A Thesis Submitted in Partial Fulfilment of the Degree of Doctorate in Clinical Psychology

Volume One: Research Component

- Literature Review: How Effective are Parenting Group Programmes at Improving the Attachment Relationships of Fostered and Adopted Children in the UK?

- Empirical Paper: Evaluation of an Attachment Theory Based Parenting Programme for Adoptive Parents and Foster Carers.

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OVERVIEW

This thesis, submitted in partial fulfilment of a Clinical Psychology Doctorate, consists of two volumes. The research component of the thesis is presented in Volume One. It includes a literature review, empirical paper and executive summary.

The literature review considers how effective parenting group programmes delivered in the UK are at improving the attachment relationships of fostered and adopted children. The empirical paper presents an evaluation of such a programme, the 'Fostering Attachments' programme for adoptive parents and foster carers. An executive summary of the evaluation is presented in the public domain paper.

The clinical component is presented in Volume Two. The first two clinical practice reports present work completed as part of learning difficulties placement. The models formulation report presents an assessment of a lady who was anxious about travelling alone on the bus. Two psychological formulations are detailed, one from a cognitive behavioural (CB) and one from a systemic perspective. The Service Evaluation presents an investigation of the extent to which local services meet the needs of carers who have learning difficulties. Information was gathered from interviews with key members of local statutory and private health and social care organisations. The themes of the interviews were considered with reference to national directives regarding service provision and a model of organisational change.

The third clinical practice report describes an AB single case experimental design of a CB intervention for low self-esteem provided to a man with psychosis, residing at a probation hostel.

The final reports present work completed as part of placements within children's services. The case study considers the assessment of a child presenting with generalised anxiety. The volume concludes with the abstract of a case study describing consultation and supervision provided to a foster carer who looked after a child with attachment difficulties.

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LITERATURE REVIEW:

How Effective are Parenting Group Programmes at Improving the Attachment Relationships of Fostered and Adopted Children in the UK?

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How Effective are Parenting Group Programmes at Improving the Attachment Relationships of Fostered and Adopted Children in the UK?

ABSTRACT

The review examines the efficacy of parenting group programmes for foster and adoptive parents at improving the attachment relationships of the children they care for. Evaluations of such programmes were selected for review if they met the following inclusion criteria: that they evaluated programmes delivered in the UK, were published in peer reviewed journals subsequent to 2000, and reported quantitative outcome data that had not been previously published. Ten such publications were identified. To evaluate the validity of the evaluations' findings, methodological quality was rated according to the National Institute for Health and Clinical Excellence's (2009) quality appraisal checklist for quantitative intervention studies.

The publications consistently reported that carers were highly satisfied with the programmes. The programmes' provision of parenting advice, peer support and a framework of understanding that empowers carers has substantial face validity as an intervention for foster and adoptive families. However, the majority of the evaluations were of a low methodological quality, as rated according to NICE (2009)'s quality appraisal checklist. The programmes were consequently classified as innovative or novel treatments, according to Saunders, Berline and Hanson's (2004) Treatment Classification Criteria.

It is concluded that the quality of the evidence base is currently too limited to make conclusions regarding the programmes' efficacy. It is recommended that future clinical and academic work develops the evidence base in order to address the significant gaps in our

knowledge regarding if and how parenting group programmes for adoptive and foster carers can improve children's attachment relationships.

1. INTRODUCTION

Approximately 60,000 children in England are looked after by the state because it is not safe for them to live with their birth parents, just over 3000 of whom are adopted each year (Department for Education and Skills [DfES], 2008). These children are likely to have suffered separations from their parents and subsequent carers, as well as other adverse and traumatic experiences (Rushton, Mayes, Dance & Quinton, 2003) and are consequently at greater risk than children in the general population of developing mental health and educational difficulties, and poor outcomes in terms of employment and criminality (e.g. Ford, Vostanis, Meltzer & Goodman, 2007; Quinton, Rushton, Dance & Mayes, 1998). The attachment relationships of fostered and adopted children are thought to be key to their emotional and behavioural development and to underpin their vulnerability to poor psychosocial outcomes (e.g. Golding, 2008; Howe & Fearnley, 2003). Several group parenting programmes have been developed aiming to improve the attachment relationships of fostered and adopted children. This review will focus on the efficacy of such programmes.

1.1. The importance of the attachment relationship

The attachment relationship between parent and child is considered integral to children's emotional and behavioural functioning (Golding, 2006; Tarabulsy at al., 2008). It is the foundation from which we develop our understanding of ourselves, others, and the nature of relationships in general. A positive and secure attachment experience in early childhood is believed to promote resiliency and wellbeing through the lifespan (Weinfield, Sroufe, & Egeland, 2000).

A secure attachment relationship is one where the primary caregiver provides a safe base for the child to explore and learn about the world (e.g. Bowlby, 1982). *S*ensitive, responsive, predictable and coherent caregiving is thought to facilitate such a relationship (e.g. Bowlby, 1982). Sensitive caregiving promotes co-regulation of the child's emotions and behaviours by modulating their high arousal states and providing stimulation during their low arousal (Schore, 1994). This helps the child develop the skills to self-regulate (Howe, 2005; Tarabulsy et al., 2008). Research suggests that within a secure attachment relationship a child receives intimate attuned interactions, such as eye contact, which stimulates brain development (Wassell, 2008). The neural-networks of the orbito-frontal cortex, which support emotional regulation (Locke Welborn, Papademetris, Reis, Rajeevan, Bloise & Gray, 2009) are particularly sensitive to such stimulation (Wassell, 2008). Consequently such interactions further facilitate the development of self-regulatory skills (Schore, 2001). The attachment relationship is believed to influence cognitive development by setting down an 'Internal Working Model' (IWM), or blueprint of the carer-child relationship (Bowlby, 1982). The IWM influences the child's understanding and expectations of themselves, others and future relationships (e.g. Bowlby, 1982; Golding, 2004, 2006). For example, a child within a secure attachment relationship is likely to develop a positive and integrated view of themselves and others, with a capacity to recognise and manage their needs and emotions, and to perceive relationships as a source of comfort and support (e.g. Hazan & Shaver, 1987; Feeney, Noller, & Callan, 1994; Mikulincer, 1995).

Factors which reduce the sensitivity, responsivity, predictability and coherence of the child's care are hypothesised to reduce the security of their attachment relationships and consequently disrupt development (Bowlby, 1982). For example, a carer whose emotional

availability is regularly compromised or inconsistent may provide limited opportunities for their child to engage in healthy dyadic behaviours that facilitate positive growth and development (Cairns, 2002; Schore, 2003). To encourage their carer to continue to tolerate and attend to them, the child might reduce their demands on their carer by suppressing and minimising their emotions and needs, and so develop an insecure-avoidant attachment style (e.g. Main, 1990; Mikulincer & Shaver, 2003; Mikulincer, Shaver, Bar-On & Ein-Dor, 2010). In comparison, an insecure-ambivalently attached child might maximise displays of emotion to ensure their needs receive their carers' attention (e.g. Main, 1990; Mikulincer & Shaver, 2003; Mikulincer et al., 2010). Such attachment relationships are likely to affect a child's cognitive, physiological, behavioural and emotional development (Golding, 2006), and increase their risk of anxiety, depressive and disruptive behaviour disorders (e.g. Graham & Easterbrooks, 2000; Greenberg, Speltz, DeKlyen, & Endriga, 1991; Warren, Huston, Egeland, & Sroufe, 1997).

Children who experienced abusive and/or frightening care may perceive their carer as frightening or frightened, rather than as a secure base, which leads to the development of a disorganized and disorientated attachment relationship style (Main & Soloman, 1986). These children are hypothesised to develop an equally incoherent sense of self and others, and relationship patterns characterised by mistrust and lack of attunement (e.g. Green & Goldwyn, 2002). This is reflected in their disorganised behaviours which consist of contradictory behaviours appearing to both approach and avoid their carer (Main & Soloman, 1986). For example, a child might move towards their carer whilst simultaneously avoiding eye contact or physically freezing (e.g. Main & Soloman, 1986). Such children are at risk of developing strategies to increase their sense of safety which are unhelpful for future relationships. For

example, a child who has been physically abused by their carer might cope with feelings of fear and helplessness by seeking to control their environment (Golding, 2006). This could result in challenging behaviour which might elicit negative reactions in others and perpetuate patterns of disrupted relationships. Those with disorganised attachment relational patterns are more likely to develop internalising and externalising problems, poor social adjustment and low self-esteem (Solomon, George, & DeJong, 1995; Verschueren & Marcoen, 1999).

1.2. The attachment relationships of fostered and adopted children

Fostered and adopted children experience disruptions to their attachment relationships, including separation from birth parents and subsequent carers. Sixty-two percent of fostered children have experienced abuse and neglect (Department of Health [DoH], 2002), which further disrupts children's attachment relationships and consequently their physical, emotional, social and intellectual development (Golding, 2006). Foster children are more likely than children in the general population to develop attachment, emotional and behavioural difficulties, to be cautioned or convicted and receive a poor education (e.g. DfES, 2007; Fernandez, 2008; Ford et al., 2007; McCann, James, Wilson & Dunn, 1996; Lavigne et al., 1998; Minnis & Del Priore, 2001;). Similarly, the Maudsley Adoption and Fostering study found that over 50% of their sample of children placed late into adoption had emotional and behavioural difficulties (Quinton, et al., 1998). Such difficulties can challenge carers, increase the risk that they feel unable to cope with the child's difficulties, and consequently the risk of placement breakdown. Placement instability further exacerbates existing attachment difficulties (Leathers, 2002; Rostill-Brookes, Larkin, Toms & Churchman, 2011; Schwartz, Ortega & Guo, 1994; Unrau, Seita, & Putney, 2008) and is associated with poor outcomes in socio-emotional development, mental health, education, employment, social relationships and

criminality (e.g. Biehal, Clayden, Stein, & Wade, 1995; Lewis, Dozier, Ackerman, & Sepulveda-Kozakowski, 2007; Ryan, & Testa, 2005; Webster, Barth & Needell, 2000).

1.3. Parenting programmes as an intervention to improve attachment relationships

It is recommended that foster carers receive training to deliver the nurturing and supportive parenting considered integral to providing stability and promoting resilience for fostered children (DfES, 2007). The National Institute for Health and Clinical Excellence (NICE) recommend training which ensures carers "have a high level of understanding of attachment theory, and the impact of trauma and loss on child development and the forming of attachments" and for carers to be "skilled . . . at parent–child interactions" (2010, p.36). NICE suggest that such interventions could facilitate attachment and help fostered children to feel "safe, valued and protected" (2010, p.11). Interventions aiming to do this "are based upon the idea that children can be helped to recover from early traumatic parenting experiences, often by providing them with the experience missed in infancy of a reliable and sensitive long-term relationship with a parent or carer" (Golding, 2006, p. 25). Examples include individual therapeutic work with the child and/or carer, and parenting programmes delivered in groups, home visits or video-feedback (e.g. Allen & Vostanis, 2005; Dorsey, et al., 2008; Gilkes & Klimes, 2003; Golding, 2003).

Programmes for foster and adoptive carers can be defined as education or training that provides carers with information and skills (Turner, MacDonald & Dennis, 2007) to help them parent "children who have experienced extraordinary and often turbulent childhoods" (Lowe & Murch, 1999, p. 436). The aim of these programmes is to illuminate the 'meaning' of children's behaviours for carers (Gilkes and Klimes, 2003; Golding & Picken, 2004;

Rushton et al., 2006) so that they can better understand and manage children's behaviours (Holmes & Silver, 2010). Programmes typically seek to achieve this by sharing a theoretical framework through psycho-education. The group format gives carers the opportunity to discuss, share and reflect on the application of the theory to specific situations (Golding, 2006). The group format also facilitates carers' access to peer support, and has attractive resource efficiency benefits (Golding, 2006), which are in line with NICE's (2010) recommendations for cost-effective programmes.

There has been no review of the efficacy of foster and adoptive parent group programmes aiming to improve children's attachment relationships in the UK. An overview and synthesis of existing evaluations of the efficacy of programmes for adoptive and foster carers would enhance the information available to health and social care services. This could support services' decisions regarding which programme to provide to facilitate healthy attachment relationships and reduce costs for ongoing health and social care support, as advised by NICE (2010). This review consequently aims to examine the efficacy of parent group programmes for foster and adoptive parents which aim to improve the attachment relationships of the children they care for.

The review will consider interventions for both foster and adoptive parents because both care for children who have experienced disrupted attachment relationships, and are consequently likely to face similar parenting challenges (K. Golding, personal communication, April 20, 2011) and could find similar interventions effective.

2. METHOD

2.1. Search strategy

Eight databases were searched utilising terms synonymous with foster or adopt, child or carer and training. Searches were limited to peer reviewed journals published subsequent to 2000 in the UK reporting quantitative outcome data.

The search retrieved a total of 7012 papers, including duplications (see Appendix 1 for full search details). To ensure all relevant studies were identified, key researchers (Appendix 2), the internet forum of the National Network of Clinical Psychologists working with Looked-After and Adopted Children (CPLAAC)[a] and bibliographies of key studies were consulted. Titles, and where necessary, abstracts and full papers were read to apply the following inclusion and exclusion criteria

Inclusion Criteria

- Evaluations of group parenting programmes for adoptive or foster carers aiming to improve the children's attachment relationships. This criterion was met if the authors explicitly stated this aim, or the programmes were based on, or the curriculum included attachment theory.
- Programmes for all types of foster carers including kinship carers[b] and those with special guardianship orders[c].

[a] The CPLAAC network consists of clinical psychologists and other professionals working with fostered and adopted children. They host an internet forum to facilitate discussion and sharing of resources (British Psychological Society, 2011).

[b] Kinship carers are friends or family members who look after children "who are placed . . . . by social work in circumstances where they would otherwise be accommodated in local authority care" (Aldgate & MacIntosh, 2006, p. 13).

c A carer with a Special Guardianship Order has responsibility for the daily care of a child, and parental responsibility which can be exercised to the exclusion of any others with parental responsibility, unless it affects

Exclusion Criteria

- Multi component programmes (which might include other support) to limit the number of confounding variables when comparing the findings of the different studies.
- Programmes primarily for professionals or residential home staff, as the context and relationships were considered qualitatively different to that of a foster carer or adoptive parent[a].
- Data presented is included in a later publication.

decisions legally requiring the consent of all those with parental responsibility, or the rights of birth parents in relation to the child's adoption (Her Majesty's Court Service [HMCS], 2006).

a For example, a child in a residential placement might be cared for by a team of staff, employed permanently, temporarily or by an agency, who work on a shift rota. This differs from an adoptive or foster placement where the child's care would be more reflective of the typical family household, with perhaps one or two carers who live with the child at all times.

3. RESULTS

Ten papers were identified (see Appendix 3). To evaluate the validity of the studies' findings, methodological quality was rated according to NICE's (2009) quality appraisal checklist for quantitative programme studies (see Appendix 4) which was designed to inform the development of NICE public health guidance. The quality ratings were utilised to evaluate the evidence the studies provide for the efficacy of group programmes aiming to improve the attachment relationship. The efficacy of the programmes was classified according to Saunders, Berline and Hanson's (2004) Treatment Classification Criteria. The criteria were originally designed to guide clinicians' judgements regarding the appropriateness and efficacy of interventions for children and families who have experienced abuse. The criteria have since been applied to interventions for foster families (Craven & Lee, 2010).

4. METHODOLOGICAL QUALITY

According to NICE's (2009) quality rating checklist (see Table 1), all but one study received the 'negative' rating given when few checklist criteria are fulfilled. According to the criteria, a negative rating indicates the study's findings are limited in their generalisability from the sample to the study's source population, and that the study is subject to biases that are likely to make any estimates of a programme's effect inaccurate. Minnis and colleagues' study (2001) received a 'single positive' rating which indicates that some of the quality appraisal checklist criteria were fulfilled, and it was considered likely that conclusions will not alter.

The main reason for many of the evaluation's low quality ratings was the lack of comparison groups. Further common methodological limitations included unblinded assessors, considerable attrition rates without employing intention to treat analyses, lack of treatment fidelity assessment and a reliance on subjective outcome assessments. Increasing the quality, range and relevance of outcomes could also have been improved by focusing further on attachment relationship measures, or outcomes related to the service providing the programme, such as placement breakdown or the economic costs and benefits of the programme. In addition, the insufficiently detailed descriptions of the source population, recruitment and inclusion and exclusion criteria reduced the generalisability of findings.

The studies' strengths which supported their findings' internal and external validity included their delivery as part of existing service provision, which increased generalisability of findings to current health and social care. Most studies comprehensively detailed each programme's curriculum, delivery and methods, included at least one assessment with established reliability and validity and utilised appropriate analyses.

The mostly low ratings of the evaluations reduce confidence in the validity and generalisability of their findings. The evidence provided by the studies for the efficacy of the programmes will be reviewed with reference to the quality ratings. This will then inform the classification of the programmes according to the Treatment Classifications Criteria.

Table 1

Ratings according to NICE's (2009) Quality rating checklist for quantitative intervention studies

		1. Golding & Picken (2004).[a]	**2. Gurney smith et al., (2010)**	**3. Herbert & Wookey (2007)**	**4. Holmes & Silver (2010)**	**5. Laybourne et al., (2008)**	**6. MacDonald & Turner (2005)**	**7. Minnis et al., (2001)**	**8. Robson & Briant, (2009)**	**9. Selwyn et al., (2009).[b]**	**10. Warman et al., (2006)**
1.Population	Source population well described	+	+	+	-	-	NR	+	-	+	-
	Eligible population representative of source	NR	-	-	-	-	+	-	-	+	+
	Participants representative eligible population	NR	-	-	-	+	+	++	NR	-	+
2.Method of Allocation	Allocation to group (i.e. randomised?)	n/a	n/a	++	n/a	n/a	++	++	n/a	-	n/a
	Well described programme	++	++	+	+	++	++	++	-	+	+
	Concealed allocation	n/a	n/a	++	n/a	n/a	++	NR	n/a	n/a	n/a
	Blind assessors	-	-	-	-	-	-	+	-	-	-
	Adequate exposure to treatment	-	-	-	-	-	-	-	-	-	-
	Low contamination between groups	n/a	n/a	+	n/a	n/a	++	++	n/a	++	n/a
	Additional programmes similar across groups	n/a	n/a	+	n/a	n/a	+	+	n/a	+ +	n/a
	Participants accounted for at conclusion	-	++	-	+	-	-	-	NR	-	NR
	Setting reflects usual practice	++	++	++	++	++	++	++	++	++	++
	Programme reflects UK practice	++	++	++	++	++	++	++	++	++	++
3.Outcomes	Reliable outcome measures	+	+	+	+	+	++	+	-	+	+
	Outcomes completed	-	++	-	-	-	-	+	NR	-	++
	All outcomes assessed	-	+	+	+	+	+	+	-	+	+ +
	Relevant outcomes	+	++	++	+	++	++	+	+	+	++
	Similar follow-up times across groups	n/a	n/a	n/a	n/a	n/a	++	++	n/a	++	n/a
	Meaningful follow-up time	-	+	n/a	-	–	+	++	-	-	-

4.Analyses	Group similarity at baseline	n/a	n/a	-	n/a	n/a	+	++	n/a	++	n/a
	Intention to treat analysis	-	-	-	-	-	-	++	NR	-	NR
	Sufficiently powered sample	-	-	++	-	-	++	+ +	-	-	++
	Effect size given	++	++	-	+	++	++	n/a	n/a	++	++
	Appropriate analysis	++	++	NR	++	++	+	++	++	++	++
	Precision of programme effects given	+	+	-	+	+	+	++	n/a	+	+
Internal Validity	Total +	13	20	17	13	15	28	31	7	21	19
	Total -	8	4	8	6	7	5	2	7	8	3
	Summary rating for internal validity	-	-	-	-	-	-	-	-	-	-
External Validity	Total +	1	1	1	0	1	2	3	0	2	2
	Total -	0	2	2	3	2	0	1	2	1	1
	Summary rating for external validity	-	-	-	-	-	-	+	-	-	-

Note: Scores base on NICE guidelines (2009) outlined below

Checklist Criteria

++ = The study has been designed / carried out in a way that minimises the risk of bias, with regards to this specific checklist criterion.

+ = Either the study did not address all potential sources of bias for this specific checklist criterion, or its fulfilment of the criterion was not clearly detailed in the report.

− = Significant sources of bias may persist, with regards to these specific checklist criteria.

NR = Not Reported.

n/a = Not applicable

Internal / External Validity

++ = All / most of the checklist criteria were fulfilled. Where they were not fulfilled, the conclusions are considered very unlikely to alter.

+ = Some of the checklist criteria were fulfilled. Where they were not fulfilled / not adequately described, the conclusions are considered unlikely to alter.

− = Few / no checklist criteria were fulfilled. Conclusions are considered likely / very likely to alter.

[a]Golding and Picken (2004) evaluated two programmes, one of which aimed to improve the attachment relationship and one which did not. Consequently only details related to the programme aiming to improve the attachment relationship were considered within the review.

[b]Selwyn and colleagues (2009) detailed the findings of both a retrospective and prospective evaluations. The reviewer focused on the prospective study, as this was considered to be of higher quality.

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5. DESCRIPTIVE SUMMARY

The ten selected studies varied in style and quality of methodology, theoretical approach, and delivery of programme, outcomes and key findings. Key characteristics are summarised below (see Table 2, and see Appendix 5 for more detailed Tables). Following the descriptive summary, the implications of these characteristics when establishing the efficacy of group programmes aiming to improve children's attachment relationship will be considered[a].

5.1. Methodology

Most studies were non-comparative. The exceptions were four control trials, three of which were randomised and one where assessors were blind (3, 6, 7, 9). The comparison groups received treatment as usual, two of which were waiting-list control groups. The majority of studies assessed participants before and immediately after the programme. Only three studies reported follow up data after this point, at three (2), six (6) or nine months (7).

Most studies recruited foster carers; three included adoptive carers (2, 4, 8) and one included only adoptive carers (9). The type of foster carers included was rarely detailed; MacDonald and Turner (2005) reported excluding respite carers[b], Holmes and Silver (2010) included therapeutic[c] and kinship carers, and Gurney-Smith and colleagues (2011) included a carer with a special guardianship order.

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[a] For concise reading, the reviewed studies will be numerically cited throughout the remainder of the review: 1 = Golding and Picken (2004), 2 = Gurney-Smith and colleagues, (2010), 3 = Herbert and Wookey (2007), 4 = Holmes and Silver (2010), 5 = Laybourne and colleagues (2008), 6 = MacDonald and Turner (2005), 7 = Minnis and colleagues (2001), 8 = Robson and Briant (2009), 9 = Selwyn and colleagues (2009) and 10 = Warman and colleagues (2006).

