant effects. All adoptive families: No significant effects of intervention on any area of outcome.

9. Juffer (1997)	Video/book-based training, providing adoptive parents with information on sensitive parenting and, in one condition, video-based feedback on the parent's responsiveness to the child's needs.	90 adoptive families. All children were internationally adopted (Asian children adopted into white Dutch families) before the age of 5 months. Child was aged between 5 and 12 months at the time of the intervention	Pretest-posttest control group design ó families allocated to one of two intervention groups (book only or book + video feedback) or no intervention control group. Adoptive mother's sensitive responsiveness and infant exploratory competence were assessed at pre-test (infant aged 6 months) and posttest (infant aged 12 months) by video recording and subsequent coding according to predetermined criteria based on attachment principles.	MANCOVA applied to test effects of each intervention programme on maternal responsiveness: no significant effect of intervention in book only group, but significant improvement in the book + video feedback group ($F(2,56=10.31, P=.002$). Mann-Whitney tests applied to test the effects of each intervention on infant exploratory competence (contingency analysis) also revealed a significant effect in the book + video feedback group ($U(N1=19, N2=20)=118, p=.04$) but not the book only group. MANOVAs found no effect of either intervention group on infant exploratory behaviour. Log linear analyses comparing infant-mother attachment@12 months across the 3 groups found a significant association in the book+video feedback group (LR $\chi^2(1,60)=3.89, p=.049$), but not book only group.
10. Treacy (1993)	Family Life Education Program for foster parents of children who have been sexually abused. Group training aiming	All foster parents in county invited to participate. 20 carers, including 5 married couples. 52% of	Pretest-posttest design with Sexual Abuse Information Questionnaire and Sexually Abused Child Comfort Questionnaire (both constructed by authors and	ANOVAs applied to test pretest-posttest differences showed significant increases on the Sexual Abuse Information Questionnaire and Sexually Abused Child Comfort Questionnaire (not validated measures). Significant increase in PSOC scores across

	to developing carers' understanding of child's abuse history and the ongoing impact of this, and to increase parental sense of competence in caring for child.	carers reported currently caring for a sexually abused child; 33% were unsure whether they were caring for a sexually abused child at present. No control group	have not been validated), the Parental Sense of Competence Scale (PSOC, completed for each child in home) and Index of Parental Attitudes (IPA, completed for each child in home), which measures parent-child relationship problems, as outcome measures.	all children carers were parenting (biological, non sexually abused and sexually abused foster children). No significant pretest-posttest differences on IPA.
11. Barth (1994)	Psycho-educational groups for foster parents of children who have been sexually abused. Aimed increased parents' understanding of abuse and impact of this and increase skills in managing difficulties.	Sampling procedure not reported. 15 foster parents of sexually abused children (average age 9 years) and no treatment control group of 12 foster parents caring for sexually abused children.	Cohort study investigating impact of training programme on child behaviour, as measured at pretest and posttest by CBCL and Child Sexuality Inventory (CSI).	Statistical methods not reported. No significant pretest-posttest difference in overall scores on CBCL or CSI.

Appendix B: Studies excluded from literature review

Study	Reasons for exclusion
Lee & Holland (1991)	Intervention ó no attachment/trauma based component; behavioural/procedural focus
Hampson & Tavormina (1980)	Intervention ó no attachment/trauma component. Behavioural/reflective counselling focus
McNeil et al. (2005)	Intervention ó no attachment/trauma component. Behavioural intervention with parent-child interaction training.
Timmer et al. (2006)	Parent-child interaction training ó as above
Burry & Noble (2001)	Focus is educating about the effects of prenatal substance exposure ó focus is on biological rather than relational trauma
Puddy & Jackson (2003)	Behaviourally focused intervention and potential rather than current foster carers
Burry (1983)	Intervention ó lacks attachment/relational trauma focus
Fisher et al. (2000)	Treatment foster care rather than foster carer training
Clarkson & Whistlecraft (1987)	Inadequate measurement of outcomes - no validated outcome measures
Chamberlain, Moreland & Reid (1992)	Intervention ó lacks attachment/relational trauma focus. Inadequate measurement of outcomes ó no validated measures.
Linares et al. (2006)	Training of foster and biological parents jointly to facilitate co-parenting
Hill-Tout, Pithouse & Lowe (2000)	Intervention ó lacks of attachment/relational trauma focus, behavioural intervention.
Pithouse, Hill-Tout & Lowe (2002)	Intervention ó lacks of attachment/relational trauma focus, behavioural intervention
Zeanah et al. (2001)	Children still residing with birth families ó not foster parent training