[b] Respite foster carers provide brief, temporary care for children to give the regular carer and / or the child a short break from the existing care arrangement.

[c] Therapeutic foster carers are trained to deliver specialist therapeutic interventions within their homes. They typically receive more training, supervision and support than typical foster carers, and often have only one child placed with them at a time (Shepperd et al., 2007).

5.2. Group Programmes

All programmes emphasised the importance of attachment relationships when caring for fostered and adopted children, and sought to improve this by increasing carers' understanding of children's attachment needs. Most emphasised the importance of collaboration between participants and facilitators, and utilised curriculums influenced by numerous theories.

The programmes also varied greatly. Three studies evaluated Golding (2006)'s 'Fostering Attachments' programme (1, 2, 5) which aims to support carers by increasing their confidence, understanding and skills when caring for children with attachment difficulties Golding (2006). Similar to the other programmes, it includes psycho-educational components, group discussions and interactive exercises. The curriculum is based on attachment and social learning (SL) theories to help carers link their child's past experiences with current behaviours and explore different ways of parenting that take into account children's attachment needs (Golding, 2008). The manual also presents Golding's (2006) House model of therapeutic parenting. This was the lengthiest programme, consisting of 18 sessions. In comparison, Minnis and colleagues' (2001) and MacDonald and Turner's (2005) programmes were considerably briefer, lasting three to five sessions.

The other programmes differed in their aims and theoretical basis. For example, Holmes and Silver's (2010) 'Managing Behaviour with Attachment in Mind' programme also focused on attachment and SL theories, but additionally incorporated narrative approaches (4). In contrast to the 'Fostering Attachments' programme a fundamental focus was the management of children's behaviour. Their programme consisted of attachment theory, examples of

behaviour management techniques, relaxation techniques and information for schools (4). Similar to Golding (2006), the programme focused on developing attachment relationships by increasing carers' empathy and attunement with the child, supporting carers to develop formulations of their child and reflecting on how their behaviours affect attachment formation (4).

Three other programmes also focused on improving the carer-child relationship by supporting carers to manage children's difficult behaviours, but based their curriculum on cognitive behavioural (CB) as well as attachment and SL theories. For example, Warman and colleagues (2006) evaluated the 'Fostering Changes Programme', which included psycho-educational sessions looking at positive and negative reinforcement and setting clear boundaries, while supporting carers to keep the attachment needs in mind and reflect on their own beliefs and feelings. The 'Child-Wise programme' evaluated by Herbert & Wookey (2007) and the programme evaluated by MacDonald and Turner (2005) also used CB ideas in their curriculum, teaching carers to consider the antecedents and consequences of children's behaviours, while emphasising the importance of attending to the attachment relationship during this process.

Minnis and colleagues' (2001) programme was based on the Save the Children Manual 'Communication with children: Helping children in distress' (Richman, 1993) on the assumption that improving carers' and children's communication could strengthen their attachment relationships. Carers are taught how children communicate through behaviours, the links between communication and emotions and how to support children. Robson and Briant (2009) cited its primary aim as increasing carers' understanding and knowledge to help

carers' formulate their child's difficulties and develop corresponding strategies, techniques and skills. Their varied curriculum included improving emotional literacy by modelling emotional expression and reflective listening, attachment theory, an introduction to local services, supporting survivors of abuse, child-directed play and formulation of their child's difficulties. Selwyn and colleagues' (2009) evaluated 'It's a Piece of Cake', the nationally delivered programme for adoptive parents. Its curriculum included attachment issues while focusing on affirming and increasing adopters' confidence in their existing parenting methods and encouraging self-care. The authors explain that increasing carers' confidence and self-care helps them manage challenging behaviour and conflict by reducing tension in the home and breaking unhelpful cycles of blame and guilt within the family, which in turn improve the carer-child relationship. Selwyn and colleagues (2009) were not alone in emphasising the importance of self-care in their programmes, indeed all of the programmes described including teaching and discussions regarding this, apart from those evaluated by Minnis and colleagues (2001) and MacDonald and Turner (2005).

5.3. Outcome Assessments

Most evaluations included multiple outcomes which were predominantly carer-report assessments. A wide range of variables were assessed: Almost all considered children's emotional and behavioural function, but only half assessed children's attachment relationship or style (1, 2, 5, 7, 9). Most assessed outcomes related to carers' wellbeing or experience. For example, half the studies included assessments of carers' wellbeing (2, 4, 5, 9, 10), four considered carers confidence and sense of competence in their care of and relationship with the child (1, 2, 4, 5), and four assessed changes in carers' understanding, knowledge and parenting strategies (2, 3, 6, 9). All but one (10) gathered feedback from carers on the

acceptability of programmes and reported high participant satisfaction levels. Three studies provided quantitative data to support this (1, 4, 8). Four studies considered the impact of the programme on providing services, considering quantitative variables such as the economics of foster care or placement stability (3, 6, 7) or gathering qualitative feedback from service providers who had purchased the programme (9).

As will be discussed in more detail later in the review, most studies reported a mixture of significant and non-significant differences between baseline and post programme outcome assessments, and relative to any control group. None reported significant deterioration on any outcomes following a programme. The implications of the summarised characteristics of the reviewed studies for establishing the efficacy of group programmes which aimed to improve children's attachment relationships will now be considered.

Table 2
Summary of Reviewed Studies

	1.Golding & Picken, (2004)	**2.Gurney-Smith et al., (2011)**	**3.Herbert & Wookey, (2007)**	**4.Holmes & Silver, (2010)**	**5.Laybourne et al., (2008)**	**6.MacDonald & Turner, (2005)**	**7.Minnis et al., (2001)**	**8.Robson & Briant, (2009)**	**9.Selwyn et al., (2009)**	**10.Warman et al., (2006)**
Design	Non-comparative	Non-comparative	Unblinded RCT	Non-comparative	Non-comparative	Unblinded RCT	Single blinded RCT	Non-comparative	unblinded RCT	Non-comparative
Control group type			Waiting-list			Waiting-list	Treatment as usual		Treatment as usual	
Assessment	-Pre -Post	-Pre -Post -3 mnth post	-Pre -Post	-Pre -Post	-Pre -Post	-Pre -Post -6 mnth post	-Pre -Post -9 mnth post	-Post	-Pre -Post	-Pre -Post
Sample size & type	6 foster carers	13 foster & adoptive carers	117 foster carers	(i)14 (ii)22-27 foster & adoptive carers	7 foster carers	117 foster carers	160 foster carers 182 children	28 foster & adoptive carers	35 adoptive parents	87 foster carers
Theoretical basis of group programme	attachment & SL theories.	attachment & SL theories	CB, SL & attachment theories.	attachment, SL and narrative theories.	attachment & SL theories.	CB, SLT & Consideration of individual relationships & attachment history	NR	Not explicitly reported - family attachment narrative, CB, Trans-actional analysis, SLT	NR	CB, SL & attachment theories.
Group schedule	45h (18 x 2.5h)	45h (18x2.5h)	20-25h (5 x 5h + 1h)	Total hrs NR 7 sessions	48h (16 x 3h)	15-20h (5x3h/4x5h)	18 h (3 x 6h)	28h (4 x full day)	30h (6 x 5h)	30 h (10 x 3h)

Table 2 (continued)

	1.Golding & Picken, (2004)	**2.Gurney-Smith et al., (2011)**	**3.Herbert & Wookey, (2007)**	**4.Holmes & Silver, (2010)**	**5.Laybourne et al., (2008)**	**6.MacDonald & Turner, (2005)**	**7.Minnis et al., (2001)**	**8.Robson & Briant, (2009)**	**9.Selwyn et al., (2009)**	**10.Warman et al., (2006)**
Outcome measures	-SDQ -CQ -Pen Portrait & Symptom checklist	-SDQ -PSI/SF -CQ -Satisfaction -MM -EFRQ	-CBCL -Satisfaction -KBPAC -Course Task -Evaluation -Unplanned placement breakdown	(i)- PSI/SF - MBAM (ii) -CQ -MBAM	-SDQ -PSI/SF -CQ -RPQ	-CBCL -Satisfaction -KBPAC -Placement breakdowns	-SDQ -RADS -RSE -Costs of foster care	-Helpfulness	-SDQ -EFRQ -GHQ -Management strategies	-SDQ -PSI -Concerns about my child scale
Statistically significant improvements in treatment group, relative to baseline / control **or** **Findings supportive of the programme**	Satisfaction -SDQs (peer difficulties, hyperactivity & total) -CQ (Child's problems & combined score)	Satisfaction -SDQ total (post-3mnth) -Hyper-activity subscale (pre-3mnth) -CQ's PSU & CRC (pre-post-3 mnth) -PB 1 & 2 MM- carer focused (pre-3mnth) -EFRQs disinhibition subscale (post-3mnth)	-Satisfaction -Confidence in managing children's behaviour, belief in efficacy of group at improving children's behaviour.	-PSI/SF (difficult child & total stress) -CQ (8 of 12 items)	PSI/SF (Parenting distress & total)	Satisfaction		-High helpfulness ratings	Confidence in managing behaviour. over time	-SDQ (emotional problems & total difficulties) -PSI/SF (carer distress, difficult child & total stress) -Concerns about my child scale,

Table 2 (continued)

	1.Golding & Picken, (2004)	2.Gurney-Smith et al., (2011)	3.Herbert & Wookey, (2007)	4.Holmes & Silver, (2010)	5.Laybourne et al., (2008)	6.MacDonald & Turner, (2005)	7.Minnis et al., (2001)	8.Robson & Briant, (2009)	9.Selwyn et al., (2009)	10.Warman et al., (2006)
Non-significant improvement in Treatment Group, relative to baseline / control Findings which don't support the programme	SDQ's remaining scales Pen portrait & symptom checklist	-SDQ total & remaining subscales(pre-post) -PSI/SF -EFRQ -CQs PCR & PB 3 -MM remaining aspects	CBCL Number of unplanned placements KBPAC	CQ remaining items	SDQ PSI/SF(child RPQ CQ	CBCL Number of unplanned placements KBPAC	SDQ Costs of foster care. RAD (pre-follow-up) Self-esteem		SDQ Management of Behaviours EFRQ	SDQ (conduct / hyperactivity / peer problems / pro-social behaviour) PSI/SF (difficult interaction)

Note: Strengths and Difficulties Questionnaire (SDQ); Reactive Attachment Disorder Scale (RADS); Relationship Problems Questionnaire (RPQ); Expression of Feelings in Relationships Questionnaire (EFRQ); Rosenberg Self-Esteem Questionnaire (RSE); Carer Questionnaire (CQ); Child Responsiveness to Care subscale of the CQ (CRC); Parental Skills and Understanding subscale of the CQ (PSU); Parent-Child Relationship subscale of the CQ (PCR); Child Behavioural Checklist (CBCL); Parenting Stress Index / Short Form (PSI/SF); General Health Questionnaire (GHQ); Managing Behaviour with Attachment in Mind (MBAM); Mind-Mindedness interview (MM); Knowledge of Behavioural Principles as Applied to Children (KBPAC);
Selwyn and colleagues' (2009) findings regarding the GHQ were not clearly reported, and so are not detailed here.

6. HOW EFFECTIVE ARE PARENTING GROUP PROGRAMMES AT IMPROVING FOSTERED AND ADOPTED CHILDREN'S ATTACHMENT RELATIONSHIPS?

To consider how effective parenting group programmes are at improving fostered and adopted children's attachment relationships, the outcome assessments of attachment relationships are considered. Several studies did not directly assess this. Consequently, related 'indirect outcomes' will be considered to establish if they can further inform our understanding of parenting group programmes' efficacy.

6.1. Attachment Related Outcomes

Five studies assessed carers' perceptions of children's attachment using varying methodology (1, 2, 5, 7, 9). These included Golding and Picken's (2004) 'Pen Portrait and Symptom Checklist' which asks carers to read descriptions of attachment styles and rate the presence of behaviours with respect to their child. Two brief 17-18 item questionnaires assessing Reactive Attachment Disorder symptoms were also used; the Reactive Attachment Disorder Scale ([RADS]; Minnis, Rabe-Hesketh & Wolkind, 2002) and its subsequent version, the Relationships Problem Questionnaire ([RPQ]; Minnis, et al., 2007). Two studies (2, 9) utilised the Expression of Feelings in Relationships Questionnaire ([EFRQ]; Quinton et al., 1998) which assesses how children relate emotionally to carers. It is scored according to three subscales reflecting attachment difficulties; disinhibition, inhibition and dysregulation. Most studies' results suggested post-programme improvements in aspects of children's attachment relationships which did not reach statistical significance (1, 2, 5, 7). Another study found no signs of improvement, scores being stable over time in both the experimental and control group (9). These findings suggest the programmes were ineffective at improving children's attachment relationships.

It could be hypothesised that the time span of the assessment period utilised by the studies was too short to observe changes in the outcomes: Three studies did not conduct follow-up assessments after the programme. The possible mechanisms for change by which a parenting group might influence the attachment relationship appear lengthy, involving multiple variables. It seems unlikely that the outcome measures would change significantly during and immediately post programme, but might change in the period following the programme. Attachment theorists suggests that developing carers' perception and understanding of their relationship with their child, as the parenting groups aimed to, could improve carers' ability to perceive and understand their child's emotional cues, and so respond more sensitively (e.g. Fonagy, Steele & Steele, 1991; Robinson, Emde & Korfmacher, 1997; Suchman, DeCoste, Castiglioni, Legow & Mayes, 2008). This is hypothesised to lead to improvements in carers' responsivity, and, consequently, the likelihood of children expressing emotional distress, which increases carers' opportunities to support the child to regulate (Cassidy, 1994; Suchman et al., 2008). The child's ability to self-regulate is hypothesised to be a protective factor against the social, emotional and behavioural difficulties associated with attachment disorders (Sroufe, Carlson, Levy & Egeland, 1999). Changes in carer sensitivity, responsivity and co-regulation opportunities could also help shape the child's 'IWM' or blueprint for relationships, which is hypothesised to facilitate children's social development (Bowlby, 1982). If the programme is effective at improving carers' insight, the predicted changes in children's relationships and behaviours would be expected months and years after the programme (Everson-Hock et al., 2011). The length of follow-up did not reflect this predicted rate of change, and so it is perhaps unsurprising that the studies did not find significant changes in attachment over the assessment period.

The studies' low methodological quality prevents firm conclusions from being made. For example, three studies had 13 or fewer participants (1, 2, 5), which is less than the 50 per group recommended to achieve the conventional power of 80 percent for a significant test of a medium difference (Chambless & Hollon, 1998). This could reflect the limited resources available to the researchers.

The assessment methods contribute to the low methodological quality. There is currently no 'gold standard' assessment of attachment which can assess children in infancy, middle and late childhood, and assessments for children beyond infancy have particularly limited validity (Kerns & Seibert, 2011). The author knows of no assessment comprehensive enough to capture the complex nature of attachment styles, with established reliability and validity and, as highlighted by Thomas O'Connor and Gerard Byrne's review (2007), which is also accessible and affordable for services with limited resources. The protocols of the reviewed studies reflect the varied and limited assessment measures available. For example, they varied in their psychometric robustness: the RADS and RPQ were the most psychometrically robust with established internal consistency; however the RPQ requires test-retest reliability data. As brief carer-report measures they also have limited face validity as assessments of complex attachment relationships. They also assess the clinical symptoms of RAD, and so may not be sensitive to changes in children whose attachment difficulties are not clinically significant. The EFRQ and the Pen Portrait and Symptoms Checklist would also benefit from further psychometric investigation.

Minnis and colleagues' (2001) study was the highest quality of the four studies assessing attachment, having received a positive rating according to the NICE quality appraisal. The higher methodological quality increases confidence in its findings, which the authors' state suggests their programme did not significantly improve children's attachment relationships, as assessed by the RADS. However, Minnis and colleagues (2001) note the programme was a relatively brief three sessions and so the findings do not exclude the possibility that more intensive programmes might be more effective.

The lack of inclusion of attachment related outcomes in half the studies limited the ability to make conclusions regarding the efficacy of group programmes aiming to improve the attachment relationship. This could be due to the limited range of good quality, sensitive, easily administered measures with high face validity. In response to this obstacle, studies may have selected easily administered valid and reliable assessments which less directly reflect attachment relationships, such as general assessments of carer or child wellbeing. These outcomes will be considered to see if they add further insights regarding the programmes' efficacy.

6.2. Indirect Outcomes

All the reviewed studies included assessments of other variables which were theoretically linked, but not directly reflective of, the attachment relationship. These variables will be termed 'indirect outcomes' and will be reviewed below to establish if they offer further insights regarding the efficacy of group programmes aiming to improve the attachment relationship.

6.2.1 Carers' stress levels

Almost half the studies assessed carers' stress levels. High stress levels are hypothesised to restrict carers' engagement with, and emotional availability to, their child, and consequently their ability to deliver sensitive, responsive and effective parenting (Farmer, Lipscombe & Moyers, 2005; Fisher & Moolstiller, 2008; Halme, Tarkka, Nummi, & Åstedt-Kurki, 2006). As described previously, sensitive and responsive parenting could affect factors associated with the carer-child attachment relationships, such as children's co-regulation, self-regulation and the development of their IWM (Bowlby, 1982; Cassidy, 1994; Suchman et al., 2008). A reduction in carers' stress levels following the programmes' could suggest that they are effective at setting the conditions for improvements in attachment relationships.

Stress was assessed using the Parenting Stress Index (Abidin, 1995), a well validated and robust self-report assessment (2, 4, 5, 10). Three studies (4, 5, 10) reported statistically significant reductions in stress post-programme, with effect sizes ranging from medium (r=.27) to large (r=.37), and one found no significant differences (2). The mostly statistically significant findings suggest that attending the programmes reduced carers' stress levels, which theoretically could facilitate future improvements in children's attachment relationships.

The reduction in stress was found by studies evaluating both CB (10) and attachment theory based programmes (4, 5). Such findings raise questions regarding which aspects of the programmes might contribute to decreasing stress levels. For example, the reductions in stress may be due to the peer support rather than programme's curriculum per se. Participant feedback from one study described the powerful impact of peer support, reporting carers

"intense relief of discovering they were not alone in their experiences, and the support and friendship" (Selwyn et al., 2009, p.38).

Confidence in the conclusion that attending the programmes reduces stress levels is limited by the studies' low methodological quality, and specifically their use of non-comparative designs, which prevent us from establishing whether attending the programmes reduces carer stress any more than treatment as usual.

6.2.2 Carers' Mind-Mindedness

Gurney-Smith and colleagues (2011) considered Mind-Mindedness (MM), or the degree to which carers treat their child as an individual with a mind of their own (Meins, 1999). MM is a concept associated with reflective functioning (Rosenblum, McDonough, Sameroff & Muzik, 2008) hypothesised to promote carers' sensitivity (Meins, 1999) and consequently facilitate the carer-child attachment relationship. No significant differences in MM were found between assessments, suggesting the 'Fostering Attachments' group did not affect carers' MM. The study extended the MM Assessment to include carers' consideration of their own mental experiences as well as their child's while describing a 'rupture' in the carer-child relationship[a]. The study found statistically significant increases in carers' consideration of their own mental attributes three months after the programme relative to baseline. Self-focused MM could be hypothesised to be similarly associated with reflectivity and subsequently sensitivity, in which case these findings could support the programme's efficacy at improving carers' abilities to develop the attachment relationship with their child. However

[a] A rupture in the relationship refers to a break in the relationship, or a disagreement or argument between the carer and child (Gurney-Smith et al., 2011).

the novel nature of the assessment and the study's low quality rating prevents firm conclusions being made regarding the meaning or validity of these findings.

6.2.3. Child's emotional and behavioural functioning

As previously detailed, it is hypothesised that children's attachment relationships are associated with their emotional and behavioural functioning (Golding, 2006; Tarabulsy et al., 2008). Findings which suggest programmes are effective at improving children's emotional and behavioural functioning could be indicative of prior improvements in the attachment relationship. Additionally, improvements in children's emotional and behavioural functioning could facilitate the development of the carer-child attachment relationship. Improvements in children's emotional and behavioural functioning could then support the efficacy of programmes at improving attachment relationships.

Almost all studies assessed carers' perceptions of children's emotional and behavioural function utilising carer-report assessments such as the well validated Strengths and Difficulties Questionnaire (SDQ) or Child Behaviour Checklist (CBCL), and / or assessments whose psychometric properties have not been established, such as the Carer Questionnaire (CQ) or the Concerns about my Child Scale. The studies found mixed results. Two studies (1, 10) found significant decreases in carers' reports of children's emotional and behavioural difficulties following the programme. One study (2) found significant decreases during the three months following the programme. In contrast, five studies (3, 5, 6, 7, 9) found no significant decreases over time, or relative to the control group, where utilised.

The varied findings could be due to differences in the programmes' theoretical content or presentation. However, as with carers' stress, there are no clear differences in efficacy according to these factors. For example, three studies (3, 6, 10) delivered predominantly CB and SL theory based curriculums with some consideration of attachment issues, yet found conflicting results. Similarly, three studies evaluated an attachment and SL theory based programme (1, 2, 5) and reported differing results. The variability in findings could be due to other confounding factors, such as the differing facilitators or group dynamics.

The studies which met the highest number of NICE's (2009) quality appraisal checklist items were MacDonald and Turner (2005) and Minnis and colleagues (2001). They found no change in carers' perceptions of children's emotional and behavioural functioning following the programme, in comparison to a control group. These were the only studies to utilise randomised control groups and gather follow-up data at least six months post-programme. They recruited significantly larger samples (N=160, N=117 respectively). In comparison to the other studies which relied on carer-report assessments, MacDonald and Turner (2005) included a child-report assessment of well-being. Consequently, we have more confidence in their findings than the other studies, which suggest that the programmes did not improve children's emotional and behavioural functioning.

Further weight is added to this conclusion when considering the aforementioned lengthy mechanism of change, which suggests that improvements in children's functioning take considerable time. As stated by Selwyn and colleagues (2009, p. 35) "it would have been suspicious if parents had reported significant changes in such a short period". Congruent with this suggestion, Gurney-Smith and colleagues (2011) did not find significant improvements in

children's functioning during the programme, but did within the three months after it ended. This argument appears particularly applicable when considering evaluations of the briefer programmes. When considering lengthier programmes, such as the 18 session long 'Fostering Attachments' programme, the expectations of observing evidence of its efficacy shortly after programme completion are increased, if it is indeed effective at improving children's emotional and behavioural functioning.

In conclusion, the studies reported varied findings. Those with the highest methodological quality in which we have most confidence suggest the programmes do not improve carers' perceptions of children's emotional and behavioural functioning, and consequently do not support the development of the carer-chid attachment relationship in this regard. However, consideration of the hypothesised lengthy mechanism of change suggests that even if the programme was effective at improving children's emotional and behavioural functioning we would not expect to observe changes within the short periods of assessment utilised. Consequently higher quality studies incorporating multiple report and objective assessments over lengthy follow-up periods are required before confident conclusions regarding the programmes' efficacy can be drawn.

6.3. Summary

The lack of statistically significant improvements in assessments of attachment reported by the reviewed studies suggests that programmes aiming to improve the children's attachment relationship do not achieve this goal. However, half the studies did not investigate attachment related outcomes. Consequently the review considered studies' 'indirect outcomes' to further

inform the evaluation of parenting group programmes' effect on children's attachment relationships.

Several studies found that following the programme carers' stress levels reduced, and one study found an increase in self-focused MM during ruptures. These improvements could theoretically facilitate the carer-child attachment relationship. However, the low methodological quality of these studies limits confidence in the findings' validity and generalisability. Furthermore, the hypothesised links between improvements in these variables and the attachment relationship were not explicitly investigated in these studies.

Almost all studies considered children's emotional and behavioural functioning, which was hypothesised to be associated with improved attachment relationships: Improvements in children's functioning could be considered both a setting condition and/or a consequence of improved attachment relationships. Varied findings were reported: The studies rated as being of the highest quality reported no effect of the programme on carers' reports of children's emotional and behavioural functioning. This suggests that the programmes do not support the development of the carer-child attachment relationship in this regard. However, the lack of significant findings does not prove that the programmes were ineffective. This is because the short assessment periods employed were unlikely to observe changes, which could be predicted to occur over longer time periods.

In conclusion, some studies report findings that could be interpreted as supportive of the efficacy of the parenting group programmes, including non-significant improvements on assessments of attachment and statistically significant improvements of variables thought to

facilitate the attachment relationship, such as carers' stress and self-focused MM. However, the studies' poor quality limits confidence in the validity or generalisability of the findings. Furthermore, the findings of the only study considered to be of adequate methodological quality suggested their programme was not effective at improving the attachment relationship, or related variables. It is concluded that there is currently no robust evidence to support the efficacy of such programmes aiming to improve the attachment relationship of fostered and adopted children. These conclusions will now be considered to classify the efficacy of the programmes, according to the Treatment Classification Criteria.

7. EFFICACY CLASSIFICATION

Following consideration of the reviewed studies' methodological quality and key findings, it is possible to classify the efficacy of the programmes at improving the attachment relationships of fostered and adopted children. The programmes will be classified according to Saunders and colleagues' (2004) Treatment Classification Criteria (Table 3), which was designed to guide clinicians' judgements regarding the appropriateness and efficacy of an intervention.

The Treatment Classification Criteria categorise programmes according to their theoretical basis, acceptance and use in clinical practice, replicability, potential for harm and empirical support. There is evidence to support a high classification of programmes aiming to improve the attachment relationship: The majority of the programmes reviewed have a sound theoretical basis in generally accepted psychological principles. Most evaluations reported high participant satisfaction levels, and programmes were delivered within existing service provision, which supports their acceptability to services and clients. Most programmes were comprehensively detailed or manualised to ensure replicability. None of the studies found the programmes to be risky or harmful for carers or children, although this is based on data from only participants who completed the programmes, as all but one study neglected to employ intention to treat analyses[a]. The studies report findings considered supportive of the programmes' efficacy regarding improving conditions considered theoretically important for establishing attachment relationships, such as carers' stress levels. However the negative quality rating of most studies reduces the quality of the evidence they provide for the

[a] An 'intention to treat' analysis "includes all randomised patients in the groups to which they were randomly assigned, regardless of the compliance with the entry criteria, regardless of the treatment they actually received, and regardless of subsequent withdrawal from treatment or deviation from the protocol'' (Fisher et al., 1990, as cited in Whittaker, Sutton & Burton, 2006, p.859).

programmes' efficacy, and the only study of adequate quality reported findings which did not support the programme's efficacy. Consequently, although the programmes reviewed fulfil the majority of criteria required to be classified as a 'promising and acceptable' treatment, it cannot be confidently claimed that there is a "substantial clinical-anecdotal literature" indicating the treatments' efficacy (Saunders et al., 2004, p.22). Parenting group programmes aiming to improve the attachment relationships of foster and adoptive children reviewed are classified as category five, an 'innovative or novel treatment'.

Table 3

Treatment Classification Criteria (adapted from Saunders, Berliner & Hanson, 2004, as cited in Craven & Lee, 2006)

Category 1:Well-supported, efficacious treatment 1. The treatment has a sound theoretical basis in generally accepted psychological principles. 2. A substantial clinical, anecdotal literature exists indicating the treatment's efficacy with foster and adoptive children. 3. The treatment is generally accepted in clinical practice for foster and adoptive children. 4. There is no clinical or empirical evidence or theoretical basis indicating that the treatment constitutes a substantial risk of harm to those receiving it, compared to its likely benefits. 5. The treatment has a manual that clearly specifies the components and administration characteristics of the treatment that allows for replication. 6. At least two randomized, controlled outcome studies have demonstrated the treatment's efficacy with foster and adoptive children. This means the treatment was demonstrated to be better than placebo or no different or better than an already established treatment. 7. If multiple outcome studies have been conducted, the large majority of outcome studies support the efficacy of the treatment. Category 2: Supported and probably efficacious 1. The treatment has a sound theoretical basis in generally accepted psychological principles. 2. A substantial clinical, anecdotal literature exists indicating the treatment's efficacy with foster and adoptive children. 3. The treatment is generally accepted in clinical practice for at risk children and foster and adoptive children. 4. There is no clinical or empirical evidence or theoretical basis indicating that the treatment constitutes a substantial risk of harm to those receiving it, compared to its likely benefits. 5. The treatment has a manual that clearly specifies the components and administration characteristics of the treatment that allows for implementation. 6. At least two studies utilizing some form of control without randomization (e.g., wait list, untreated group, placebo group) have established the treatment's efficacy over the passage of time, efficacy over placebo, or found it to be comparable to or better than already established treatment. 7. If multiple treatment outcome studies have been conducted, the overall weight of evidence supported the efficacy of the treatment.	Category 3: Supported and acceptable treatment 1. The treatment has a sound theoretical basis in generally accepted psychological principles. 2. A substantial clinical, anecdotal literature exists indicating the treatment's efficacy with foster and adoptive children. 3. The treatment is generally accepted in clinical practice for foster and adoptive children. 4. There is no clinical or empirical evidence or theoretical basis indicating that the treatment constitutes a substantial risk of harm to those receiving it, compared to its likely benefits. 5. The treatment has a manual that clearly specifies the components and administration characteristics of the treatment that allows for replication. 6a. At least one group study (controlled or uncontrolled), or a series of single subject studies have demonstrated the efficacy of the treatment with foster and adoptive children; or 6b. A treatment that has demonstrated efficacy with other populations has a sound theoretical basis for use with at-risk children and foster and adoptive children, but has not been tested or used extensively with these populations. 7. If multiple treatment outcome studies have been conducted, the overall weight of evidence supported the efficacy of the treatment. Category 4: Promising and acceptable treatments 1. The treatment has a sound theoretical basis in generally accepted psychological principles. 2. A substantial clinical-anecdotal literature exists indicating the treatments efficacy with foster and adoptive children. 3. The treatment is generally accepted in clinical practice for foster and adoptive children. 4. There is no clinical or empirical evidence or theoretical basis indicating that the treatment constitutes a substantial risk of harm to those receiving it, compared to its likely benefits. 5. The treatment has a manual that clearly specifies the components and administration characteristics of the treatment that allows for implementation.

Table 3 (continued)

Category 5: Innovative or Novel treatments	Category 6: Concerning treatment
1. The theoretical basis for the treatment is novel and unique, but with reasonable application of accepted psychological principles. 2. A small and limited clinical literature exists to suggest the efficacy of the treatment. 3. The treatment is not widely used or generally accepted by practitioners working with foster and adoptive children. 4. There is no clinical or empirical evidence or theoretical basis suggesting that the treatment constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.	1. The theoretical basis for the treatment is unknown, a misapplication of psychological principles, or a novel, unique, and concerning application of psychological principles. 2. Only a small and limited clinical literature exists suggesting the efficacy of the treatment. 3. There is a reasonable theoretical, clinical, or empirical basis suggesting that, compared to its likely benefits, the treatment constitutes a risk to those receiving it. 4. The treatment has a manual or other writings that specify the components and administration characteristics of the treatment that allows for implementation.

8. CONCLUSIONS

The reviewed studies do not provide convincing evidence regarding the efficacy of adoptive and foster parent group programmes aiming to improve the attachment relationships of children. They were consequently classified as an 'innovative or novel treatment'. This classification reflects the reviewed studies' slightly exploratory nature, in that the studies evaluated programmes with a wide range of theoretical influences and presentation formats, and utilised a wide range of outcome measures. This suggests there is little consensus regarding the necessary components of such programmes, or by which processes the programme might affect its attendees. Congruent with this conclusion, Golding states that "little is known about the mechanism by which the programme can enhance skills or how this in turn impacts upon the functioning of the child" (2006, p. 217).

8.1. Recommendations for clinical practice

Saunders and colleagues (2004) advise that programmes categorised as 'novel and innovative' can be implemented, but with caution. Consideration of the high satisfaction levels and perceived helpfulness reported by participants suggest it is unlikely that the programme harms foster and adoptive families, and so caution is not necessary in this regard. The delivery of the evaluated programmes within existing service provision suggests that they are, and can be, integrated into current UK practice. Caution is justified when considering financial costs to the service provider of delivering programmes without established efficacy, particularly when considering NICE's (2010) guidance regarding cost-effective programmes.

The ambitious task of improving the attachment relationships of foster and adoptive children should not be underestimated. As considered previously, disruptions to fostered and adopted

children's attachment relationships due to factors such as leaving their birth family, neglect and abuse and placement instability affect their brain development, coping mechanisms, cognitive representations of themselves and the world (e.g. Bowlby, 1982; Cassidy, 1994; Suchman et al., 2008). Combined with the observation that the stability of attachment relationships tends to be substantial and significant (e.g. Main et al., 1985; Main & Cassidy, 1988; Owen, Easterbrooks, Chase-Lansdale, & Goldberg, 1984; Waters, 1978; Waters, Merrick, Treboux, Crowell & Albersheim, 2000), it becomes unsurprising that evaluations of the programmes, some as brief as three or four sessions, have not produced evidence of substantial improvements in children's attachment relationships.

However it should be noted that parenting programmes may have been designed to complement rather than replace existing service provision, forming an integral part of a wider care package including various supports for carers and/ or the child. A limitation of this review was that in order to consider the efficacy of group programmes, evaluations considering programmes delivered in combination with anything other than treatment as usual were excluded. This was done to exclude confounding variables and focus the review on the efficacy of this particular aspect of care. However a future review might consider whether further insights regarding the efficacy of such programmes can be found in studies evaluating group programmes as part of a wider care package.

8.2. Recommendations for further investigation of the efficacy of parenting group programmes aiming to improve the attachment relationship

Graduation from an 'innovative or novel' to a 'promising and acceptable programme' classification, which services might deliver with more confidence, requires "substantial

clinical-anecdotal literature" (Saunders et al., 2004, p.22) demonstrating the programme's efficacy. The review concludes that the sparse inclusion of attachment assessment measures, the debatable validity and reliability of the included assessments, and the generally poor methodological quality prevented this criterion from being met. Future research should address these issues.

8.2.1 Improved Assessment of Attachment Relationship

To establish the efficacy of programmes aiming to improve children's attachment relationships, evaluations should include assessments of children's attachment relationship with their carer. It is likely that many practical obstacles prevented the inclusion of such assessments. For example, O'Connor and Byrne's (2007) review of attachment assessments notes that measures with established reliability and validity often require training to deliver and interpret. The limited availability of training, and the temporal and financial resources required to deliver and / or attend training, challenges health and social care services conducting evaluations (O'Connor & Byrne, 2007). Furthermore, assessment methods vary with developmental stage; the evidence base for assessments of older children is considerably weaker than for infants, and there is no valid measure applicable across the age range of children whose carers might attend a programme (O'Connor & Byrne, 2007). An assessment with face validity would involve observing child and carer in a situation which activates the attachment system i.e. a situation of mild stress where the child's need for safety and security from threat is activated (O'Connor & Byrne, 2007). This would require considerable resources which could challenge researchers, particularly when considering that most of the reviewed studies did not appear to be large grant funded trials, but rather clinicians evaluating existing service provision with their service's limited resources. To evaluate the efficacy of

programmes, research should first focuses on developing the accessibility, utility, validity and reliability of assessments of children's attachment relationships for future evaluations.

8.2.2 Improving the methodological quality of the evaluations

Research should consider reducing the substantial biases present in the reviewed studies, which limited the ability to draw conclusions regarding the programmes' efficacy. It is debatable whether the current evidence base justifies the expense of large scale randomised control trials. Improvements could be made to future evaluations' methodological quality and consequent validity of findings with limited resources, such as including assessments of treatment fidelity, multiple report assessments and single-blind designs.

The scarcity of comparative designs raises questions regarding the efficacy of attending programmes as opposed to treatment as usual. The inclusion of control groups, although involving extra cost, should be considered a necessary development in future work. If future studies including adequate assessments of attachment and addressing these biases appear to support the efficacy of the programmes, larger scale research with sufficiently powered samples and, as recommended by Everson-Hock and colleagues (2011), substantial follow-up periods, would be advised to convincingly evaluate the efficacy of such programmes.

The range and quality of outcome measures utilised should be extended. To develop current understanding regarding if and how programmes affect attachment relationships, future evaluations should be designed with reference to the theoretical models by which the programmes are hypothesised to affect the attachment relationships. The reviewed studies tended to only utilise well validated assessments for carers' stress levels and children's

emotional and behavioural functioning. However, as discussed throughout the review, the literature suggests that there are considerably more key variables, including carers' knowledge and understanding, reflective function, sensitivity and responsivity, children's comfort seeking behaviour, attachment relationship and emotional regulation. Consequently it would be informative to consider the effect of the intervention on these outcome variables utilising psychometrically robust assessments.

8.3. Summary

Parenting group programmes supporting adoptive and foster carers by providing parenting advice, peer support and a framework of understanding that empowers carers have substantial face validity. This is supported by the carers' high satisfaction with the programmes, which was consistently reported by the studies. The importance of the attachment relationship to the well-being of foster and adoptive children makes it imperative that health and social care services continue to strive to improve their attachment relationships. The quality of the evidence base is currently too limited to make conclusions regarding the programmes' efficacy. It is therefore recommended that future clinical and academic work develops the evidence base in order to address the significant gaps in our knowledge regarding if and how parenting group programmes for adoptive and foster carers can improve children's attachment relationships.

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EMPIRICAL PAPER:

Evaluation of an Attachment Theory Based Parenting Programme for Adoptive Parents and Foster Carers.

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Evaluation of an Attachment Theory Based Parenting Programme for Foster Carers and Adoptive Parents

ABSTRACT

Aims

The trial evaluated the efficacy of the attachment theory based 'Fostering Attachments' group parenting programme for foster carers and adoptive parents.

Design

Participating foster carers and adoptive parents were allocated alternatively to either Group 1 (n=11), which attended the first scheduled programme, or Group 2 (n=14), which remained on a waiting-list for six months before attending the second programme. To investigate the programme's affect on the outcome measures, participants were assessed pre-, post-, and eight months following invention. To assess the stability of outcome variables when receiving no intervention, the attendees of Group 2 were assessed over their waiting-list period. Outcome variables included: children's emotional and behavioural difficulties and sense of security with their carer; placement stability; carers' stress levels; carers' mind-mindedness; carers' sense of self-efficacy, competence and confidence in their parenting.

Results

Carers' sense of competence and confidence significantly improved immediately and eight months following intervention. This change was not observed over the waiting-list period. Sense of self-efficacy was found to improve eight months following, but not immediately post-intervention. Group analyses revealed no significant improvements post-intervention on

any other variable. Individual analyses revealed some post-intervention improvements for a few participants.

Conclusions

The intervention appears affective at improving carers' sense of competence and confidence, but not at improving carers' perception of their foster / adoptive child, their stress levels or children's emotional, behavioural or relational functioning. The programme could act as a foundation for a wider care package, equipping carers with the confidence and sense of competence to cope with the challenges of their role. However, the programme is not sufficient to address the substantial challenges faced by carers. Confidence in the conclusions is moderated by the methodological limitations.

1. INTRODUCTION

Adopted and fostered children[a] are more likely to have physical and/or mental health difficulties, to achieve poorer educational outcomes, and to be cautioned or convicted of an offence (Department for Education and Skills [DfES], 2007; Ford, Vostanis, Meltzer & Goodman, 2007; Quinton, Rushton, Dance & Mayes, 1998;). The DfES (2007) advocates that nurturing and supportive parenting is key to providing stability and building resiliency in children growing up in the care system. It is recommended that foster carers receive support and training to provide such parenting, and that the evidence base for the efficacy of such support is developed (DfES, 2007; National Institute for Health and Clinical Excellence [NICE] & Social Care Institute for Excellence [SCIE], 2010). A range of interventions exist to support foster carers which aim to build resilience in fostered children, utilising various psychological approaches including cognitive behavioural, social learning and attachment-based approaches (e.g. Herbert & Wookey, 2007; MacDonald & Turner, 2005; Minnis, Pelosi, Knapp & Dunn, 2001). However, research evaluating the efficacy of these interventions is in its infancy. This has recently been highlighted in reviews of intervention evaluations, which noted the limited quantity and methodological quality of research to date (Everson-Hock, et al., 2011; Turner, MacDonald & Dennis, 2006). To develop the evidence base, the present research evaluates the efficacy of the 'Fostering Attachments' programme (Golding, 2006) for foster carers and adoptive parents.

1.1 Why evaluate the 'Fostering Attachments' Programme?

The 'Fostering Attachments' Programme is a group programme currently delivered by a number of health and social care services. It is one of the most intensive parenting

[a] The term 'foster child' refers to those cared for by the state where the 1989 Children Act is applicable (NICE/SCIE, 2010). These include children subject to a care order and those temporarily classed as looked after on a planned basis, such as those in respite care (NICE/SCIE, 2010).

programmes for adoptive and foster carers available, consisting of 18 sessions lasting approximately two and a half hours each. When considering the current economic climate and NICE's (2010) guidance regarding cost-effective interventions, it is important to investigate the efficacy of interventions that require this level of resources. Services considering commissioning the programme require further evidence regarding its efficacy. The present research aims to address this gap in current knowledge.

The evidence base for the programme is limited. The popularity of the programme may be due to the high satisfaction reported by participants (Golding & Picken, 2004; Gurney-Smith, Granger, Randle & Fletcher, 2011; Laybourne et al., 2008) and its face validity, which stems from the programmes' curriculum being informed by attachment theory. Attachment theory is considered a particularly applicable framework within which to understand the challenges faced by foster and adoptive families because it proposes that the development and maintenance of a secure emotional relationship between a child and their carer facilitates healthy development (e.g. Bowlby, 1988; Howe & Fearnley,1999; Hughes, 1997; Weinfield, Sroufe, & Egeland, 2000). Fostered and adopted children experience disruptions in their relationships with their attachment figures due to abuse or neglect within their birth families (Department of Health [DoH], 2002) or following consecutive changes in carer (Golding, 2006). Disrupted attachment relationships are hypothesised to affect brain development (Schore, 1994), emotional regulation skills (Howe, 2005; Tarabulsy et al., 2008) and children's cognitive representations of themselves, others and their relationships (e.g. Bowlby, 1982; Feeney, Noller, & Callan, 1994; Hazan & Shaver, 1987; Mikulincer, 1995). These effects are thought to increase children's vulnerability to poor physical, emotional, social and intellectual development (e.g. Graham & Easterbrooks, 2000; Greenberg, Speltz,

DeKlyen, & Endriga, 1991; Golding, 2006; Solomon, George, & DeJong, 1995; Verschueren & Marcoen, 1999). Due to the apparent importance of attachment, NICE and SCIE recommend that foster carers are trained to "have a high level of understanding of attachment theory" (2010, p.36).

Fostered and adopted children both experience disruptions in their attachment relationships. Consequently, the challenges experienced by foster and adoptive parents can be similar (K, Golding, personal communication April 20, 2011), and interventions designed to meet the needs of foster families can be considered appropriate for adoptive families, and vice versa. The 'Fostering Attachments' programme is such an intervention, which has been delivered for both adoptive and foster carers (K, Golding, personal communication April 20, 2011; Gurney-Smith et al., 2011).

1.2 How does the 'Fostering Attachments' programme support foster and adoptive families?

Current understanding regarding the hypothesised causal pathways by which a carer influences child development will be discussed, followed by a proposal of the points at which the 'Fostering Attachments' programme might intervene along this pathway.

1.2.1 Hypothesised causal pathways by which a carer influences their child's development

Attachment theorists propose that a carer's ability to accurately perceive and understand their child's emotional cues is key to their ability to parent in a sensitive and responsive manner, which in turn is vital for promoting their child's social-emotional and cognitive development (Fonagy, Steele & Steele, 1991; Robinson, Emde & Korfmacher, 1997; Suchman, DeCoste, Castiglioni, Legow & Mayes, 2008). Meins (1999) links carers' perception and understanding

of their child to the concept of Mind-mindedness (MM), or "the proclivity of the parent to treat their infants as individuals with minds rather than merely entities with needs that must be met" (Meins, 1999, p332, as cited in Gurney-Smith et al., 2011). A carer with MM is thought to be more likely to utilise sensitive and responsive parenting behaviours (Meins et al., 2003, as cited in Lok &McMahon, 2006; Meins, 1997, as cited in Sharp & Fonagy, 2007).The ability to be a sensitive and responsive carer is thought to be affected by carer's stress levels (e.g. Farmer, Lipscombe & Moyers, 2005; Fisher & Moolstiller, 2008). Specifically, it is hypothesised that a carer who is stressed will be less able or motivated to engage with their child and have less emotional resources to parent their child in a sensitive and responsive manner (Farmer et al., 2005; Fisher & Moolstiller, 2008; Halme, Tarkka, Nummi, & Åstedt-Kurki, 2006).