Chamberlain et al. (2008)	Intervention – lack of attachment/relational trauma focus, behavioural intervention
Pallett et al. (2002)	Intervention – lack of attachment/relational trauma focus, exclusively CBT intervention
Herbert & Wookey (2007)	Intervention – lack of attachment/relational trauma focus. Inadequate measurement of outcomes – carer satisfaction only.
Zlotnick, Kronstadt & Klee (1999)	Evaluation of case management, not specific intervention with carers
Wotherspoon, O∅Neill-Laberge & Pirie (2008)	Not an evaluation of effectiveness
Nash & Flynn (2009)	Cross-sectional evaluation including a range of training packages, none of which were explicitly informed by attachment theory/trauma
Pacifi et al. (2006)	Inadequate measurement of outcomes – no validated outcome measures
Pacifi et al. (2005)	Inadequate measurement of outcomes – no validated outcome measures
Levant & Greer (1981)	Intervention – no attachment/trauma component

Appendix C: Guidelines to authors for journal targeted for literature review

Attachment & Human Development

Papers will be considered providing that they have not previously been published or submitted simultaneously elsewhere for publication.

EMPIRICAL REPORTS

1) The paper should conform to APA standards, with a legible abstract (100-150 words), followed by sections that include an introduction, method, results, and discussion.

THEORY/REVIEW PAPERS

2) The paper should make an original, testable and/or useful extension/revision to theory and previous literature concerning attachment processes and human development.

CLINICAL CASE-STUDIES

3) Authors should provide an account of previous clinical theory in an organized and up-to-date manner distinct from the clinical case material. Further, the clinical case material should occupy no more than a third of the paper. The first third should include only relevant background theory, while the final third should aim to discuss the descriptive presentation of the clinical case material against the background of existing theories and/or modifications needed to accommodate the clinical material.

ALL SUBMISSIONS should include an abstract, and ordinarily be about 6,000 words in length, not exceeding 7500 words in total, though occasionally longer papers are considered. In order to facilitate blind peer review, authors are encouraged to prepare a cover sheet that includes identifying details not included in the manuscript which will be sent out for review, less the cover sheet.

Appendix D: Ethics correspondence

Letter (i)

Study Title:	**Exploring Clinicians' Perspectives on the Impact of Psychological Interventions for Looked After Children**
REC reference number:	**09/H0402/110**
Protocol number:	**1**

The Research Ethics Committee reviewed the above application at the meeting held on 17 December 2009. Thank you for attending to discuss the study.

Documents reviewed

The documents reviewed at the meeting were:

Document	Version	Date	
Covering Letter		01 December 2009	
REC application	28391/81395/1/41	03 December 2009	
Protocol	1	18 November 2009	
Investigator CV: Chief Investigator		03 December 2009	
Investigator CV: Academic Supervisor			
Research Proposal Amendments			
Participant Information Sheet	1	18 November 2009	
Participant Consent Form: Study 1	1	18 November 2009	
Participant Consent Form: Study 2	1	18 November 2009	
Referees or other scientific critique report		30 October 2009	
Interview Schedule Study 1	1	18 November 2009	

Provisional opinion

In discussion, the Committee queried the following issues:

1. The Committee asked if you thought that there is any risk that confidentiality will be breached in the interview, for example if the clinician forgets to use the pseudonym for their patient. You agreed that it was a possibility and explained that precautions will be taken. At the beginning of the interview the ground rules will be set and the clinician asked to use a pseudonym, or just refer to the patient as 'the client'. They will also be asked not to give any identifiable information. The clinician will be asked to review the case notes before the interview. They can bring them if they want to use them for their own reference but should not show them to the researcher. The Committee suggested that the participant might be more likely to use the patients name if they are referring directly to the notes. You said that if they do slip up and use a client's name it will not be used in the transcript. You agreed that if the Committee would prefer the notes do not have to be brought to the interview.
2. The Committee asked how focus group participants will be recruited. You explained that they will be recruited in the same way as people for the interviews. She will go to team meetings and set up times, let people know and see who can attend. The information sheet is for use by both parts.
3. The Committee asked how the transcripts will be stored. You explained that the actual transcription will be done at your home. The Committee asked if the data will be password protected. You said that it could be but will not contain any identifiable data. The tapes will only be at home until they have been transcribed and after that they will be stored securely at the University.
4. The Committee asked how you will manage the situation if a participant becomes distressed. You explained that you recognise that it is a possibility but the clinician will already have talked about the case in supervision. If someone is upset she will stop the interview temporarily. You will recognise that they are upset but not try to go into details about why. You will remind the participant that they can withdraw at any point. The participant will be advised to access support thorough their supervision.
5. The Committee asked what you will do if you do not get enough responders. You explained that the research has come out of discussion with people in the service so you think that there will be interest in it. There are about 10 to 15 people in Leicestershire and about 19 in Nottinghamshire so the numbers should be possible.
6. The Committee explained that as well as having to report potential future risk to a client you would also have to report it if a clinician revealed poor practice.

The researcher left the meeting.

7. The Committee agreed that the storage of interview tapes at the researcher's home for transcription must be carefully managed. They thought that tapes should only be taken home one at a time and stored securely in a locked cupboard when not in use.

The Committee would be content to give a favourable ethical opinion of the research, subject to receiving a complete response to the request for further information set out below.

The Committee delegated authority to confirm its final opinion on the application to the Vice Chair.

Further information or clarification required

1.   A copy of the content of the email introducing the study is requested.
2.   Clinicians should not be encouraged to bring case notes into the interview.
3.   Interview tapes should only be taken to your home one at a time for transcription. They should be stored in a locked cupboard or briefcase at all times when not in use. Any data stored on a personal computer or memory stick should be password protected even if it does not include identifiable data.
4.   The Committee request the following changes to the information sheet:
a.   Under the heading 'Will information obtained in the study be confidential?' a statement should be added to explain that if poor practice is revealed the researcher would have a duty to report it.
b.   An independent contact for complaints should be included; this can either be through the Trust or University as appropriate.
c.   The reference to bringing the client file to the interview should be removed.
5.   The Committee request the following changes / amendments to the consent forms:
a.   The consent forms should be in the standard format with boxes to initial for each statement.
b.   The standard statement allowing University, Trust and Regulatory Authority access to research data must be included in case the study is audited.
c.   Statement one should be updated to refer to the new version number and date of the information sheet.

If you have any queries about the content of this letter, please contact the Co-ordinator.

When submitting your response to the Committee, please send revised documentation where appropriate underlining or otherwise highlighting the changes you have made and giving revised version numbers and dates. It would help to speed up review of your response if you would email your response as well as sending a hard copy.

The Committee will confirm the final ethical opinion within a maximum of 60 days from the date of initial receipt of the application, excluding the time taken by you to respond fully to the above points. A response should be submitted by no later than 30 April 2010.

Membership of the Committee

The members of the Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

Yours sincerely

Mr Mike Newman / Miss Jeannie D McKie

Vice Chair / Committee Coordinator

<u>**Letter (ii)**</u>

Study Title:	**Exploring Clinicians' Perspectives on the Impact of Psychological Interventions for Looked After Children**
REC reference number:	**09/H0402/110**
Protocol number:	**2**

Thank you for your letter of 13 January 2010, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Vice-Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where the only involvement of the NHS organisation is as a Participant Identification Centre, management permission for research is not required but the R&D office should be notified of the study. Guidance should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date	
Covering Letter		01 December 2009	
REC application	28391/81395/1/41	03 December 2009	
Investigator CV: Chief Investigator		03 December 2009	
Investigator CV: Academic Supervisor			
Research Proposal Amendments			
Referees or other scientific critique report		30 October 2009	
Interview Schedule Study 1	1	18 November 2009	
Interview Schedule Study 2	1	18 November 2009	