A carer who utilises sensitive and responsive parenting behaviours is hypothesised to increase their child's sense of security within the carer-child relationship and increase the likelihood that the child will express their emotional distress to the carer (Cassidy, 1994; Suchman et al., 2008). This allows the carer opportunities to support their child by regulating their emotions when distressed (e.g. Cassidy, 1994), which emotionally enables the child to develop skills to self-regulate and manage their emotions more autonomously. This self-regulatory capacity is believed to act as a protective factor against the early development of social, emotional and behavioural difficulties (Sroufe, Carlson, Levy & Egeland, 1999).

1.2.2 Points at which the 'Fostering Attachments' programme intervenes along the hypothesised causal pathways

The 'Fostering Attachments' programme primarily target carers' understanding of, and relationship with their child. The approach is based largely on psycho-education underpinned by attachment theory and the 'House model of therapeutic parenting', which is a framework providing guidance designed to help children feel more secure (Golding, 2008, see Figure 1). The model recommends that carers develop children's sense of a secure base, which then acts as a foundation for the development of relationships and management of behaviours. To encourage carers to reflect and apply the theory to the care of their child, the programme utilises group discussion and reflection, and individual and group tasks such as completing diaries, considering case studies and participating in role-plays (Golding, 2006).

The intervention further aims to encourage carers to perceive not only their child's often complex and difficult behaviours, but also their intentions, representations and perceptions of their relationships i.e. their MM. In line with a well established stress-buffering model (e.g. Cohen & Wills, 1985; Dennis, 2003) the peer support provided by the group format may reduce carer's stress levels. These increases in MM and reduction in stress levels are, as detailed above, hypothesised to increase carers' ability to offer sensitive and responsive care (Farmer et al., 2005; Meins, 1999).

The programme aims "to increase the skill and confidence of the carers" (Golding 2006, p.1) and their sense of self-efficacy, or expectations regarding "their ability to parent successfully" (Jones & Prinz, 2005, p.342). Carers' perceived efficacy has been linked directly to improvements in children's psychological adjustment, and indirectly through improved

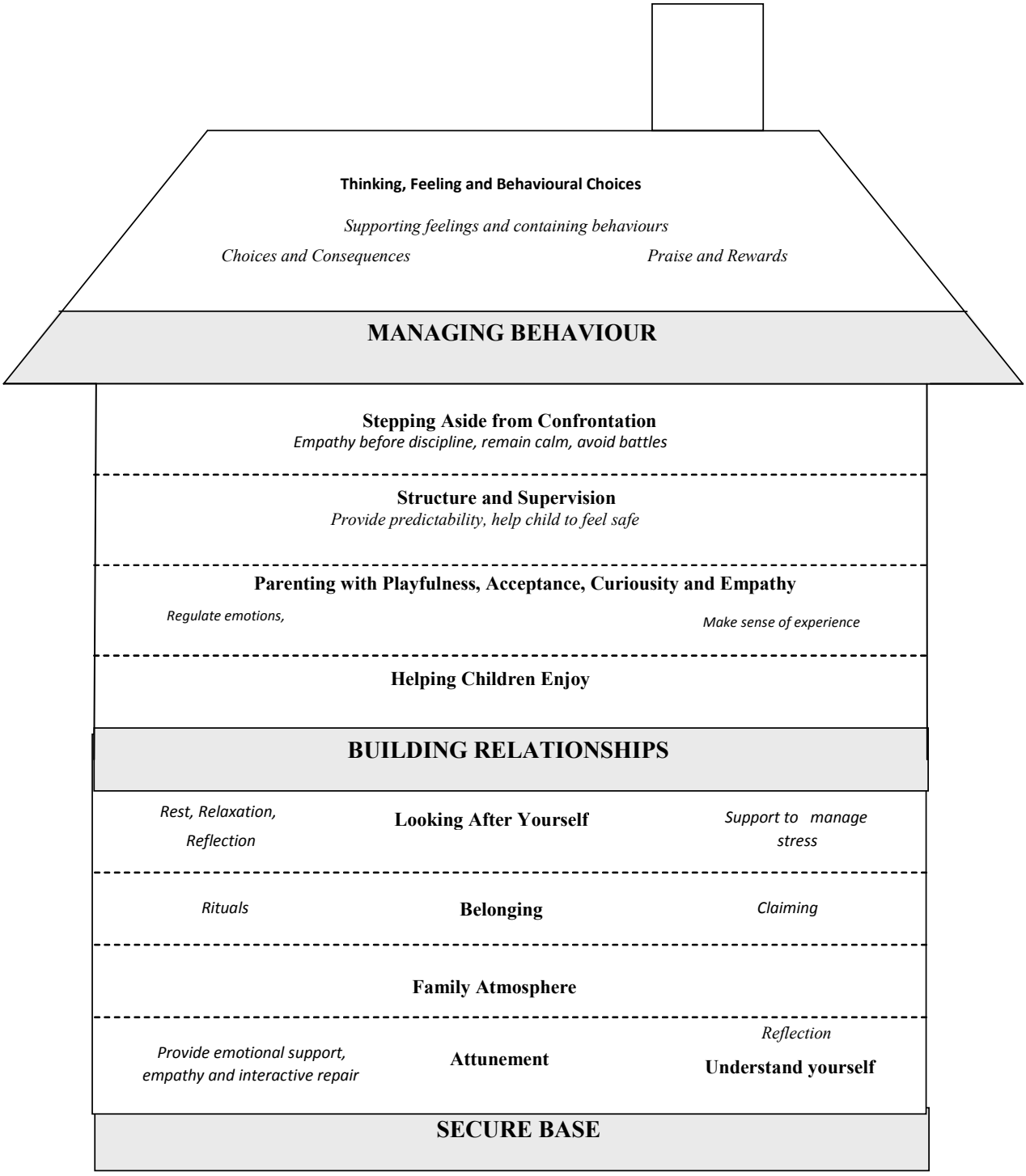

Figure 1. The House Model of Parenting (Golding, 2008)

parenting practices (Jones & Prince, 2005). For example, high parental self-efficacy in birth parents has been linked to parenting competence, greater acceptance of their child's behaviours and improvements in the child's developmental outcomes (Coleman & Karraker, 1998; Johnston & Mash, 1989; Jones & Prinz, 2005; Shumow & Lomax 2002;). Parenting efficacy has also been found to partially protect foster carers from the impact of their foster children's challenging behaviours on their stress, anxiety and depression levels (Morgan & Baron, 2011). An hypothesised consequence of an increased sense of self-efficacy and reduction in stress is that carers may feel more able to cope with the challenges of caring for adopted and fostered children, which could increase placement stability.

1.3 The evidence base for the 'Fostering Attachments' programme

There have been three evaluations of the 'Fostering Attachments' programme (Golding & Picken, 2004; Gurney-Smith et al., 2011; Laybourne, Anderson & Sands, 2008). All the studies assessed the following outcomes utilising carer-report assessment measures; carers' stress, confidence and sense of competence and children's emotional and behavioural difficulties. In addition, Laybourne and colleagues (2008) gathered qualitative information regarding carers' experiences and Gurney-Smith and colleagues (2011) assessed carer's mind-mindedness (MM). All the studies attempted to evaluate the impact of the intervention on the carer-child attachment relationship. A range of assessment protocols were used to do this, including a brief carer-report questionnaire of attachment difficulties, a carer-report questionnaire regarding expression of feelings within relationships, and the 'Pen Portrait and Symptom Checklist' exercise where carers read descriptions of attachment styles and rate how well these describe the presentation of the children they care for. All three studies reported that carers found the 'Fostering Attachments' programme supportive and

informative. Each study found statistically significant improvements on some of their outcome variables. Two evaluations found improvements over the pre/post-intervention assessment period in carers' reports of the children's emotional and behavioural functioning (Golding & Picken, 2004, Gurney-Smith et al., 2011). One study found improvements in carers' stress (Laybourne et al., 2008). Another found a significant reduction in children's disinhibited behaviours and an increase in carers' discussion of their own mental attributes when utilising their novel mind-mindedness assessment (Gurney-Smith et al., 2011). There was also a great deal of variability between the studies' findings, some studies finding improvements in carers' reports of children's emotional and behavioural functioning (Golding & Picken, 2004) or stress (Gurney-Smith et al., 2011) where the others did not.

Indeed, whilst the findings provide some initial support for the programme's efficacy, it is difficult to draw firm conclusions from the research because of variations in findings and methodological limitations. These include their non-comparative designs, small sample sizes (n = 6, n=7, n=13) and limited consideration of treatment fidelity. Furthermore, only one study considered the maintenance of effects over time, assessing participants three months following intervention (Gurney-Smith et al., 2011).

1.4 Developing the evidence base: Statement of aims

The face validity of the 'Fostering Attachments' programme and carers' satisfaction with it (Golding & Picken, 2004; Gurney-Smith et al., 2011; Laybourne et al., 2008) supports health and social care services commissioning the programme as an intervention for fostering and adoptive families. However, the limited evidence available to support the programmes' efficacy suggests further evaluations are required. This will enable services to make informed

decisions regarding continued investment and promotion of the programme. Therefore, the current study aims to address the limitations of the previous evaluations. Specifically, the effects of the intervention on outcome assessments will be evaluated with comparative reference to carers on a waiting-list for the intervention. The evaluation aims to recruit a larger sample than previous evaluations. In addition, treatment fidelity will be evaluated and follow-up assessments will be conducted approximately eight months after the intervention, and assessments will be conducted by an assessor blind to group allocation. To extend current understanding of the efficacy of the programme, analyses of post-intervention changes on outcome measures will be conducted at both a group and individual level.

To investigate the generalisability of the findings of previous evaluations, the current study will utilise similar outcome assessments of carers' stress levels, sense of competence, confidence and MM, and children's emotional and behavioural functioning. In addition, a well validated child-report assessment of their sense of security in their relationship with their carer and a well-validated assessment of carers' sense of parenting self-efficacy will be included. The specific hypotheses and prediction in relation to the aforementioned research questions are detailed below.

1.5 Predictions

- Following attendance of the programme, Carers' stress levels will reduce and carers' MM will increase. Children's emotional and behavioural difficulties will decrease, and their sense of security in their relationship with their carers will increase. These changes will occur

immediately and be maintained eight months following intervention. In comparison, no changes on these variables will be observed over the waiting-list period.

- Following attendance of the programme, carers' sense of self-efficacy in their parenting, sense of competence and confidence in their care of and relationship with their child will increase. These changes will occur immediately and be maintained eight months following intervention. In comparison, no changes on these variables will be observed over the waiting-list period.

2. METHOD

2.1 Design

Participants intending to attend the 'Fostering Attachments' programme, were assigned to one of two groups. Group 1 attended the first scheduled programme, and Group 2 remained on a waiting-list for eight months before attending the second scheduled programme (see Figure 2). Upon referral, potential participants were allocated alternatively and equally to either Group 1, or Group 2. Alternative allocation was employed to reduce the risk of confounding variables affecting group allocation. Allocation occurred prior to their research assessments to limit the possibility of biased allocation.

Participants were assessed pre- and post-intervention to investigate the effect of the intervention. The outcome variables assessed were carers' stress levels, sense of competence, confidence, sense of self-efficacy and mind-mindedness, and children's emotional and behavioural difficulties, sense of security in their relationship with their carer and placement stability. To ensure the analyses did not consider only those who completed the intervention, data from all participants who attended at least one session were included. Data from participants who withdrew prior to attending the programme were excluded. Furthermore, to assess the stability of outcome variables when receiving no intervention, the attendees of Group 2 were assessed at the start (assessment point 1 on Figure 2) and six months in to their waiting-list period (pre-intervention, assessment point 2). To investigate the prevalence of any effects from the intervention, Group 1 was assessed approximately 8 months following intervention (assessment point 3). Finally, throughout the waiting-list, intervention and follow-up periods, participants also received treatment as usual.

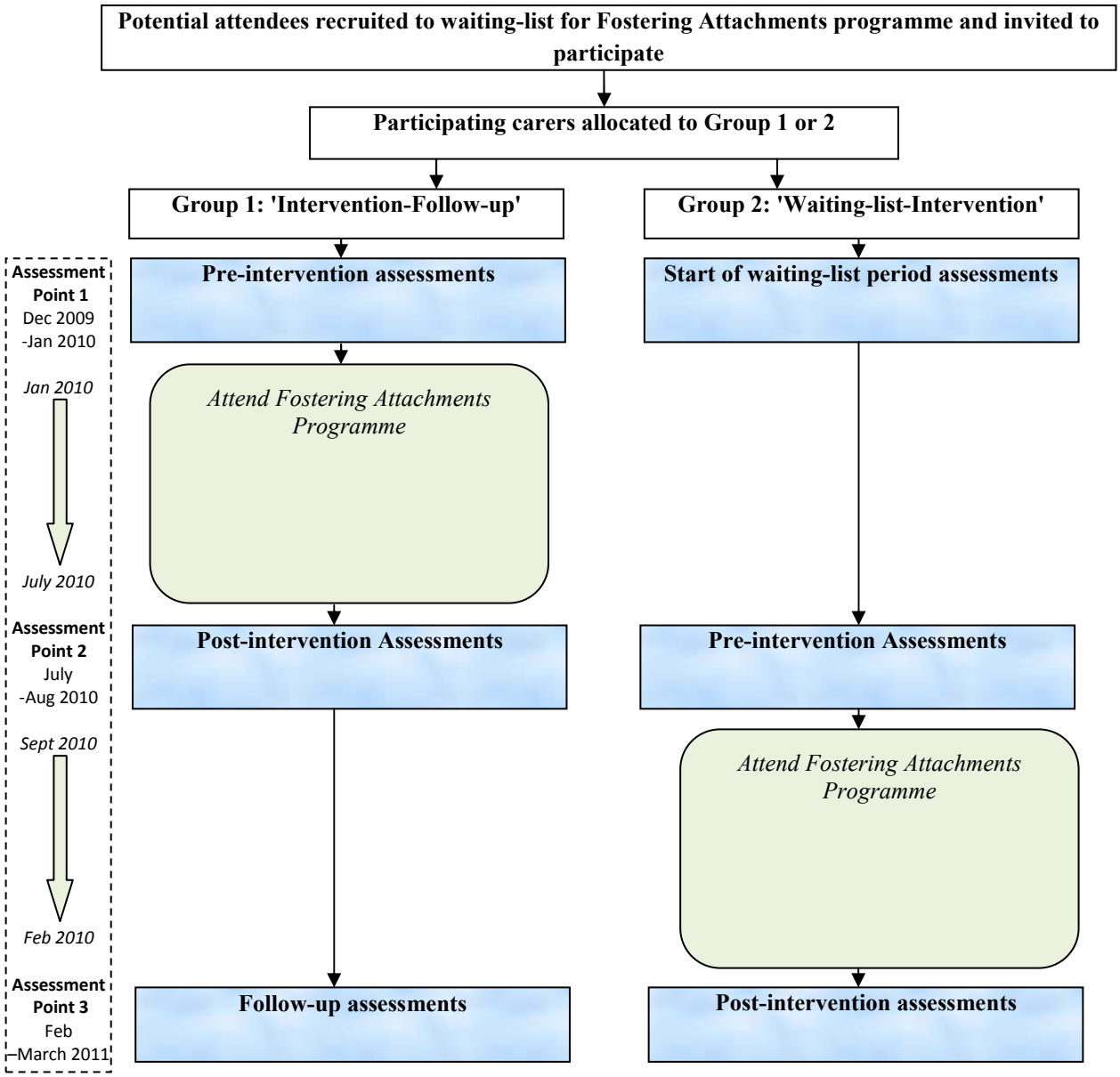

Figure 2: Evaluation design

2.2 Participants

2.2.1 Participating carers

Participants were recruited from a waiting-list for the 'Fostering Attachment' programme. The programme was provided by a health and social care service which supports foster carers employed by the local county council and adoptive parents living within the county. The locality is largely rural, with a population that is over 93% white British (Office for National Statistics, 2011). To enhance recruitment, carers employed by independent fostering agencies were invited to attend, from which only one foster carer accepted. To recruit attendees, the programme was advertised through local services supporting foster and adoptive families. This included placing a flyer in a fostering support newsletter and distributing leaflets to local adoption support services. The path of referral for the programme attendees are detailed in Table 1.

Table 1

Referral Pathways for programme attendees

Referral Pathway		**Total**
Self-referral	. . . following leaflet distributed by the adoption support service	6
	. . . following leaflet / advertisement in Fostering Together newsletter	1
	. . .following recommendation by previous attendee	2
	. . .following recommendation by social worker	2
	. . .following attendance of training held by group facilitator	2
Referral from health / social care practitioner	. . .by social worker	5
	. . .by member of team delivering the 'Fostering Attachments' programme.	4
	. . .by adoption support team	4
	. . .by Child Psychologist	1

Carers were considered eligible for the research if they were adoptive or foster carers and fluent speakers of the English language. This was necessary as the assessments were delivered in English. Participants were enrolled into the programme waiting-list by the facilitators. The number of participants recruited was based on availability. Twenty-five carers participated in the evaluation (see Figure 3), including 13 adoptive parents, eight foster carers and four carers who both adopted and fostered children. These included three married couples, who were treated as six participants: One married couple attended Group 1 together, another couple attended Group 2 together. The third couple had one partner in each group. Between them, the carers looked after 21 adopted children, 15 short-term or long-term fostered children, twelve fostered children on respite placements, and seven birth children.

All 24 carers on the programme waiting-list were considered eligible for the evaluation. After receiving information regarding participation, all but two consented to participate. Those who did not consent to participate also withdrew their interest in attending the group at a later stage. One withdrawal was due to a limited availability of time to attend the programme and the second was due to personal difficulties.

Four participants withdrew from the waiting-list prior to the programme beginning, following the pre-intervention, assessment point 2. Three participants withdrew because of a limited availability of time to attend and difficulties arranging child care. The fourth did not attend because of personal difficulties. No participants dropped out during the programme.

Three participants were recruited after the start of the waiting-list, assessment point 1 and consequently data from only the latter two assessment points was collected. The demographic

details of participants are described in Table 2. To assess how well the groups were matched, group comparisons of demographic variables and pre-intervention assessment variables were conducted, and are discussed in the results section.

Having reviewed the planned outcome assessment measures, the providing service insisted that, to maintain children's confidentiality, the foster carers should receive consent from the person holding parental responsibility in order to disclose details of the children they cared for. This was obtained for only two of the twelve foster carers; the remaining ten participants were not able to provide detailed information relating to the foster children in their care, which restricted the outcome measures they could complete.

2.2.2 Participating children

Children looked after by the carers, aged between nine and fourteen years, were eligible to participate. Thirteen children met these criteria. Assent and consent to participate was received for seven of these children. The carers of three children were allocated to Group 2 but withdrew their own and their children's participation from the research after completing the pre-intervention assessments (assessment point 2). One child was recruited late to the research, and consequently they completed assessment measures at assessment points 2 and 3 only. The demographic details of participating children are described in Table 3.

Table 2

Demographic details of participants at the pre-intervention assessment

Gender	**Ethnicity**	**Age (yrs)**	**Type of carer**	**Number of birth children currently living in household, per birth parent** *(under 18)*	**Number of adopted children currently living in household, per adoptive parent** *(under 18)*	**Number of LT & ST fostered children currently living in household, per foster carer**	**Number of respite placements currently provided, per foster carer**	**Education / Qual -ifications**	**Mean no. of previous foster placements provided by foster carers**	**Years of foster experience among per foster carer**	**Years of adoptive experience per adoptive parent**
5 male 20 female	22 British-white 2 British Asian 1 Other	Mean =47.77 S.D. = 7.55 Range = 33-59	13 adoptive 8 foster *(including 3 offering respite)* 4 foster and adoptive	Mean = 1.00 S.D. = 0.00	Mean = 1.38 S.D. = 0.74 Range = 1-3	Mean = 1.33 S.D. = 0.52 Range = 1-4	Mean = 4.00 S.D. = 0.00	13 Higher education 11 GCSE / A'level / equivalent 1 No qualifications	Mean = 18.17 S.D. = 24.75 Range = 1-60	Mean = 5.46 S.D. = 6.89 Range =0.58-16	Mean = 7.86 S.D.= 5.19 Range = 0-16

Table 3

Demographic details of adopted, long term and short term fostered children cared for by participants at the pre-intervention assessment

Gender	**Ethnicity**	**Age (yrs)**	**Care order**	**Reason for removal from birth family**	**How long since removed from birth family (yrs)**	**No. of foster placements prior to living with carers**	**How long been in current placement (yrs)**	**Diagnoses**
18 male 18 female	30 British white 4 British Asian 2 Other	Mean =8.31 S.D. = 4.67 Range=0-15.5	21 adopted 6 full care orders 5 interim care orders 2 voluntary orders 2 legal care placement order	14 risk of neglect 12 neglect 6 physical abuse 3 risk of physical abuse 3 sexual abuse 2 risk of sexual abuse 17 other (e.g. parent's drug misuse, exposure to DV between parents)	Mean = 6.13 S.D.=3.9 Range = 0 -4.42	Mean = 1.69 S.D. = 2.70 Range=0-12	Mean = 5.01 S.D.=3.9 Range =0-12.25	15 diagnosed developmental disorder or mental health difficulties, including: 4 Attention Deficit and Hyperactivity Disorder 3 Dyslexia, 2 Dyspraxia 1 Foetal Alcohol Syndrome 1 charge syndrome 1 Autism 3 Speech and language difficulties 1 moderate learning disabilities 1 eating disorder 1 right hemisphere cerebral palsy 3 Reactive Attachment Disorder

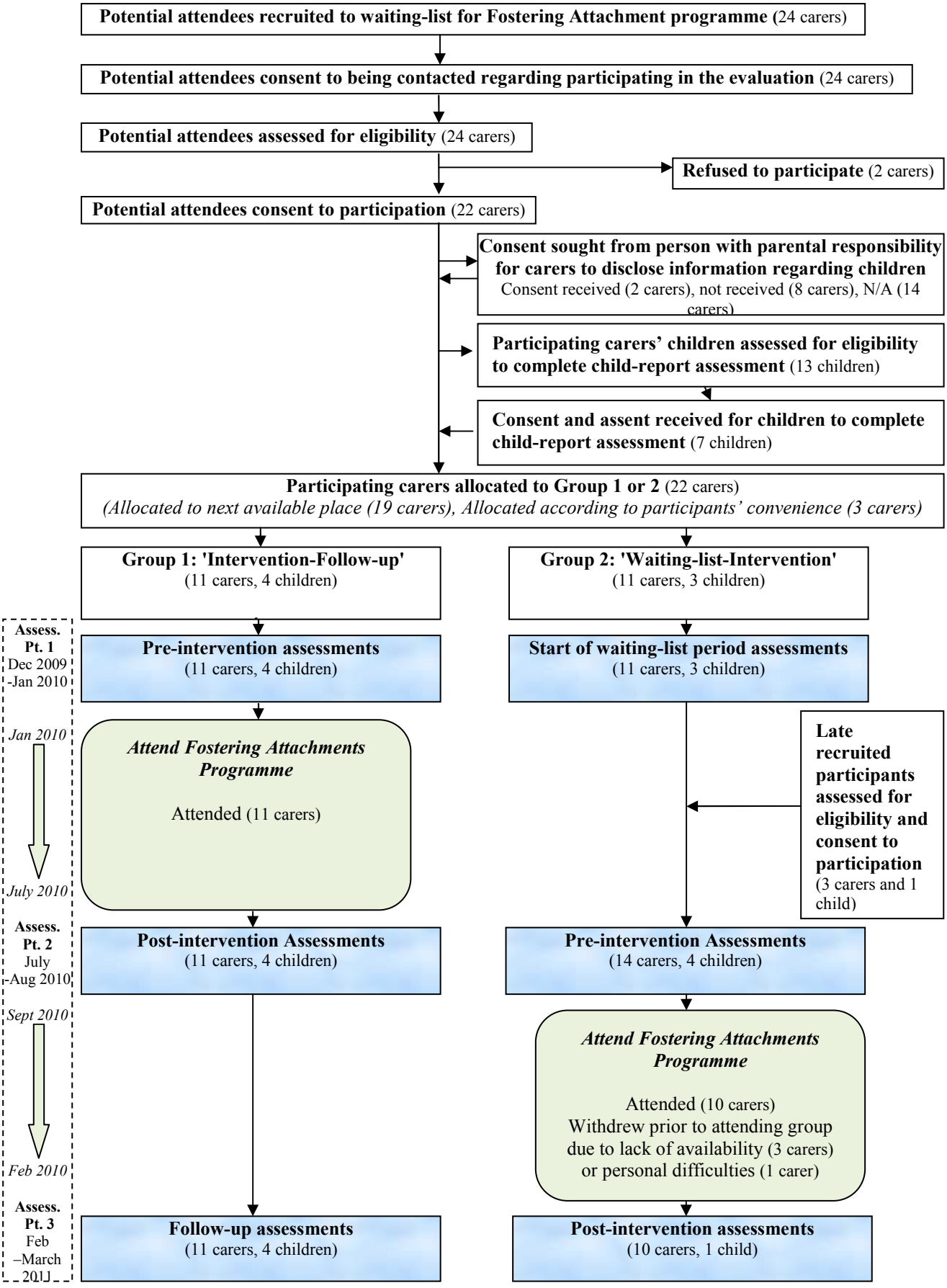

Figure 3: Evaluation design and CONSORT diagram (as recommended by Schulz, Altman & Moher, 2010).

2.3 Measures

The outcome assessments measures are detailed in Tables 4 and 5. To assess placement stability, unplanned placement breakdowns were documented at each assessment point.

2.3.1 Treatment Fidelity Assessments

2.3.1.1 Process

The following factors were considered integral to the delivery of the 'Fostering Attachments' programme: facilitators' ability to be empathic, sensitive and non-judgemental in their manner; that attendees are encouraged to apply the curriculum to the children in their care, feel safe to share information, and engage in discussions. These are process skills which previous research also considered integral to parenting programmes and have been included in treatment fidelity assessments (Eames et al., 2009). A process questionnaire was designed (Appendix 1) to assess treatment fidelity with respect to these key factors. The questionnaire requires participants to rate the presence of each process from 0 to 10, where 0 indicated that they strongly disagreed and 10 indicated that they strongly agreed that these aspects were present during the intervention.

2.3.1.2 *Curriculum*

To assess adherence to the 'Fostering Attachments' manual, a checklist (Appendix 2) was designed listing the curriculum topics detailed in the manual. To score the checklist, each curriculum criterion was scored one point, partially delivered was scored half a point and not delivered scored no points.

Table 4

Outcome measures considering carers' well-being

Outcome variable	Outcome Measures	Mode	Participation restrictions	No items	Sub scales considered	Example Test-retest reliability	Cronbach's alpha coefficient
Self efficacy	Self-efficacy scale of the Parenting Sense of Competence (Johnston & Mash, 1989: Appendix 3)	Self-report Questionnaire		7	n/a	0.86 over a week. (Wassall, Golding & Barnbrook, 2011).	$\alpha = 0.72$ for the orignal eight item scale (Cutrona & Troutman, 1986)
Stress	Parenting Stress Index (PSI: Abidin, 1995)	Self-report Questionnaire	Carers of children aged between one month and 11 years old at assessment point one	120	Child Domain Parenting Domain	Total = 0.96 Child domain =0.63 Parenting Domain =0.91, over 1-3 months (Abidin, 1995)	$\alpha = 0.70$ - 0.90 (Abidin, 1995)
	Stress Index for Parents of Adolescence (SIPA: Sheras, Abidin & Konold, 1998)		Carers of children over 11 years old at assessment point one	112		Total = 0.93 Child Domain= 0.92 Parent Domain = 0.87 (Sheras et al., 1998).	$\alpha > 0.80$ (Sheras et al., 1998)

Table 4 (continued)

Outcome variable	Outcome Measures	Mode	Participation restrictions	No items	Sub scales considered	Example Test-retest reliability	Cronbach's alpha coefficient
Carer's sense of competence and confidence in their care of and relationship with their child	Carer Questionnaire (Golding & Picken, 2004: Appendix 4)	Self-report Questionnaire		30	Subscales of Problem Behaviour 1, 2, 3 were not included.	Total = 0.77 Over a week (Wassall, Golding & Barnbrook, 2011).	As yet unestablished
Carer's Mind-Mindedness	Maternal Mind-Mindedness Interview (Meins, Fernyhough, Russell, & Clark-Carter, 1998) scored according to Meins and Fernyhough's (2010) scoring manual (Appendix 5)	Structured interview with carer, audio recorded and transcribed	One interview excluded at assessment point 2 and one at assessment point 3 due to child being present reducing the data's validity.	1	n/a	As yet unestablished	n/a

Table 5

Outcome measures considering children's well-being

Outcome variable	Outcome Measures	Mode	Participation restrictions	No items	Sub scales considered	Example Test-retest reliability	Cronbach's alpha coefficient
Children's emotional and behavioural functioning	Parent report version of the Strengths and Difficulties Questionnaire 4-16 (SDQ: Goodman, 1997: Appendix 6)	Carer-report Questionnaire	Carers of children aged between four and 16 years old at assessment point one	25	Hyperactivity, Pro-social behaviour, Emotional problems, Conduct problems, Peer problems, Severity and impact of difficulties	0.62 over 4 to 6 months (Goodman, 2001).	$\alpha = 0.73$ (Goodman, 2001).
Attachment: Child's sense of security with their carer	Sense of Security Questionnaire (Kerns, Klepac & Cole, 1996: Appendix 7)	Child-report Questionnaire	Children aged between nine and 14 years old.	15	n/a	0.75 over a two week period (Kerns, Klepac & Cole, 1996).	$\alpha = 0.93$ (Kerns, Klepac & Cole, 1996).

2.4 Procedure

2.4.1. Recruitment

2.4.1.1 Participating Carers

Once placed on the service's waiting-list, carers were asked to verbally consent to being contacted by the researcher. All carers consented and met with the researcher to discuss participation (see Appendices 8 & 9 for participant information sheets and consent forms). All but two carers subsequently contacted the researcher to consent to participating.

To adhere to the providing service's guidelines, consent was sought from the person with parental responsibility for each child cared for by a participating foster carer. Typically this involved providing information regarding participation and requesting consent from the social worker and/or birth parent of the fostered child (see Appendices 10 - 12 for ethics committee approval, participant information and consent forms).

2.4.1.2 Participating children

Carers of, and the person with parental responsibility for, children aged between were nine and 14 were given information regarding their child's participation in the research. If they gave consent for the child to participate, carers asked the child if they would like to participate. If the child wished to, meetings were arranged with the researcher to inform the child about the research requirements and take their consent (see Appendices 13–16 for participation and consent forms).

2.4.2. Allocation

As detailed in Figure 3, participants were allocated equally and alternately to either Group 1 or Group 2 upon referral. Allocation was conducted by a facilitator not involved with the later assessment of participants. Three carers were allocated according to availability because they were unable to attend their allocated group. Three carers were recruited following the commencement of the first programme and were consequently allocated to Group 2.

2.4.3 Assessment

All assessments were administered during a home visit by an independent researcher who was blinded from the allocation.

The researcher was made aware of group allocation for three participants recruited late to the study (i.e. allocated to Group 2), and three participants who accidently disclosed their allocation. The scoring of the assessment data for these participants was conducted by a second researcher who remained blind to their group allocation.

All assessment measures, apart from the process questionnaire, were administered at each assessment point. To reduce the burden of participation, where carers looked after more than one child, they were asked to provide responses in relation to one child. However, the Strengths and Difficulites Questionnaire (SDQ) assessment was considered of particular interest and sufficiently brief to justify inviting participants to complete it for each child they cared for. Where a carer did not have parental responsbility for the children in their care and had not recevied consent from the person with parental responsbility to disclose information

about the children, the providing service gave permission for carers to complete the self-efficacy scale and MM assessments only.

The process questionnaire was distributed to Group 1 by the facilitators during the final session. Disruptions to Group 2's final session prevented the questionnaires being distributed. Instead the questionnaires were sent by post following the last session. To preserve carers' anonymity and the validity of the data, the process questionnaires were anonymised.

2.4.4 Intervention

Two consecutive 'Fostering Attachments' programmes were scheduled during the period of research, the first from January 2010 until July 2010 and the second from September 2010 to February 2011. Each programme was facilitated by a social worker and two clinical psychologists and delivered as specified in the manual. The curriculum is detailed in Figure 4.

2.4.5 Treatment Fidelity

To ensure the intervention was delivered in accordance with the 'Fostering Attachments' manual, and therefore replicable, facilitators completed a checklist of the curriculum topics covered during each session. To enable assessment of the accuracy of the facilitators' reports, consent for the sessions being videoed was gathered at the beginning of the programme (see Appendices 17 & 18 for participant information and consent forms). The researcher independently watched videos of ten randomly selected sessions (approximately 27%) and compared their observations, as recorded on the checklist, to the facilitators' reports. To preserve the researcher's blind regarding group allocation, the researcher watched the videos after all assessment data had been gathered, scored and analysed.

'FOSTERING ATTACHMENTS' Programme
Curriculum Topics

Module 1: Attachment Theory

Introduction to Attachment Theory
Caregiving and the Attachment System
The Internal Working Model and Patterns of Attachment
The Organized Attachment Patterns
The Disorganized Attachment Pattern
Parenting Children with Attachment Difficulties

Module 2: A model for parenting the child with attachment difficulties: Providing a Secure Base

Introduction to the model and creating a Secure Base
Empathy and support from the Secure Base
Attunement and empathy
Protecting the family atmosphere
Creating a feeling of belonging for the child
Looking After Yourself

Module 3: A model for parenting the child with attachment difficulties: Building Relationships and managing behaviour

Helping the child to enjoy being part of the family
Learning to parent with Playfulness Acceptance, Curiosity, and Empathy
Providing structure and supervision
Managing confrontation and coercive interactions
Thinking, feeling and behavioural choices
Managing behaviour whilst maintaining a secure base

Figure 4. Curriculum topics of the 'Fostering Attachments' Programme (Golding, 2006).

2.4.6 Analysis

To assess the stability of outcome variables when receiving no intervention, the difference between Group 2's scores on assessment measures at assessment point 1 and 2 will be compared using paired t-tests. To establish the validity of combining data from Group 1 and 2, the difference between group's pre-intervention scores will also be analysed using paired t-

tests. To investigate the intervention's efficacy and maintenance effects, paired t-tests will be used to compare Group 1's scores pre-, post- and eight months following intervention. The paired t-tests will report both asymptotic probabilities and bootstrap confidence intervals. This is because, unlike asymptotic methods, bootstrap methods do not require the assumptions of normality to be met, and are less likely to provide type I or type II errors in small sample situations. For the purposes of this evaluation, differences will only be considered to be significant if the analyses reveal statistically significant differences on both the asymptotic and bootstrap measures.

Chambless and Hollon (1998) recommend that samples of 50 participants per group are required for a sufficiently powered study to evaluate an intervention's efficacy. The available sample was substantially smaller and there is a consequent risk of a type II error, where the statistical test is insufficiently sensitive to demonstrate the differences between groups and non-significance is presumed despite an intervention's efficacy. To evaluate the intervention's efficacy within this smaller sample, the response of individual participants to the intervention will be investigated by calculating the Reliable Change Index (RCI), according to Jacobson and Truax's (1991) formula. The RCI statistic indicates whether the difference between two scores reflects more than would be expected from the fluctuations of the measurement instrument (Jacobson & Truax, 1991). It can be defined as the ratio of observed change over the distribution of change scores that would be expected if no actual change had occurred (i.e., that attributed to measurement error and naturally occurring variation under the non-treatment condition) (Jacobson & Truax, 1991). Change will be considered significant where the RCI is more than 1.96 or less than -1.96, which represents a significant improvement or deterioration at an alpha <=0.05 (Jacobson & Truax, 1991).

3. RESULTS

3.1 Inter-rater reliability

Inter-rater reliability was established for the Mind-Mindedness interview assessment. Eleven of the 58 interviews were randomly selected to be marked by a second assessor. The correlation between markers was highly significant correlation ($r = 0.93$; $p < 0.01$) and the mean scores for both assessors were similar ($t_{20}=0.14$; $p=0.89$).

3.2 Treatment Fidelity

Facilitators reported a high level of compliance with the manual; Group 1 reportedly received 87% (51.5 of the 59 curriculum criteria) and Group 2 reportedly received 94% of the curriculum (55.5 of the 59 curriculum criteria). The researcher independently reviewed videos of 10 randomly selected sessions from a possible 36. There were no differences between the researcher's and facilitators' rating of the coverage of curriculum criteria, and so the accuracy of the facilitators' reports was verified.

Participants' reports of process variables and facilitators' process skills considered integral to the delivery of the 'Fostering Attachments' programme are summarised in Table 6. The mean average rating of the presence of these skills and variables within the programme ranged from 8.67 – 9.91 out of 10, with standard deviations from 0.30 - 3.02. This suggests participants' perceived these aspects to be present in the programme's delivery. For the purposes of this evaluation, differences were only considered to be significant if the analysis revealed statistically significant differences on both the paired t-tests using the asymptotic probabilities and bootstrap confidence intervals. No significant differences between groups were found, suggesting participants had similar experiences of the programme's delivery.

Table 6

Differences between groups on intervention delivery variables

		Group 1 (n=11)		**Group 2** (n=9)		**t**	**p**	**Bootstrap 95% CI**	**Cohen's D**
		Mean (Range)	**SD**	**Mean (Range)**	**SD**				
Facilitators' Manner	Sensitive	9.82 (8-10)	0.60	9.78 (9-10)	0.44	1.51	0.17	variance near to 0	0.07
	Non-Judgemental	8.91 (0-10)	3.02	9.67 (9-10)	0.50	0.82	0.43	variance near to 0	-0.25
	Empathy	9.73 (8-10)	0.65	9.89 (9-10)	0.33	0.72	0.48	variance near to 0	-0.25
	Encourage Reflectivity	9.91 (9-10)	0.30	9.56 (8-10)	0.73	1.36	0.20	variance near to 0	1.17
Carer's Expereince Of The Programme	Felt Safe To Share Information	9.45 (7-10)	1.04	8.67 (1-10)	2.92	0.77	0.46	-1.73 to 2.15	1.11
	Felt Able To Ask Questions	9.91 (9-10)	0.30	9.44 (8-10)	0.73	1.80	0.10	variance near to 0	-21.56
	Felt Able To Contribute To Group Discussion	9.73 (8-10)	0.65	9.67 (9-10)	0.50	0.24	0.82	variance near to 0	0.09

Note: Bootstrap estimates resulted in a large number of bootstrap samples evidencing zero or near zero variance. In such circumstances the bootstrap estimates may be biased.

3.3 Group Analysis

3.3.1 Differences between groups

To assess the validity of combining the data from the two treatment groups to analyse change during the intervention period, the differences between groups were analysed. Independent t-tests and bootstrapped analyses were conducted to investigate differences on participants'

attendance of the programme, children's demographic details and outcome measures. Data from the Parenting Stress Index and its developmentally sensitive upward extension, the Stress Inventory for Parents of Adolescence, were converted to t-values to allow the data from these different assessments of stress to be considered within the same analyses.

Differences were only considered to be significant if analyses revealed statistically significant differences on both the paired t-tests using the asymptotic probabilities and bootstrap confidence intervals. Only one of the 35 variables met this criteria (see Table 7); the mean average age of the cared for child was significantly higher in Group 1 than Group 2 (using both asymptotic and bootstrap probability estimates). As the remaining variables did not differ significantly between groups it was considered appropriate to combine the two groups' data when analysing change during the intervention period.

Table 7

Differences between groups at the pre-intervention assessment

	Group 1			**Group 2**			**t**	**p**	**Bootstrap 95% CI**	**Cohen's D**
	n	**Mean (Range)**	**SD**	**n**	**Mean (Range)**	**SD**				
Percentage Of Programme Attended By Carers	11	77.78 (5.56-100)	28.97	10	76.11 (33.33-100)	27.85	0.13	0.89	-1.85 to 2.38	0.06
Age Of Carers *(Months)*	11	563.90 (448-689)	70.82	14	580.10 (393-720)	105.60	-0.48	0.63	2.83 to 1.42	-0.24
Number Of Adopted Children, per Adoptive Parent	7	1.10 (1-3)	0.76	8	1.38 (1-3)	0.74	0.87	0.40	variance near to 0	0.43

	Group 1			Group 2			t	p	Bootstrap 95% CI	Cohen's D
	n	Mean (Range)	SD	n	Mean (Range)	SD				
Number Of Foster Children (LT/ST), per Foster Carer	6	1.33 (1-2)	0.52	3	2.33 (1-4)	1.53	-1.1	0.37	variance near to 0	-1.92
No Foster Placements Offered, per Foster Carer	5	35.6 (9-70)	28.4	7	7.14 (1-30)	10.67	2.14	0.09	0.10 to 6.21	1.00
No. Months of Fostering / Adoptive Experience	11	92.27 (6-204)	10.57	14	86.43 (0-187)	69.03	0.21	0.84	-1.89 to 2.29	0.08
Child's age *(Mean no. Months of all Children currently Cared for by Carer)*	11	120.60 (48-180)	42.27	14	61.11 (6.75-161)	6.75	2.33	0.03 *	0.42 to 5.10**	1.41
Time Children Have Resided With Carer *(Mean no. Months Of All Children Cared For By Carer)*	11	49.48 (0-143)	45.32	14	47.36 (0-143)	50.78	0.11	0.91	-1.88 to 2.24	0.05
Time Since Children were Looked-after	11	75.56 (12-161)	49.74	14	56.9 (6.75-161)	53.52	0.91	0.37	-1.04 to 3.23	0.38
No. Prior Placements *(Mean No. Of Children Cared For By Carer)*	11	1.10 (0-8)	2.25	14	0.77 (0-2)	0.70	1.34	0.21	-0.51 to 2.86	0.42
Sense of Self-Efficacy	11	26.36 (17-41)	6.04	14	28.57 (10-42)	9.25	-0.72	0.48	-3.22 to 1.18	-0.37
Sense of competence and confidence (CQ)	8	83.24 (73-107)	11.63	6	86 (69-101)	14.48	-0.38	0.10	-3.13 to 1.78	-0.24
Mind-Mindedness	10	0.30 (0.09-0.8)	0.18	12	0.39 (0.19-0.56)	0.14	-1.23	0.24	-4.43 to 0.80	-0.50

	Group 1			Group 2			t	p	Bootstrap 95% CI	Cohen's D
	n	Mean (Range)	SD	n	Mean (Range)	SD				
S tress, Total (t)	8	63.60 (49.51-74.9)	8.26	6	70.59 (38.5-117.99)	28.43	-0.58	0.58	-2.83 to 1.97	-0.85
Stress, Parenting Domain (t)	8	55.38 (39.65-65.4)	8.10	6	54.33 (31.52-73.32)	15.30	0.15	0.88	-2.22 to 2.45	0.12
Stress, Child Domain (t)	8	68.97 (52.29-84.2)	11.91	6	68.52 (51.76-81.54)	13.12	0.07	0.95	-2.35 to 2.31	0.04
SDQ Total	13	18.38 (4-32)	8.73	7	14.10 (2-38)	12.32	0.70	0.50	-1.20 to 4.01	0.42
SDQ Emotional	13	4.31 (0-9)	3.07	7	4.86 (0-9)	3.53	-0.35	0.74	-2.65 to 1.81	-0.18
SDQ Conduct	13	4.08 (1-6)	1.80	7	3.29 (0-10)	3.90	0.51	0.63	-1.45 to 5.06	0.44
SDQ Hyperactivity	13	6.69 (1-10)	2.95	7	4.86 (0-10)	4.18	1.03	0.33	-0.94 to 4.19	0.62
SDQ Peer Problems	13	3.31 (0-10)	3.09	7	3.43 (0-9)	3.31	-0.08	0.94	-1.99 to 2.58	-0.04
SDQ Pro Social	13	5.77 (1-10)	2.28	7	7.57 (3-10)	2.37	-1.9	0.13	-5.61 to 0.25	-0.79
SDQ Severity	13	1.54 (0-3)	0.88	7	2.14 (0-5)	1.77	-0.85	0.42	-3.51 to 1.21	-0.68
SDQ Impact	13	4.15 (0-10)	3.63	7	3 (0-8)	3.32	0.72	0.49	-1.22 to 3.20	0.32
Child's Sense Of Security	4	3.22 (2.40-3.67)	0.60	4	2.63 (2-3.2)	0.49	1.50	0.19	variance near to 0	0.98

Note: (*) denotes statistically significant difference where $p<0.05$; (**) denotes statistically significant difference; (Variance near to 0) denotes bootstrap estimates resulted in a large number of bootstrap sample evidencing zero or near zero variance. In such circumstances the bootstrap estimates may be biased.

3.3.2 Apriori differences

The analysis to establish stability of the measures over the waiting-list period revealed non-significant differences between the measures completed at assessment point 1 and assessment point 2 (see Table 8) by Group 2.