Protocol	2	08 January 2010	
Participant Information Sheet	2	08 January 2010	
Participant Consent Form: Focus Groups	2	08 January 2010	
Participant Consent Form: Individual Interviews	2	08 January 2010	
Introductory Email to Clinicians	1	08 January 2010	
Response to Request for Further Information		13 January 2010	

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:
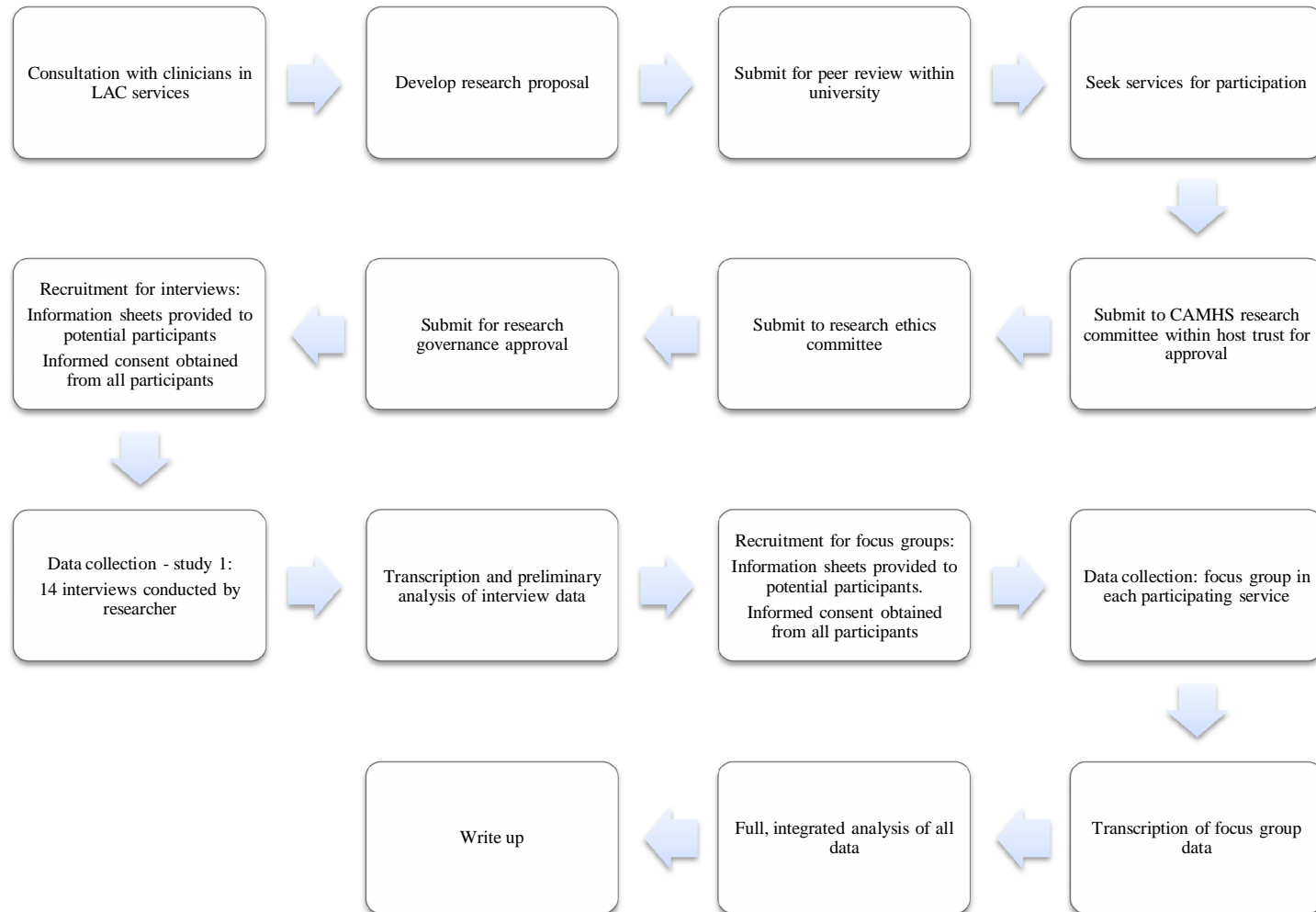
- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