3.3.3 Efficacy

Comparison of pre- and post-intervention outcome measures revealed that the only measure to significantly differ post-intervention on both the paired t-test using the asymptotic and the bootstrap probabilities, was carers' sense of competence and confidence, as assessed by the Carer Questionnaire (CQ) (see Table 9).

3.3.4 Maintenance of effects and change following intervention

The analysis (see Table 10) revealed that increases in carers' sense of competence and confidence, as assessed by the CQ, were maintained between the post-intervention and follow-up assessments. Comparisons of the measures between the pre-intervention and follow-up assessments revealed carers' sense of self-efficacy and CQ scores were the only variables to be significantly higher at follow-up on both the paired t-tests using both asymptotic and bootstrapped probabilities.

Table 8

Comparison of the outcome measures for Group 2 over the waiting-list period

		Start of Waiting-list		**Pre-intervention**		**t**	**p**	**Bootstrap 95% CI**	**Cohen's D**
	n	**Mean (Range)**	**SD**	**Mean (Range)**	**SD**				
Sense of Self-Efficacy	11	27.82 (16-39)	6.23	31 (17-42)	8.04	-2.00	0.07	-3.63 to 0.94	-0.51
Sense of competence and confidence (SC)	5	81 (63-92)	11.73	88.8 (69-101)	14.25	-1.99	0.12	variance near to 0	-0.8
Mind-Mindedness	9	0.39 (0-0.62)	0.2	0.41 (0.21-0.56)	0.14	-0.32	0.75	-2.55 to 2.00	-0.10
S tress, Total (t)	5	59.8 (25.74-90.77)	24.29	61.1 (38.58-80.38)	18.34	-0.33	0.76	-3.00 to 2.76	-0.05
Stress, Parenting Domain (t)	5	53.37 (25.78-82.34)	20.51	54.22 (31.52-73.32)	17.11	-0.26	0.81	-3.08 to 2.59	-0.04
Stress, Child Domain (t)	5	65.07 (34.20-87.39)	21.3	8.44 (51.76-81.54)	13.53	-0.31	0.77	-2.70 to 3.13	-0.06
Strengths & Difficulties (SDQ) Total	6	14.5 (0-39)	14.54	12.67 (0-38)	14.25	1.57	0.18	-2.15 to 2.90	0.13
SDQ Emotional	6	4.17 (0-10)	3.43	3 (0-9)	3.35	2.44	0.06	-1.55 to 3.80	0.34
SDQ Conduct	6	3 (0-10)	3.85	2.67 (0-10)	3.88	1.58	0.17	variance near to 0	0.09
SDQ Hyperactivity	6	5 (0-10)	4.52	4.5 (0-10)	4.46	1	0.36	-2.27 to 2.95	0.11
SDQ Peer problems	6	2.33 (0-9)	3.5	2.5 (0-9)	3.39	-0.54	0.61	-2.45 to 2.12	-0.05
SDQ Pro social	6	6.17 (0-10)	3.10	6.67 (0-9)	3.44	1	0.36	-2.84 to 2.09	-0.13
SDQ Severity	6	1.5 (0-3)	1.05	1.17 (0-3)	1.33	1	0.36	-1.75 to 3.80	0.31
SDQ Impact	6	2.67 (0-9)	4.18	2.67 (0-8)	3.5	0	1	-2.58 to 2.24	0.00
Child's Sense of Security	3	3.2 (3.07-3.33)	0.13	2.84 (2.6-3.2)	0.32	1.95	0.19	variance near to 0	2.77

Note: (Variance near to 0) denotes bootstrap estimates resulted in a large number of bootstrap sample evidencing zero or near zero variance. In such circumstances the bootstrap estimates may be biased.

Table 9

Comparison of the outcome measures over the intervention period in the entire sample

	Pre-Intervention			Post-Intervention		t	p	Bootstrap 95% CI	Cohen's D
	n	Mean (Range)	SD	Mean (Range)	SD				
Sense of Self-Efficacy	21	26.24 (10-42)	7.52	29.10 (18-42)	6.21	-2.90	0.01 *	-4.12 to 0.29	-0.46
Sense of competence and confidence (CQ)	11	82.82 (72-107)	10.98	93.09 (78-110)	8.43	-5.77	<0.01*	-6.92 to 0.55**	-0.94
Mind-Mindedness	18	0.32 (0.09-0.8)	0.16	0.33 (0.16-0.54)	0.1	-0.42	-0.42	-2.77 to 1.58	-0.06
Stress, Total (t)	11	69.79 (49.51-117.909)	18.18	62.5 (46.23-75.46	8.63	1.52	0.16	-0.77 to 2.99	0.40
Stress, Parent Domain (t)	11	56.84 (39.65-73.32)	9.12	56.27 (46.68-72.98)	7.24	0.25	0.80	-1.84to 2.59	0.06
Stress, Child Domain (t)	11	70.42 (52.20-94.20)	10.87	66.59 (46.97-85.80)	12.58	2.16	0.06	-1.28 to 3.38	0.35
Strengths & Difficulties (SDQ) Total	16	17.31 (4-32)	8.44	16.38 (5-36)	7.54	0.59	0.56	-1.81 to 2.47	0.11
SDQ Emotional	16	4.38 (0-9)	2.85	4.38 (0-9)	2.85	0.00	0.99	-2.11 to 2.11	0.00
SDQ Conduct	16	4.06 (1-7)	1.95	3.5 (0-8)	2.37	1.59	0.13	-1.19 to 3.23	0.29
SDQ Hyper-activity	16	6.75 (1-10)	2.86	5.69 (1-10)	2.8	2.35	0.03 *	-0.89 to 3.62	0.37
SDQ Peer Problems	16	3.12 (0-10)	2.8	2.81 (0-7)	2.07	0.68	0.51	-1.75 to 2.37	0.11
SDQ Pro Social	16	5.88 (1-10)	2.31	6.38 (3-10)	1.10	-1.58	0.13	-2.90 to 1.32	-0.22
SDQ Severity	16	1.81 (0-5)	1.17	1.19 (0-2)	0.83	2.44	0.03 *	-0.18 to 3.95	0.53
SDQ Impact	16	3.88 (0-10)	3.48	2.06 (0-6)	1.98	3.09	0.01 *	0 to 4.15	0.52
Child's Sense Of Security	5	2.97 (2-3.67)	0.75	3.36 (2.87-3.87)	0.4	-1.96	0.12	-4.56 to 1.30	-0.52

Note: (*) denotes statistically significant difference ($p<0.05$); (**) denotes statistically significant difference; (Variance near to 0) denotes bootstrap estimates resulted in a large number of bootstrap sample evidencing zero or near zero variance. In such circumstances the bootstrap estimates may be biased.

Table 10

Difference in outcome measures for Group 1 during and following intervention

	n	Pre Intervention		Post Intervention		Follow-up		Post Intervention-Follow-up Analysis				Pre-intervention-Follow-up Analysis			
		Mean (Range)	**SD**	**Mean (Range)**	**SD**	**Mean (Range)**	**SD**	**t**	**p**	**Bootstrap 95% CI**	**Cohen's D**	**t**	**p**	**Bootstrap 95% CI**	**Cohen's D**
Sense of Self-Efficacy	11	26.36 (17-41)	6.04	30.73 (25-42)	4.94	32.18 (25-42)	5.74	-1.28	0.23	-3.12 to 1.42	-0.29	-4.10	0.002*	-5.68 to -0.39**	-0.96
Sense of competence and confidence (CQ)	8	83.25 (73-107)	11.63	94.12 (86-110)	7.92	94.38 (84-106)	7.11	-0.14	0.89	-2.11 to 2.06	-0.03	-4.16	0.00*	-8.30 to -0.34**	-0.96
Mind-Mindedness	10	0.3 (0.09-0.8)	0.19	0.36 (0.24-0.54)	0.1	0.29 (0.11-0.56)	0.11	2.19	0.06	-0.37 to 4.99	0.70	0.36	0.72	-2.33 to 2.23	0.05
S tress, Total (t)	8	63.6 (49.51-74.9)	8.26	62.36 (46.23-75.46)	9.2	59.76 (45.14-79.29)	12.59	1.21	0.27	-1.81 to 3.30	0.28	1.50	0.18	-1.31 to 3.64	0.46
Stress, Parent Domain (t)	8	55.38 (39.65-65.4)	8.10	57.15 (46.68-72.98)	7.99	55.29 (45.86-10.46)	8.81	1.14	0.29	-1.63 to 3.19	0.23	0.04	0.97	-2.09 to 2.94	0.01
Stress, Child Domain (t)	8	68.97 (52.29-84.2)	11.91	65.31 (46.97-85.8)	12.76	62.89 (44.84-88.46)	16.24	1.01	0.34	-1.87 to 3.10	0.19	1.60	0.15	-1.17 to 4.03	0.51
Strengths & Difficulties (SDQ) Total	13	18.38 (4-32)	8.73	16.38 (5-26)	7.72	15.31 (2-30)	9.6	0.8	0.52	-1.78 to 2.10	0.14	1.48	0.16	-1.16 to 3.44	0.35

	n	Pre Intervention		Post Intervention		Follow-up		Post Intervention-Follow-up Analysis				Pre-intervention-Follow-up Analysis			
		Mean (Range)	**SD**	**Mean (Range)**	**SD**	**Mean (Range)**	**SD**	**t**	**p**	**Bootstrap 95% CI**	**Cohen's D**	**t**	**p**	**Bootstrap 95% CI**	**Cohen's D**
SDQ Emotional	13	4.31 (0-9)	3.07	4.46 (0-9)	3.15	3.46 (0-9)	3.69	1.73	0.11	-1.24to 3.18	0.32	1.09	0.30	-1.44 to 3.17	0.28
SDQ Conduct	13	4.08 (1-6)	1.8	3.46 (1-7)	2.07	3.62 (0-7)	2.22	-0.31	0.77	-2.43 to 1.86	-0.08	1.48	0.17	-1.41 to 3.09	0.26
SDQ Hyperactivity	13	6.69 (1-10)	2.95	5.62 (1-10)	2.8	5.77 (1-10)	3.35	-0.28	0.79	-2.42 to 2.03	-0.06	0.17	0.22	-1.25 to 3.20	0.31
SDQ Peer problems	13	3.31 (0-10)	3.09	2.85 (0-7)	2.23	2.46 (0-5)	1.76	0.86	0.41	-1.93to 2.75	0.17	1.25	0.24	-1.18 to 3.08	0.28
SDQ Pro social	13	5.77 (1-10)	2.28	6.23 (3-10)	1.69	6.31 (2-9)	2.21	-0.16	0.87	-2.59 to 1.89	-0.05	-1.17	0.27	-3.15 to 1.34	-0.24
SDQ Severity	13	1.54 (0-3)	0.88	1.15 (0-2)	0.8	1.08 (0-2)	0.76	0.32	0.75	-1.85 to 2.55	0.09	2.14	**0.05***	-0.519 to 4.38	0.52
SDQ Impact	13	4.15 (0-10)	3.63	2.15 (0-6)	2.12	1.92 (0-8)	2.75	0.38	0.10	-1.78 to 2.84	0.11	2.87	**0.01**	-0.11 to 4.49	0.61
Child's Sense of Security	4	3.22 (2.4-3.67)	0.6	3.48 (3.07-3.87)	0.34	3.37 (2.6-3.93)	0.57	0.77	0.50	Variance near to 0	0.32	-2.03	0.14	Variance near to 0	-0.25

Note: * = statistically significant difference where P<0.05, ** = statistically significant difference, Variance near to 0 = Bootstrap estimates resulted in a large number of bootstrap sample evidencing zero or near zero variance. In such circumstances the bootstrap estimates may be biased.

3.4 Individual Change Analysis

3.4.1Reliable Change

The percentages of participants demonstrating reliable change during and following the intervention are detailed, according to each outcome measures, in Tables 11-15. Carers' changes on each outcome measure are presented according to participant in Figures 5 and 6 on pages 98 and 99, and according to each child in Figures 7 and 8 on pages 100 and 101.

Individual analysis of carers' sense of self-efficacy revealed that 16 of the 21 participants improved, of whom five showed reliable improvement. At follow-up, the proportion demonstrating reliable improvement increased to almost half the group (n=11). Individual analyses of carers' sense of competence and confidence in their care of and relationship with the child found that 91% improved post-intervention, approximately two thirds of which demonstrated reliable improvements. A similar proportion of Group 1 maintained these increases at the eight month follow-up.

Eight of the eleven carers who completed the stress assessments reported lower total stress levels post-intervention, of which three demonstrated reliable change. At follow-up, a substantial proportion reported lower stress levels relative to their pre-intervention assessment, four of the eight participants demonstrating a reliable reduction in their stress levels. However, the results were variable, with two participants demonstrating reliable increases in their stress levels at follow-up.

Individual analyses showed very little individual change on the majority of the subscales of the SDQ. Five of the sixteen children however demonstrated reliable improvement on carers'

perception of the impact of children's difficulties post-intervention, and a similar proportion of Group 1 demonstrated reliable improvement on this variable at follow-up.

Children's reported sense of security revealed that four of the five children showed improvements post-intervention, of which two showed reliable improvements. One of these two children participated in the follow-up assessment, where the improvement was not maintained. At follow-up, three of the four children in Group 1 demonstrated improvement, but the change did not meet the requirement for statistical significance.

Table 11

Percentage of participants demonstrating reliable change on self-reported stress levels.

	Pre-Post intervention (n= 11)		**Post-intervention- Follow-up (n= 8)**		**Pre-intervention- Follow-up (n= 8)**	
	Improve	Deteriorate	Improve	Deteriorate	Improve	Deteriorate
Total Stress	27.27%	0%	12.5%	0%	50%	25%
Child Related Stress	18.18%	0%	12.5%	0%	25%	12.5%
Parent Related Stress	9.09%	18.18%	12.5%	0%	0%	0%

Table 12

Percentage of participants demonstrating reliable change on the CQ

	Pre –Post Intervention (n= 11)		**Post- intervention – follow-up (n= 8)**		**Pre- intervention – follow-up (n= 8)**	
	Improve	Deteriorate	Improve	Deteriorate	Improve	Deteriorate
CQ Total	63.9%	0%	0%	0%	62.5%	0%

Table 13

Percentage of participants demonstrating reliable change on self-reported self-efficacy

	Pre –Post Intervention (n= 21)		**Post- intervention – follow-up (n= 11)**		**Pre-Intervention – follow-up (n= 11)**	
	Improve	Deteriorate	Improve	Deteriorate	Improve	Deteriorate
Self-Efficacy	23.81%	0%	9.09%	0%	45.45%	0%

Table 14

Percentage of children demonstrating reliable change on self-reported sense of security

	Pre-Post intervention (n= 5)		**Post-intervention - Follow-up(n= 4)**		**Pre-intervention - Follow-up (n= 4)**	
	Improve	Deteriorate	Improve	Deteriorate	Improve	Deteriorate
Sense of Security	40%	0%	0%	0%	0%	0%

Table 15

Percentage of participants demonstrating reliable change on carer-reports of children's emotional and behavioural strengths and difficulties

	Pre-Post intervention (n=16)		**Post-intervention - Follow-up(n=13)**		**Pre-intervention - Follow-up (n= 13)**	
	Improve	Deteriorate	Improve	Deteriorate	Improve	Deteriorate
SDQ Total	12.5%	6.25%	7.69%	7.69%	30.77	0%
Emotional	0%	0%	7.69%	7.69%	15.38%	0%
Conduct	6.25%	0%	0%	7.69%	0%	0%
Hyperactivity	6.25%	0%	0%	7.69%	15.38%	0%
Peer problems	12.5%	0%	15.38%	7.69%	30.77	0%
Pro social	0%	0%	0%	0%	7.69%	0%
Impact	31.25%	6.25%	7.69%	7.69%	30.77%	0%

3.5 Placement Stability

To assess the effect of the intervention on the stability of placements for children provided by carers, the number of unplanned placement breakdowns that occurred during the evaluation was recorded. There were two unplanned placement breakdowns in Group 2, one nearing the end of the waiting-list period, and a second during the latter third of their intervention period. The occurrences were too low to be meaningfully analysed.

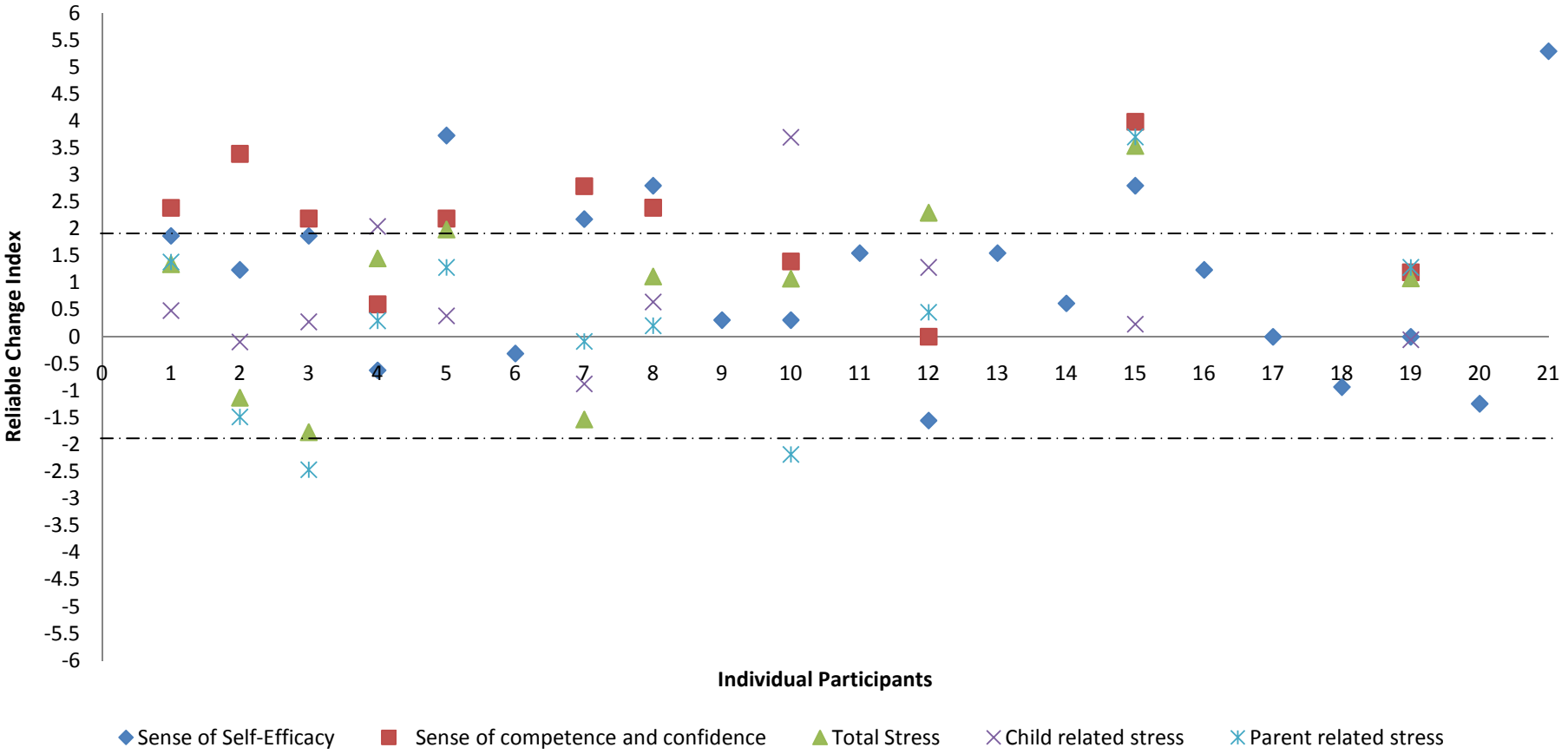

Figure 5. Individual participants' reliable change indexes (RCIs) on outcomes related to carers' well-being over the pre to post intervention period. RCIs above 1.96 and below -1.96 (dashed lines) are considered to be statistically significant ($p<0.05$).

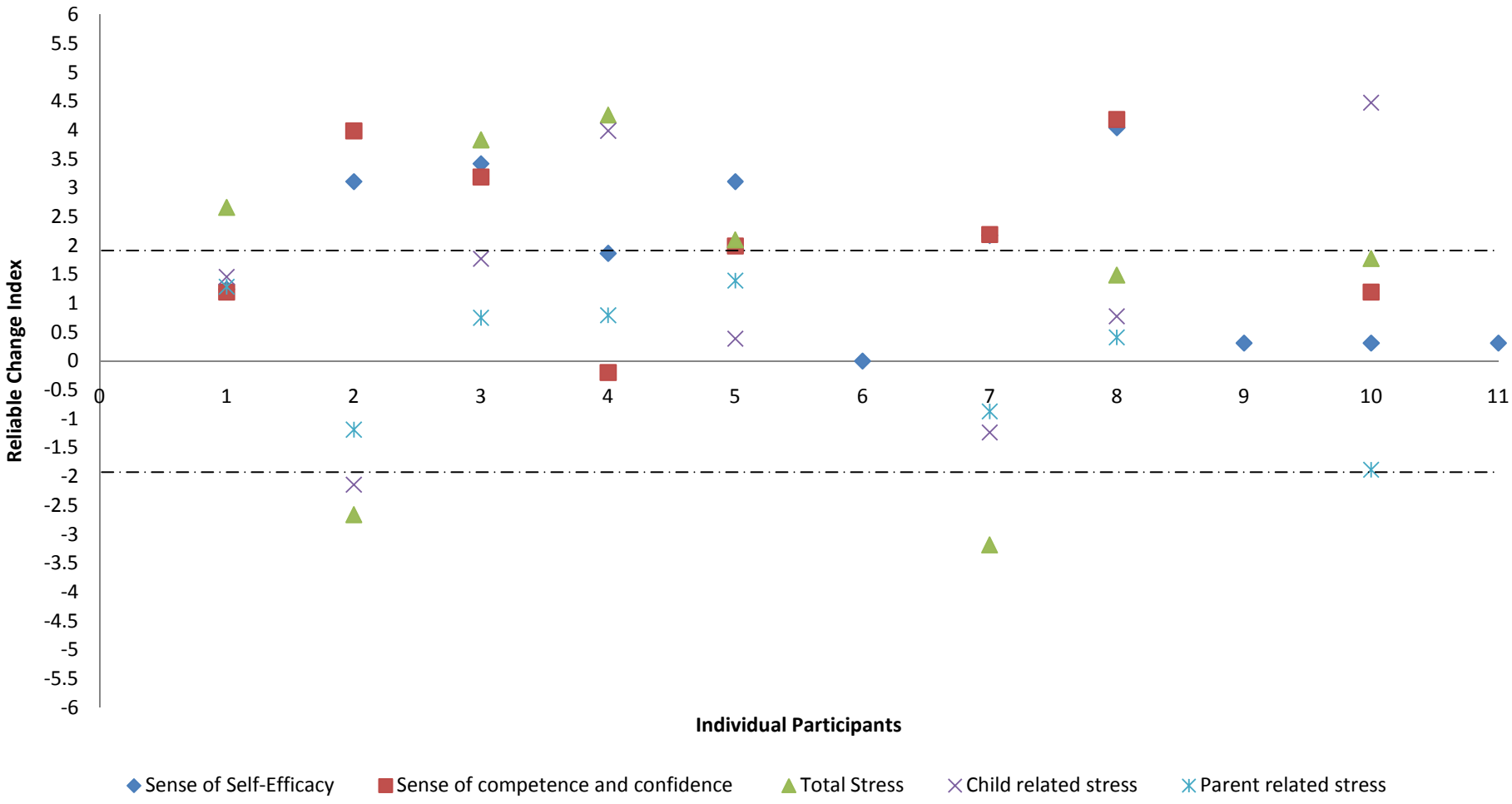

Figure 6: Individual participants' reliable change indexes (RCI's) on outcomes related to carers' well-being over the pre intervention to eight month follow-up period. RCIs above 1.96 and below -1.96 (dashed lines) are considered to be statistically significant ($p<0.05$).

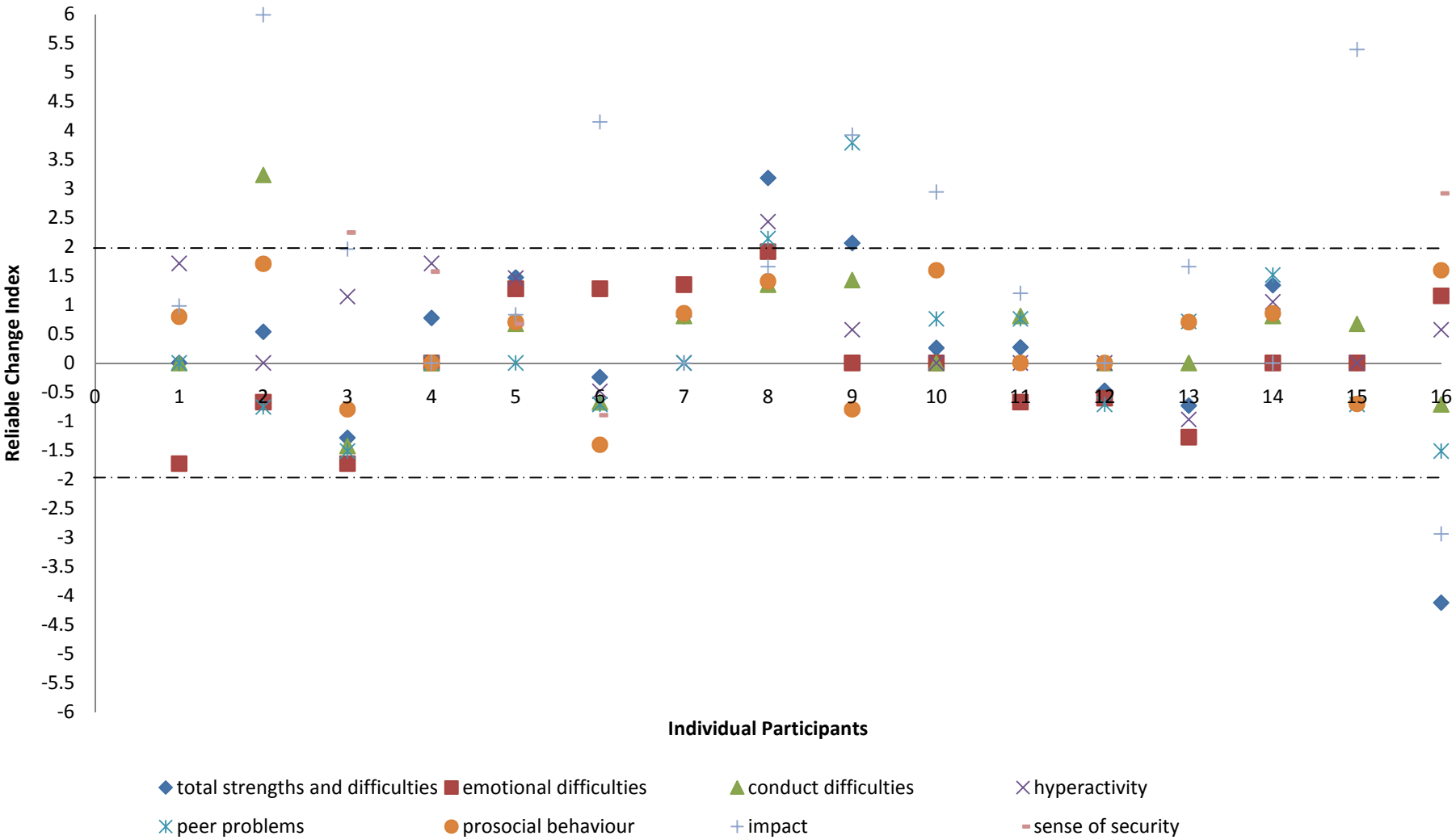

Figure 7: Individual participants' reliable change indexes (RCI's) on outcomes related to children's well-being over the pre to post-intervention period. RCIs above 1.96 and below -1.96 (dashed lines) are considered to be statistically significant ($p<0.05$).

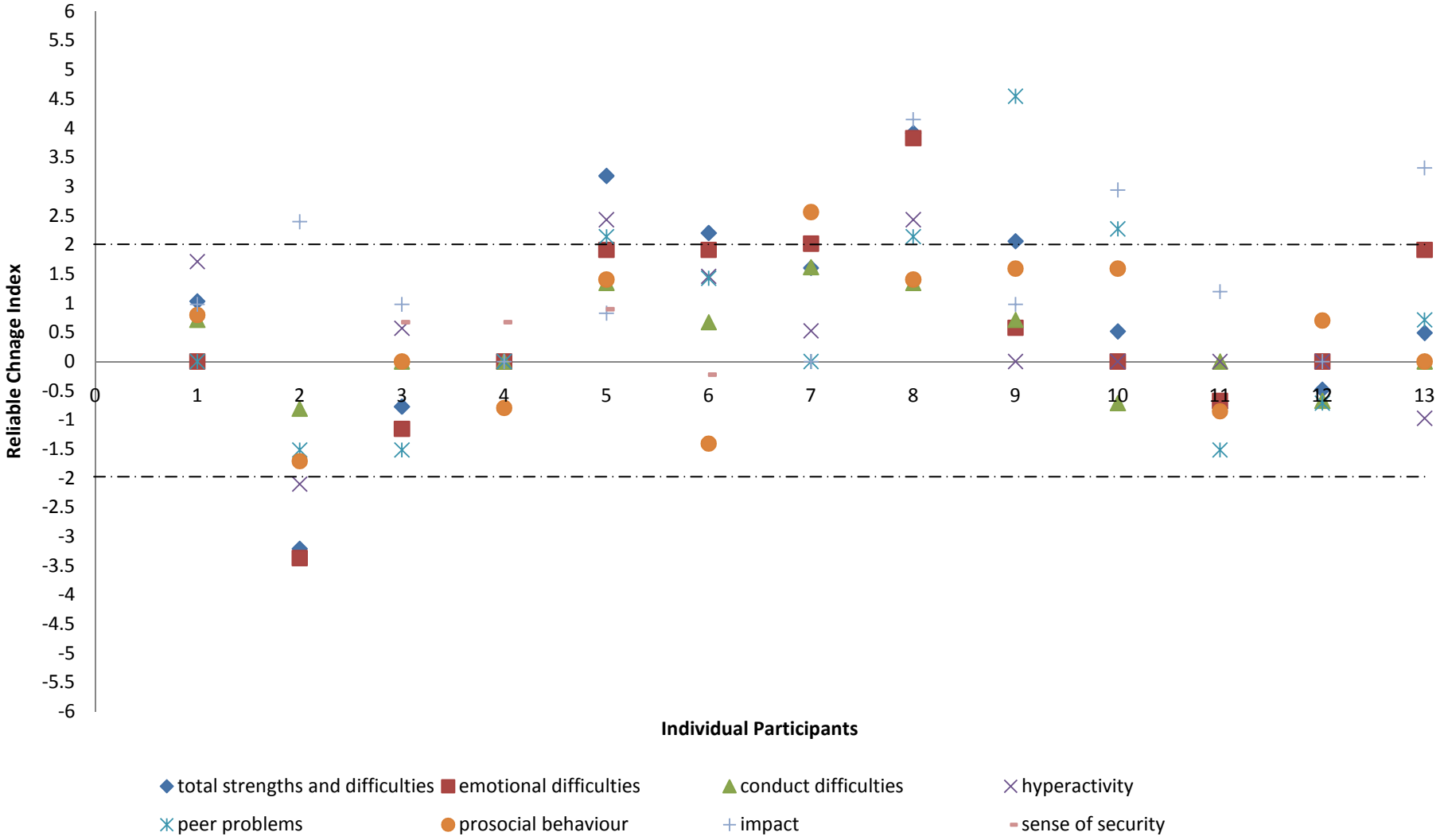

Figure 8: Individual participants' reliable change indexes (RCI's) on outcomes related to children's well-being over the pre- intervention to eight month follow-up period. RCIs above 1.96 and below -1.96 (dashed lines) are considered to be statistically significant ($p<0.05$).

4. DISCUSSION

4.1. Summary of findings

The 'Fostering Attachments' programme was hypothesised to support foster and adoptive families according to two causal pathways. Firstly, the programme aims to help carers' understanding of the children they look after, supporting them to perceive their children's thoughts and feelings as well as their often complex and difficult behaviours (i.e. to develop carers' mind-mindedness (MM)). Peer and facilitator support was hypothesised to reduce carers' stress levels. The changes in MM and stress were hypothesised to increase carers' ability to parent with sensitivity and responsivity (Meins, 1999). This could lead to increases in children's relational security, which could protect them from emotional and behavioural difficulties (Sroufe et al., 1999). Contrary to prediction, group analyses found no significant changes during or following the intervention in carers' MM and stress levels, children's sense of security or emotional and behavioural functioning. This suggests the intervention did not improve the majority of carers' and children's well-being. Individual analyses revealed variation in carers' and children's responses; some made reliable improvements on these variables post-intervention and at follow-up while others did not, and very few deteriorated. This suggests carers and children varied in how beneficial they found the intervention. The degree of confidence we can place in these conclusions and their implications for our understanding of the 'Fostering Attachments' programme's efficacy will be discussed later.

The second hypothesis suggested the programme would increase carers' knowledge, skills and understanding regarding their care of, and relationships with, their foster / adoptive children. This was hypothesised to increase carers' sense of competence, sense of self-efficacy and confidence in their foster / adoptive parenting roles. These increases, and the

hypothesised reductions in stress previously considered, were hypothesised to increase placement stability. Congruent with predictions, group analyses found significant improvements in carers' confidence and sense of competence in their care of a fostered / adopted child, which were maintained at follow-up. Two-thirds of carers demonstrated reliable improvements post-intervention and at follow-up, which increased confidence in this finding. This suggests that the intervention improved carers' sense of competence and confidence in their care of their fostered / adopted children.

Group analyses revealed that sense of parenting self-efficacy improved significantly at follow-up, but not immediately post-intervention. Similarly, the majority of participants showed improvements in their sense of self-efficacy scores post intervention, but only a quarter demonstrated reliable improvements post-intervention (n=21), rising to almost half at follow-up (n=11). This suggests the significant group differences at follow-up were not due to outliers, but due to a general trend of improvement in the group. The findings indicate that the intervention might have improved carers' sense of self-efficacy regarding their parenting, but the effect appeared to be less immediate than the changes in confidence and sense of competence regarding their care of their foster / adopted child. Confidence in the conclusions and the implications of these findings are discussed further below, according to each outcome variable.

4.2 The effect of the intervention on Carers' Mind-Mindedness

It was hypothesised that the programme's psychoeducation and activities such as role-plays and group discussions would facilitate carers' consideration and reflection upon their child's perspective and mental experience, which would be reflected in improved MM scores.

However, the expected improvement in MM post-intervention and at follow-up was absent, which is consistent with the findings of Gurney-Smith and colleagues' (2011). Facilitators informally reported observing an increase in carers' understanding and ability to empathise with their child's thoughts and feelings during the sessions. If the facilitators' perceptions were accurate, the lack of significant improvements in MM could be due to carers' difficulties transferring their learning away from the sessions. In which case, carers' might need further support to generalise understanding, knowledge and skills discussed in the programme to the care of their children.

Alternatively, the findings might be explained by carers' high stress levels limiting their ability to access and retain the curriculum. Carers' mean stress levels pre-intervention were at a clinically significant level. Previous research suggests high stress levels limit the ability to learn and retain information (see Joels, Pu, Wiegert, Oitzl & Krugers, 2006 and Wolf, 2009 for reviewand are inversely related to the ability to empathise with others (Beddoe & Murphy, 2004; Galantino, Baime, Maguire, Szapary, & Farrar, 2005). Future research with a larger sample is required to investigate whether stress levels in carers moderate or mediate the effect of the intervention on MM. If stress is found to affect carers' ability to benefit from therapeutic work or training, perhaps the first stage of any intervention should be to concentrate on reducing stress levels before supporting the development of carers' parenting competence.

The non-significant findings might also be due to the assessment measurement. At present the MM interview has no established test-retest reliability. It is possible that practice effects may have masked the intervention effect. For example, carers' answers at the second and third

assessments might have been less elaborate than at the first assessment. Further investigation is required into the MM interview's psychometric properties and it's suitability as an outcome assessment measure.

4.3 The effect of the intervention on Carers' Stress

The prediction that the intervention would reduce carers' stress levels was based on a well established stress-buffering model (e.g. Cohen & Wills, 1985; Dennis, 2003), which advocates that peer support can reduce stress. Previous evaluations reported that carers found the programme's support helpful and appreciated the benefits of "off loading" (Golding & Picken, p.32). their stress in a group format. The results provide only partial support for this hypothesis. No significant differences were found in the group analyses. Individual analyses suggested small numbers of participants demonstrated reliable reductions in stress post-intervention. Half of Group 2 (n=8) demonstrated reliable reductions and a quarter demonstrated reliable increases at follow-up. These findings suggest a consistent effect on carers' stress levels cannot be ascribed to the intervention.

Failure to reduce stress in all participants might be explained by the sample's high baseline stress levels. This is not unexpected given carers' wide ranging responsibilities. For example, many looked after more than one child, and care for children with highly complex needs. The 'Fostering Attachments' programme might not be sufficiently potent to buffer the impact of the extremely challenging role of an adoptive or foster carer, but there could be some value in exploring its contribution as a combination therapy. For example, it could be delivered as part of a wider care-package including support such as respite or individual therapy considering stress management and self-care skills.

It is possible that the practical and emotional demands of the intervention cancelled out the beneficial effects of peer support. The emotional resources required by the intervention are substantial; carers are invited to consider their child's attachment relationships, which, as observed by Golding and Picken (2004) could lead carers to reflect on their own attachment history and relationship difficulties.

The lack of significant improvement in stress post-intervention replicates Gurney-Smith and colleagues' (2011) findings, but stand in contrast with Laybourne and colleagues (2008) who found significant post-intervention reductions in carers' stress. The pattern of replication is similar to the differing findings between the studies on carers' confidence and sense of competence, as assessed by the CQ. This suggests the sample or delivery of the programme evaluated by Laybourne and colleagues (2008) might differ from that of the current and Gurney-Smith and colleagues' (2011) evaluation. For example, the current evaluation and Gurney-Smith and colleagues' (2011) included adoptive and foster parents, whereas Laybourne and colleagues' (2008) recruited foster carers only. It could be speculated that the programme is effective at reducing stress for foster carers but not adoptive parents. It is possible that, as employees of local authorities or private agencies, foster carers might wish to present as good employees who respond to intervention as expected. This might have led to minimisation of their self-reported stress levels post-intervention. The higher percentage of foster carers' in Laybourne and colleagues (2008) evaluation could then explain the significant decrease in stress found only by this study.

An alternative tentative explanation is that foster carers' status as employees means they have more professional and financial support than adoptive parents (e.g. Biehal, Sinclair, Baker, Ellison & Beeker, 2009, The Scottish Government, 2009), which could buffer them from the intervention's practical and emotional demands. Alternatively, adoptive parents might differ to foster carers in their emotional investment with the child, which might make them more vulnerable to the intervention's emotional demands. Further research considering the effect of stress on foster carers and adoptive parents is needed to increase our understanding on this point.

4.4 The effect of the intervention on children's sense of security

Contrary to prediction, group analyses revealed no significant differences immediately or eight months post-intervention on children's self-reported sense of security. Individual analyses revealed that the sense of security scores of four of the five children increased post-intervention, of which two children showed reliable improvements. At follow-up, three of the four children reported an increased sense of security, but these improvements did not reach the criteria for reliable change. One of the children who demonstrated reliable improvements immediately post-intervention was assessed at the follow-up assessment, where the improvement was not maintained. The statistically insignificant group differences and low numbers of children who met the criteria for reliable change suggest the intervention was ineffective at improving children's sense of security.

If the insignificant findings are an accurate reflection of the intervention's efficacy, the suggested inefficacy could be due to the length and intensity of the intervention. Considering

the history of the children, some of whom could have experienced multiple, traumatic disruptions to their attachment relationships, and the stable, pervasive nature of attachment relationship difficulties(e.g. Main et al., 1985; Main & Cassidy, 1988; Owen, Easterbrooks, Chase-Lansdale, & Goldberg, 1984; Waters, 1978; Waters, Merrick, Treboux, Crowell & Albersheim, 2000), it could be argued that a six month group programme for carers would not be sufficient to affect children's relational security.

Confidence in the conclusion that the intervention was not effective at improving children's relational security is however moderated by a number of methodological limitations, such as the small sample size and the assessment measure employed. Children's responses to the Sense of Security Scale could have been affected by their level of insight into their relationships, and their ability and willingness to communicate their perspectives (Kerns & Seibert, 2011). Confidence in the validity of the findings could have been improved by including assessments which complimented the child-report assessment. The current evaluation did not have the resources to do this, but it is recommended that future research include such assessments. These could include observational, carer-report or story and play based assessments, which aim to elicit children's representations of their relationships without directly asking the children to comment on their relationship with their carer.

The length of assessment period employed should also be considered before it can be concluded that the intervention did not improve children's relational security. The hypothesised improvements in relational security were predicted to occur only after prior improvement of a number of variables, such as a reduction in carers' stress levels, increase in MM and subsequent improvements in parenting sensitivity and responsivity. We might then

expect changes in children's relational security to occur over a longer period than was assessed in this evaluation. It is possible then that the intervention might be effective at improving children's relational security, but that statistically significant improvements would only be observed over a lengthier assessment period than that utilised in this evaluation.

Given the above reflections regarding the stability and pervasive nature of attachment difficulties, and the hypothesised lengthy process and predicted slow rate of change in children's relational security, it is of note that, despite these factors, almost all the participating children improved in their sense of security scores post-intervention. Although the improvements were not statistically significant, the occurrence of the positive changes is an extremely encouraging finding. It is possible that the observed non-significant improvements represented the start of gradual improvements. These findings therefore raise the possibility that significant improvements might have occurred over a longer assessment period. It is consequently recommended that future research considers longer follow-up periods, utilising a larger sample, to investigate if these improvements continue to develop and reach the criteria for statistical and clinical significance at a later assessment point. If this were the case, such findings would be congruent with the predictions and hypotheses which proposed that carers' attendance of the programme might support carers to develop a safe base for the fostered and adopted children, which could increase the children's sense of security.

4.5 The effect of the intervention on children's emotional and behavioural difficulties

It was hypothesised that improvements in carers' MM and stress levels would improve the sensitivity and responsivity of their parenting, and consequently their child's relational

security and emotional and behavioural functioning (Cassidy, 1994; Fonagy et al., 1991; Robinson et al., 1997; Sroufe et al., 1999; Suchman et al., 2008). Contrary to this prediction, group analyses found non-significant differences in carers' perception of children's emotional and behavioural difficulties following intervention. Consistent with this result, there was little individual change. This strengthens the conclusion that the intervention had no consistent effect on this variable. However, a small proportion of children did show improvements on carers' reports of the impact of children's difficulties post-intervention. This could be due to the increases found in carers' confidence and sense of competence in their care of the children.

The non-significant differences immediately post-intervention on the total score for carers' perception of children's emotional and behavioural difficulties were congruent with Laybourne and colleagues' (2008) and Gurney-Smith and colleagues (2011), but contrasted with Golding and Picken (2004) who reported significant improvements. The difference in findings is not surprising as Golding and Picken (2004) utilised a small sample of six participants which limits the generalisability of their findings.

Gurney-Smith and colleagues' (2011), found improvements during the three months following intervention, but the current evaluation did not find improvements eight months following. This could suggest that the effects found by Gurney-Smith and colleagues are not maintained over a longer period.

The fostered and adopted children presented with substantial and sustained difficulties; the mean average scores for carers' reports of children's emotional and behavioural difficulties

and the impact of these difficulties pre-intervention were at the 91st and 98th percentile, respectively. When considered with reference to the potential complexity and length of the causal pathway hypothesised to lead to improvements in these variables (i.e. following improvements in carers' stress levels, MM, sensitivity and responsivity, leading to improvements in children's relational security), it becomes apparent that it was optimistic to expect changes in children's emotional, behavioural and relational functioning within the eight months following intervention. Future evaluations should assess children's functioning over a more prolonged period.

4.6 The effect of the intervention on carers' sense of self-efficacy, sense of competence and confidence

Although the current study had a medium sample size, both group and individual analyses suggested carers' sense of competence and confidence regarding their care of and relationship with their foster / adoptive child increased post-intervention, and was maintained eight months after. This suggests the intervention had a positive effect upon confidence and competence.

In contrast, the results of both group and individual analyses of carers' sense of self-efficacy in their foster/adoptive parenting revealed that most carers' experienced a slight but non-significant improvement in self-efficacy post-intervention. However, improvements were statistically significant at the follow-up assessment. The findings suggest the intervention might trigger a gradual improvement in self-efficacy which continues to develop following intervention.

The improvement in carers' confidence and sense of competence replicate those reported by Gurney-Smith and colleagues (2011) and Golding & Picken (2004) The replication in this larger sample, with blind assessors and comparison with the lack of change over the waiting-list period increases confidence in the conclusion that the intervention improves carers' sense of competence and confidence.