Yours sincerely

Mr Mike Newman / Miss Jeannie D McKie

Vice Chair / Committee Coordinator

Appendix E: Overview of Research Process

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┌─────────────────────┐      ┌─────────────────────┐      ┌─────────────────────┐      ┌─────────────────────┐
│ Consultation with   │ ──▶  │ Develop research    │ ──▶  │ Submit for peer     │ ──▶  │ Seek services for   │
│ clinicians in       │      │ proposal            │      │ review within       │      │ participation       │
│ LAC services        │      │                     │      │ university          │      │                     │
└─────────────────────┘      └─────────────────────┘      └─────────────────────┘      └─────────────────────┘
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                                                                                                  ▼
┌─────────────────────┐      ┌─────────────────────┐      ┌─────────────────────┐      ┌─────────────────────┐
│ Recruitment for     │ ◀──  │ Submit for research │ ◀──  │ Submit to research  │ ◀──  │ Submit to CAMHS     │
│ interviews:         │      │ governance approval │      │ ethics committee    │      │ research committee  │
│ Information sheets  │      │                     │      │                     │      │ within host trust   │
│ provided to         │      │                     │      │                     │      │ for approval        │
│ potential           │      │                     │      │                     │      │                     │
│ participants        │      │                     │      │                     │      │                     │
│ Informed consent    │      │                     │      │                     │      │                     │
│ obtained from all   │      │                     │      │                     │      │                     │
│ participants        │      │                     │      │                     │      │                     │
└─────────────────────┘      └─────────────────────┘      └─────────────────────┘      └─────────────────────┘
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┌─────────────────────┐      ┌─────────────────────┐      ┌─────────────────────┐      ┌─────────────────────┐
│ Data collection -   │ ──▶  │ Transcription and   │ ──▶  │ Recruitment for     │ ──▶  │ Data collection:    │
│ study 1:            │      │ preliminary         │      │ focus groups:       │      │ focus group in      │
│ 14 interviews       │      │ analysis of         │      │ Information sheets  │      │ each participating  │
│ conducted by        │      │ interview data      │      │ provided to         │      │ service             │
│ researcher          │      │                     │      │ potential           │      │                     │
│                     │      │                     │      │ participants.       │      │                     │
│                     │      │                     │      │ Informed consent    │      │                     │
│                     │      │                     │      │ obtained from all   │      │                     │
│                     │      │                     │      │ participants        │      │                     │
└─────────────────────┘      └─────────────────────┘      └─────────────────────┘      └─────────────────────┘
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┌─────────────────────┐      ┌─────────────────────┐      ┌─────────────────────┐
│ Write up            │ ◀──  │ Full, integrated    │ ◀──  │ Transcription of    │
│                     │      │ analysis of all     │      │ focus group data    │
│                     │      │ data                │      │                     │
└─────────────────────┘      └─────────────────────┘      └─────────────────────┘
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Appendix F: Interview Schedule (Study 1)

1. Clinician details: professional role, length of time working in the service, main ways of working clinically/alliance to particular therapeutic models etc.

2. Briefly describe the client's presenting problems, their background and current social situation (prompts: current family/living situation, relevant details about client's history, birth family background etc)

3. What were the aims of the intervention? What was the nature of the intervention undertaken (e.g. therapeutic model, direct/indirect work, professionals involved, length of intervention etc)? What did you expect to change as a result of this intervention?

4. To what extent were the aims of the intervention met?

5. What kind of changes, if any, did you observe in the child during their contact with the service?

6. What kind of changes, if any, did you observe in the systems around the child as a result of their contact? (Prompt did you notice any changes in the child's relationships with people around them, their parents/carers etc).

7. What factors do you think facilitated the intervention/process of change for the child?

8. What factors do you think hindered the intervention/process of change for the child?

Appendix G: Focus group schedule (Study 2)

Ground rules will be established at the start of each focus group, including confidentiality of material discussed within the focus group, one person to speak at a time and respect for othersø views.

1. How do these themes reflect your experiences generally? Are the themes similar for other clients in the service? (Use prompts relating to specific themes)

2. Are there any points about change and outcomes for clients which you think are important and are not captured by these themes?

3. What are your views on the outcome measures currently used by the service (e.g., SDQ)? How do these fit with the themes identified from this study?

4. What do you feel are the main issues with measuring outcomes in this service?

5. What are your ideas about how to best measure outcomes in this client group?

6. How do you think the results of this study can be used to inform the measurement of outcome in this client group?

Appendix H: Participant Information Sheet

Exploring Clinicians' Perspectives on Outcomes of Psychological Interventions with

Looked After Children

Principle Investigator: Miranda Roberts   Contact Details: mjr42@le.ac.uk

What is the purpose of the study?

This study aims to explore the perspective of clinicians working in CAMHS services for Looked After Children on the process of change for clients during their contact with the service. Deeper understanding of the impact of psychological interventions on looked after children will facilitate decisions about how to measure outcomes in this client group.

Who can participate?

Clinicians from any professional background, who have worked in the service for at least 6 months and provide therapeutic or psychological interventions of some form to clients as part of their role within the service. To participate in individual interviews, clinicians must be able to select a client for discussion whose case they have closed within the last 6 weeks and they feel able to discuss in detail the outcome and process of change for this client and their family/carers.

Participants may select clients whose intervention has mainly involved indirect work with parents/carers, provided the clinician has also had sufficient contact with the child to be able to make detailed comments on the impact of the intervention on the child. As a guide, it is recommended that that the clinician has had at least 30 minutes of child-focused contact (i.e., speaking directly with the child and/or observing them in some context) during the first and last month of treatment. However, clinicians should use their own judgement as to whether they have had enough contact with the child in order to discuss the impact of the intervention on them in detail.

What will be involved if I take part in the study?

There are two parts to the study; participants may wish to take part in one or both parts.

Individual Interviews

Interviews will be conducted with individual clinicians in a private room at the team base. Participants will be asked to select a specific client to discuss and to review their file before the interview. The clinician must have undertaken psychological/therapeutic intervention of some form with the client selected and have closed their case within the last 6 weeks. Interventions which involved limited direct work with the client, but rather focused on working with parents/carers, are acceptable, provided the clinician has had sufficient contact with the child to be able to make detailed comments on the impact of the intervention on the child as well as the family. As a guide, it is recommended that that the clinician has had at least 30 minutes of child-focused contact (i.e., speaking directly with the child and/or observing them in some context) during the first and last month of treatment. However, clinicians should use their own judgement as to whether they have had enough contact with the child in order to discuss the impact of the intervention on them in detail.

  Interviews will last approximately 45 minutes and will be tape-recorded. Participants will be asked to use a pseudonym to refer to the client during the interview, in order to preserve their anonymity. Participants should also avoid providing any other information which might make it easy to identify the client, e.g., family names, names of schools or residential homes.   Interview questions will

enquire about the nature and process of the intervention undertaken with the client, and the clinician's views of the impact of this intervention.

<u>Focus Groups</u>

Participation in a focus group will involve meeting with other members of your team for a discussion about the issues and difficulties in measuring outcomes of psychological interventions with looked after children and how these can be resolved. Themes identified during individual interviews (see above) will be presented and used as the basis for the discussion. The focus group will be tape-recorded and facilitated by the researcher. It will last approximately 1 hour.

Will information obtained in the study be confidential?

Nothing that you discuss during the interview/focus group will be shared with anyone else. However, the interviews/focus groups will be tape-recorded and later transcribed. The researcher will write a report based on what people have said during interviews/focus groups; the report will include direct quotes from participants, but these are labelled only with the role of the person who said them, e.g., õpsychologist1ö. Labels will never be used where there is only one person with that role in the team as this might enable the person to be identified. In this situation, a broader identifier, reflecting a category consisting of more than one person, would be used, for example õpsychological therapistö rather than õCBT therapistö or õfamily therapistö. A summary of the research, which will include direct quotes in the same way, may be published in peer-reviewed journals. No information that will enable identification of staff, clients, or specific services will be included in reports or journal publications, or shared with anyone else in any way. The researcher will share the contents of interviews with the research supervisor as part of the data analysis process, but again this will not include information that will allow staff or clients to be identified.

The only exception to confidentiality of interviews/focus groups is in the event of disclosure which may indicate a risk of harm to a client, clinician or other person, or reveals poor clinical practice. In this situation, the researcher has a responsibility to inform someone in a suitable position of authority, usually the clinician's line manager, about these concerns. The researcher will always discuss their concerns with the participant before taking any action.

What happens if I do not wish to participate in the study or wish to withdraw from the study?

Participation is completely voluntary. There are no consequences for not participating and you can choose to do so entirely anonymously ó you do not need to contact me to indicate that you do not wish to take part. If you do agree to participate, you are free to withdraw from the study at anytime without needing to justify your decision.

Complaints

If you have a concern about any aspect of this study, you should speak to the researcher who will do their best to answer your questions (see contact details above). If you remain unhappy and wish to complain formally or discuss your concerns further, you should contact the research supervisor, Dr Marilyn Christie (Email: mc110@le.ac.uk Tel. 0116 2231639). Complaints can also be made via the Complaints Office at Leicestershire Partnership Trust (0116 225 6525) or via the Service Liaison Department in Nottinghamshire Healthcare Trust (0115 993 4542).

Appendix I: Participant Consent Form

Exploring Cliniciansø Perspectives on Outcomes of Psychological Interventions for

Looked After Children

Principle Investigator: Miranda Roberts

Please initial box

1. I confirm that I have read and understand the information sheet dated
   8/1/10 (version 2) for the above study. I have had the opportunity to
   consider the information, ask questions and have had these answered
   satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw
   at any time without giving any reason, without my professional or legal rights
   being affected.

3. I understand that the interview will be tape-recorded and the results,
   including direct anonymous quotes from participants, may be published
   in peer-reviewed journals.

4. I understand that data collected during the study may be looked at by
   individuals from Leicester University, from regulatory authorities or from the
   NHS Trust, where it is relevant to my taking part in this research.
   I give permission for these individuals to have access to my records.

5. I agree to take part in the above study

_____   _____   _____

Name of participant   Date   Signature

_____   _____   _____

Name of person taking consent   Date   Signature

Appendix J: Example of coding (extract)

Taken from QSR N6 document.

<u>Examples of coding: Interventions: individual therapy: Making sense of emotions and experiences</u>

+++ ON-LINE DOCUMENT: Interview 12
Coded
..
[Interview 12 : 109 - 118]
No, and hasn't done for kind of, 8 years. But they were still around,
she would kind of occasionally make references to them. And then we did
quite a lot of work about food and feelings, and kind of, trying to break
down some of her feelings....so one thing we did was a food diary, food
and feelings diary, so what she ate, how she was feeling, when she ate
it, which was all very kind of, can't think of the word, kind of black
and white, it was either happy or sad, there was no kind of shadings in
between, so it was then about kind of introducing different words for
feelings, and think about what might, she might be feeling, and making
suggestions that she might connect with. So it was a lot about that.
+++ ON-LINE DOCUMENT: Interview 4
coded
 [Interview 4 : 104 - 111]
Well at the very beginning, I suppose very basically, was to try and make
sense of his anger outbursts, I mean other people were labelling them
anger, so I suppose my aims were to think about is this anger and rage or
is it another emotion. Erm, and to help him to express that, and to be
able to either manage that better himself, or at least to be able to then
have a think about what do the adults around him need to do, because he
is still very little, he's only 9, so what do the adults around need to
do to help him to do that. So that was my initial aim I think.

..
[Interview 4 : 217 - 226]
help him with that, so we did some of that work with him. As part of
that, what then came out from that was, erm, some of his worries were
around memories that he had, erm and he talked a lot about, they didn't
have a ptsd feel to them, it wasn't anything that intrusive, but memories
that he had of being at home with his mum, and the violence, so he had
some kind of clear memories about that. And, when we talked about how,
because that was in his worry bag, how could we deal with that, he said
that he would like, he wanted to talk about that and think about those.
So that's what we then went on to do, was to spend some time doing that
with him really.
...
[Interview 6 : 312 - 314]
their understanding of him and the impact of his experiences, as well as
helping him to make some more sense of that so it didn't feel like a big
jumbled mess for him...and alongside that, throughout the assessment,