The findings stand in contrast to the non-significant findings reported by Laybourne and colleagues (2008). The discrepancy could be due to factors such as variation in characteristics of the sample, or the delivery of their programme. Replications of this evaluation utilising larger samples and assessing treatment fidelity using the measures designed by this study could assist investigation of the variations in findings.

The increases in carers' sense of competence and confidence following intervention support the hypothesis that the psychoeduction, normalisation and encouragement received during the programme increases carers' belief and confidence in their skills. It was of note however that carers' sense of self-efficacy was only significantly higher at the follow-up assessment, which suggests the hypothesised improvements were not as immediate as expected. It is possible that, despite facilitators' reassurance, attending a parenting intervention might initially raise carers' awareness of where they could improve their parenting, which could reduce their parenting sense of self-efficacy. Consolidation and further development of the skills and knowledge acquired during the programme could lead to increases in self-efficacy during the months following the intervention. To investigate this hypothesis, future research might consider assessing how self-efficacy changes during as well as post-intervention.

The sense of competence and confidence as assessed by the Carer Questionnaire (CQ) was significantly higher immediately post-intervention, but this was not reflected in self-efficacy as measured with the Parenting Sense of Competence (PSOC) subscale. The discrepancy might be related to the PSOC's requirement for carers to consider their foster / adoptive parenting in general, whereas the CQ focuses on their care of a specific child. It is possible that the immediate improvements on the CQ but not the PSOC were because carers focused more on their care of a specific fostered / adopted child during the programme, rather than their general parenting.

4.7 Strengths and Limitations of the Evaluation

The present study aimed to improve on earlier evaluations of the 'Fostering Attachments' programme by using a larger sample, assessors blinded to treatment condition and assessments of treatment fidelity. One of the primary strengths of the study was the inclusion of a waiting-list control group. Ideally, changes seen over the waiting-list period would be compared to changes seen over the course of the intervention. However, the study did not have a sufficient sample size for this type of analysis. Instead, the stability of the outcome variables during the waiting-list period was examined initially. The results revealed no significant changes between scores over the waiting-list period, which supports the assumption that the outcome variables are stable when carers' receive only treatment as usual. This stability increases confidence in the conclusion that any significant differences found between pre and post-intervention assessments can be attributed to the effect of the intervention, rather than natural improvement on these variables over time.

The sample's heterogeneity increased the likelihood of finding non-significant group differences. A unique strength of the current evaluation was the use of individual analysis to partially compensate for this limitation, which revealed that individuals reliably changed on some variables, despite there being no evidence of a group trend. This suggests that the intervention might be helpful for some but not all of the participants. The sample was too small to fully consider which carer or child characteristics might mediate or moderate the intervention's effect. Consideration of this within future research could inform the development of screening tools to ensure that services enrol only carers' who would benefit from the programme.

When considering the conclusions of this evaluation it is important to recognise the methodological limitations, which are outlined below. Although the sample size was considerably bigger than previous evaluations, it was too small to provide the evaluation with sufficient power. This reduces the generalisability of the findings and increases the possibility of making type II errors. The sample size also prevented direct comparisons being made between changes during the intervention period with changes during the waiting-list period. Such analysis would have greatly improved the evaluation's quality. The limited sample was due to several factors, including restrictions on carers' participation placed by the providing service to ensure children's confidentiality. In addition, the recognised absence of relevant outcome measures appropriate for children of all ages (see O'Connor & Byrne, 2007, for review) resulted in measures being used which excluded some (younger) children.

A large number of outcome variables were assessed. Informal statistical correction for multiple comparisons, such as the Bonferroni correction, may significantly increase the risk of

type II error and result in overly conservative analysis strategies (Clark-Carter, 1997), particularly given the sample size. Accordingly, no formal correction for familywise error was employed and as such the reader should consider these conclusions as preliminary and requiring replication.

A further limitation, inherent in psychological outcome studies, was the single-blind design of the evaluation. Participants informally reported a great deal of respect and appreciation for the facilitators which may have biased their responses, as might a social desirability bias. Risk of such a bias is increased by the reliance on self-report assessments; all but one assessment was based on carers' reports. To address these difficulties, further research should attempt to include multi-modal assessments measures for variables such as carers' competence and children's emotional, behavioural and relational functioning. The study extended the evidence base by including a child-report assessment. However, resource limitations and difficulties obtaining consent from those with parental responsibility for children prevented the use of other assessment methods, such as observational assessments.

An additional limitation related to the outcome variables is that the CQ and MM still require investigation into their psychometric properties. The novel assessments were used because they are the best accessible assessments for small scale evaluations with limited resources. It is well recognised that there are limited accessible, affordable, psychometrically robust assessments, with face validity, considered appropriate for foster and adoptive families, of variables such as carers' reflective function, sensitivity, competency and children's attachment relationships and difficulties (Colton, Roberts & Williams, 2008; Golding, 2006;

Gurney-Smith et al., 2011; Laybourne et al., 2008; O'Connor and Byrne, 2007). Future work that further establishes the psychometric properties of these assessments will be important.

4.8 Conclusions

The improvements in carers' sense of self-efficacy, sense of competence and confidence suggests the 'Fostering Attachments' programme could offer valuable support for foster and adoptive carers. These valuable improvements could lead to knock-on effects which further benefit the carers, the children they care for and health and social care services. For example, recent research suggests improvement on these variables can partially protect foster carers from the impact of children's challenging behaviours on their stress, anxiety and depression levels (Morgan & Baron, 2011).

The increases in carers' confidence and sense of competence and the extremely high satisfaction levels consistently reported by carers attending the programme (Golding & Picken, 2004; Gurney-Smith et al., 2011, Laybourne et al., 2008) appear paradoxical in comparison with the variable and often non-significant differences found in carers' MM, stress levels and children's emotional, relational and behavioural functioning (Gurney-Smith et al., 2011).

The improvements in carers' confidence and sense of competence, despite the lack of observable changes in children's difficulties suggest the programme might change carers' attributions and expectations regarding the challenges they face. The programme's normalisation of difficulties and psychoeducation regarding attachment difficulties might lead carers' to attribute their children's difficulties to their children's early attachment relationship

experiences, rather than failures in their parenting (Laybourne et al., 2008). Future evaluations might consider directly assessing changes in carers' attributions.

Evaluations of the 'Fostering Attachments' programme are not alone in finding that such an intervention improves carers' confidence and sense of competence, but that these changes do not lead to significant observable differences in children's behaviour or well-being. These findings mirror those of previous evaluations considering a range of interventions for adoptive and foster carers, including training, consultation and education (Golding, 2002; see Oke, 2009, for review).

This could be because foster and adoptive families require more support to cope with the substantial and sustained difficulties they face than can be provided by a single programme, training package or consultation. Such a hypothesis is supported by the current study's findings regarding carers' high stress levels and children's emotional and behavioural difficulties, which could evidence the severity and impact of the difficulties experienced by foster and adoptive families.

It is concluded that the findings suggest the 'Fostering Attachments' programme might provide an initial motivating boost for carers, equipping them with the confidence and sense of competence to cope with the challenges of their role. However, it is not sufficient to address the challenges they face, and so might be best delivered as a foundation for a wider care package.

Future clinical work and research should consider the development and evaluation of sustained, wrap-around care packages for foster and adoptive families. This might involve direct and indirect support, encompassing both the child's home and school life. An example of such an approach is the Multi-dimensional Treatment Foster Care approach which provides a multi-level intervention for young people, including individual therapy and support for foster carers consisting of specialist training, a weekly foster carer group and 24 hour support (e.g. Roberts, 2007).

These recommendations are challenging for commissioners within the current economic client. However, they must be considered with recognition of the importance of early intervention for foster families (NICE, 2010) which could prevent further cost to health and social care services in the future. Furthermore, sufficient support for carers could lead to increases in placement stability and foster carer retention which would benefit foster and adoptive children and the network of carers and services around them. (MacGregor, Rodger, Cummings & Leschied, 2006; Rhodes, Orme & Buehler, 2001).

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Public Domain Briefing Document

Parenting programmes for foster and adoptive parents which focus on children's attachment relationships

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Parenting programmes for foster and adoptive parents which focus on children's attachment relationships

A literature review was conducted to examine the efficacy of parent group programmes for foster and adoptive parents aiming to improve the attachment relationships of the children they care for. The review concluded that the quality of the evidence base is currently too limited to make conclusions regarding the programmes' efficacy. It is recommended that future research addresses these significant gaps in our knowledge. Research was then conducted which aimed to do this by evaluating the 'Fostering Attachments' programme for foster carers and adoptive parents.

Aims

The 'Fostering Attachments' programme[1] is an 18 session psychoeducation group programme for foster and adoptive parents, informed by attachment and social learning theories. There have been three evaluations of the programme [2, 3, 4] which provided some support for its efficacy. A number of factors reduce confidence in their findings. These included the small numbers of participants and lack of comparison of the programme's effect with that of receiving typical support without the programme. The current evaluation's design aimed to address these difficulties.

Details of the Study

Twenty-five foster carers and adoptive parents were allocated alternatively to either Group 1 (n=11), which attended the first scheduled programme, or Group 2 (n=14), which remained on a waiting-list for six months before attending the second programme. To investigate the programme's effect on the outcome measures, participants were assessed before, immediately

after and eight months following the programme. Group 2 was assessed over their waiting-list period to assess the stability of the outcome variables when participants were not attending the programme.

Carers participated in questionnaire and interview assessments of their stress, sense of self-efficacy and competence, confidence and their thinking about their foster /adoptive child's thoughts and feelings. To consider the effect of the programme on their fostered / adopted children, carers completed a questionnaire about the children's' emotional and behavioural difficulties. Children aged nine to fourteen completed a questionnaire about their relationship with their carer. To ensure the assessment data was valid, the researcher conducting the assessments did not know which group participants were allocated to.

Main findings

Carers' sense of competence and confidence significantly improved immediately and eight months following the intervention. This change was not observed in the assessments of carers over the waiting-list, suggesting that the programme contributed to the change. Carers' sense of self-efficacy was found to be improved eight months following but not immediately after the programme.

Following the programme, no significant differences in carers' stress levels, their thinking about their foster / adoptive child's thoughts and feelings, or children's emotional, behavioural or relational functioning were found in the group as a whole. Consideration of individual participants' data suggested that although a few participants demonstrated substantial improvements on these variables, there was no evidence for a systematic effect.

Limitations of the study

The evaluation recruited more participants than previous evaluations. However, the sample size was still relatively small, which reduces confidence in the validity and generalisability of the findings. The questionable quality of some of the assessment measures used also reduces confidence in the findings. Future work should establish the quality of assessment measures.

Conclusions

The observation that some carers and children improved on variables while others did not suggests the programme may be more beneficial for some than others. Further research should consider how we can predict who would benefit most from the intervention. This would help services to ensure that only carers who will find the programme useful are enrolled on the programme.

The programme seems to improve carers' sense of competence and confidence. The evaluation did not provide evidence to suggest the programme changes carers' perception of their children's thoughts and feelings, reduces carers' stress levels or improves children's emotional, behavioural or relational functioning. It appears that the programme is not sufficient to address the substantial challenges faced by carers. It could however be delivered as a foundation for a wider care package, equipping carers with the confidence and sense of competence to cope with the challenges of their role.

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LITERATURE REVIEW APPENDICES

Appendix 1: Details of Literature Search

Database searched	Search Terms	Limits to search	Number of papers retrieved	Papers identified
Psycinfo PsycINFO 1987 to February Week 1 201 PsycARTICLES and Journals @Ovid Ovid MEDLINE(R) In-Process & Other Non-Indexed Citations and Ovid MEDLINE(R) 1948 to Present EMBASE 1996 to 2011 Week 0 Journals@Ovid Full Text February 08, 2011	(foster* OR adopt* OR surrogate OR kinship OR looked-after OR "looked after") AND train* OR program* OR group* OR intervention* OR psychoed* OR psycho-ed* OR prevent* or treat*) AND (child* OR caregiver* OR parent* OR carer OR adolesce* OR "young person" OR "young people")	Inclusion Criteria: Year: 2000-current Country of Publication: England or UK or "United Kingdom" or "Great Britain" or Britain or Wales or Scotland or Ireland or Northern Ireland Peer reviewed journals English language Population Groups: Human Methodology: Outcomes Research AND Evidence based Medicine AND Empirical study AND quantitative study AND prospective AND retrospective AND experimental replication AND follow-up study AND longitudinal AND Treatment Outcome or Randomised Control Trial Subject Area = (general psychology or developmental psychology or marriage & family or childrearing & child care or psychological & physical disorders or psychological disorders or affective disorders or health & mental health treatment & prevention or psychotherapy & psychotherapeutic counselling or cognitive therapy or behavior therapy & behavior modification or group & family therapy or interpersonal & client centered & humanistic therapy or psychoanalytic therapy or specialized interventions or self help groups or health & mental health services or outpatient services or community & social services or professional psychological & health personnel issues or professional education & training or personnel management & selection & training) [Limit not valid in Journals@Ovid, EMBASE, Ovid MEDLINE(R),Ovid MEDLINE(R) In-Process, Your Journals@Ovid; records were retained] (evidence based medicine or outcomes research) [Limit not valid in Journals@Ovid, Ovid MEDLINE(R),Ovid MEDLINE(R) In-Process, Your Journals@Ovid, PsycINFO; records were retained]	2056 (excluding duplicates)	MacDonald & Turner (2005) Minnis, Pelosi, Knapp & Dunn (2001)

Database searched	Search Terms	Limits to search	Number of papers retrieved	Papers identified
Web of Science Science Citation Index Expanded (SCI-EXPANDED) --1899-present Social Sciences Citation Index (SSCI) --1898-present Arts & Humanities Citation Index (A&HCI) --1975-present Conference Proceedings Citation Index- Science (CPCI-S) --1990-present Conference Proceedings Citation Index- Social Science & Humanities (CPCI-SSH) --1990-present	(foster* OR adopt* OR surrogate* OR kinship* OR looked-after OR "looked after") AND (train* or program* or group* or interven* OR psychoed* OR psycho-ed* OR prevent* or treat*) AND (child* OR caregiver* OR parent* OR carer OR adolesce* OR "young person" OR "young people")	Inclusion Criteria: English language Articles Year: 2000-present Countries/Territories=(IRELAND OR SCOTLAND OR ENGLAND OR WALES) Exclusion Criteria = Subject Areas= (Allergy Or Anesthesiology Or Food Science & Technology & Hematology Or Biochemistry & Molecular Biology Or Geriatrics & Gerontology Or Microbiology Or Business Or Cardiac & Cardiovascular Systems Or Chemistry (Inorganic & Nuclear Or Multi-Disciplinary Or Organic Or Physical) Or Hospitality, Leisure, Sport & Tourism Or Immunology Or Infectious Diseases Or Law Or Linguistics Or Medical Informatics Or Computer Science, Interdisciplinary Applications Or Reproductive Biology Or Respiratory System Or Microbiology Or Dentistry, Oral Surgery & Medicine Or Nutrition & Dietetics Or Obstetrics & Gynecology Or Sport Sciences Or Oncology Or Ophthalmology Or Surgery Or Orthopedics Or Transplantation Or Endocrinology & Metabolism Or Parasitology Or Tropical Medicine Or Urology & Nephrology Or Or Peripheral Vascular Disease Or Virology Or Pharmacology & Pharmacy Or Zoology Or Biology Or Biophysics Or Public Administration Or Environmental Studies Or Environmental Sciences Or Engineering, Environmental Or Dematology Or Economics Or Ecology)	523	MacDonald & Turner (2005) Minnis, Pelosi, Knapp & Dunn (2001)

Database searched	Search Terms	Limits to search	Number of papers retrieved	Papers identified
Applied Social Sciences Index and Abstracts (CSA) Illumina Database ASSIA: Applied Social Sciences Index and Abstracts, 1987 – Current CSA Social Services Abstracts – 1979 - Current CSA Sociological Abstracts, 1952 - Current	(train* OR group* OR intervent* OR prevent* OR treat* OR psychoeducat* OR psycho-educat*) AND (foster* OR adopt* OR kinship*OR surrogate OR looked after) AND (child* OR caregiver* OR parent* OR carer OR adolesce* OR "young person" OR "young people")	2000-2011 Peer reviewed journal articles English only	1726 (excluding duplicates)	Golding & Picken (2004). Gurney-Smith, Granger, Randle & Fletcher (2011) Herbert & Wookey (2007) Holmes & Silver (2010) Laybourne, Anderson & Sands (2008) MacDonald & Turner (2005) Minnis, Pelosi, Knapp & Dunn (2001) Robson & Briant (2009) Warman, Pallett & Scott (2006)

Database searched	Search Terms	Limits to search	Number of papers retrieved	Papers identified
Adoptie Driehoek Onderzoeks Centrum	Group		358	Holmes & Silver (2010) MacDonald & Turner (2005)
	Training		121	MacDonald & Turner (2005)
	Programme		29	MacDonald & Turner (2005)
	Intervention		362	Holmes & Silver (2010) Gurney-Smith et al (2011)
	Prevention		80	No papers identified
	Treatment		514	MacDonald & Turner (2005)
	Psycho-education		Not recognised by search engine	
	Psychoeducation		Not recognised by search engine	

Appendix 2: Professionals who responded to correspondence asking them to identify relevant publications

List of professionals who responded to correspondence asking them to identify relevant publications

Appendix 3: List of Studies Selected For Review

Studies selected for review

Golding, K., & Picken, W. (2004). Group work for foster carers caring for children with complex problems, *Adoption & Fostering* 28(1), 25–37

Gurney-Smith, B., Granger, C., Randle, A., & Fletcher, J. (2011). 'In time and in tune' – the Fostering Attachments group capturing sustained change in both caregiver and child. *Adoption & Fostering,* 34(4), 50-60.

Herbert, M., & Wookey, J, (2007). The Child Wise programme: a course to enhance the self-confidence and behaviour management skills of foster carers with challenging children, *Adoption & Fostering* 31(4), 27–37

Holmes, B., & Silver, M. (2010). Managing behaviour with attachment in mind. *Adoption & Fostering Journal*, *34*, 65-76.

Laybourne, G., Anderson, J., & Sands, J. (2008). Fostering attachments in looked after children: further insight into the group-based programme for foster carers. *Adoption & Fostering* 32 (4), 9–76.

MacDonald, G., & Turner, W. (2005). An experiment in helping foster carers manage challenging behaviour, *British Journal of Social Work* 35 (8), 1265–82

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Robson, S., & Briant, N. (2009).What did they think? An evaluation of the satisfaction and perceived helpfulness of a training programme developed as an indirect intervention for foster carers. *Adoption & Fostering,* 33(2), 34-44.

Selwyn, J., del Tufo, S., & Frazer, L. (2009). Its a Piece of Cake? An evaluation of an adopter training programme. *Adoption & Fostering,* 33(1), 30-43

Warman, A., Pallett, C., & Scott, S. (2006). Learning from each other: Process and outcomes in the Fostering Changes training programme. *Adoption & Fostering,* 30(3), 17-26.

Appendix 4: The 'Quality Appraisal Checklist Protocol' as detailed within the 'Methods for the Development of NICE Public Health Guidance (2nd ed.) April 2009', p165-173.

Appendix F Quality appraisal checklist – quantitative intervention studies[15]

Public health interventions comprise a vast range of approaches, from the relatively simple through to complex national policy interventions. As a consequence, research questions about the effectiveness and efficacy of public health interventions will typically rely on quantitative evidence from a range of sources (see section 3.2). This will include evidence from small (experimental) randomised controlled trials through to large-scale observational studies (see appendix E for an algorithm outlining the range of experimental and observational quantitative study designs). Rather than include an exhaustive list of critical appraisal tools for each individual study design, we have chosen to adopt a single checklist assessing key aspects of studies designed to determine the effect of an intervention on a (quantitative) outcome.

This checklist replaces those for randomised controlled trials, case–control studies, cohort studies, controlled before-and-after studies and interrupted time series from appendix A of the 'Public health guidance: development, process and methods manual' (2006).

A number of generic quality appraisal checklists have been developed, some specifically for public health studies (Effective Public Health Practice Project 2008; Heller et al. 2008). After consultation with both internal and external reviewers, the 'Graphical appraisal tool for epidemiological studies (GATE)', developed by Jackson et al. (2006) emerged as the preferred checklist.

GATE has been revised, tailoring it to be more suitable for public health interventions. It is anticipated that the majority of study designs used to assess public health interventions will be amenable to critical appraisal with this revised tool.

It enables a reviewer to appraise a study's internal and external validity after addressing the following key aspects of study design: characteristics of study participants; definition of, and allocation to, intervention and control conditions; outcomes assessed over different time periods and method(s) of analyses.

GATE is intended to be used in an electronic (Excel) format which will facilitate both the sharing and storage of data, and through linkage with other documents, the compilation of research reports. Much of the guidance to support the completion of the critical appraisal form which is reproduced on pages 174–85 also appears in 'pop-up' windows in the electronic version[16].

[15] Appraisal form derived from: Jackson R, Ameratunga S, Broad J et al. (2006) The GATE frame: critical appraisal with pictures. Evidence Based Medicine 11(2): 35–8.
[16] Available from CPHE on request.

There are five sections of the revised GATE. Section 1 seeks to assess the key population criteria for determining the study's **external validity** – that is, the extent to which the findings of a study are generalisable beyond the confines of the study to the study's source population.

Sections 2 to 4 assess the key criteria for determining the study's **internal validity** – that is, making sure that the study has been carried out carefully, and that the outcomes are likely to be attributable to the intervention being assessed, rather than some other (often unidentified) factor. In an internally valid study, any differences observed between groups of patients allocated to receive different interventions may (apart from the possibility of random error) be attributed to the intervention under investigation. Biases are characteristics that are likely to make estimates of effect differ systematically from the truth. Each of the critical appraisal checklist questions covers an aspect of methodology that research has shown makes a significant difference to the conclusions of a study.

Checklist items are worded so that one of five responses is possible:

++	Indicates that for that particular aspect of study design, the study has been designed/conducted in such a way as to minimise the risk of bias.
+	Indicates that either the answer to the checklist question is not clear from the way the study is reported, or that the study may not have addressed all potential sources of bias for that particular aspect of study design.
–	Should be reserved for those aspects of the study design in which significant sources of bias may persist.
Not reported (nr)	Should be reserved for those aspects in which the study under review fails to report how they have/might have been considered.
Not applicable (na)	Should be reserved for those study design aspects which are not applicable given the study design under review (for example, allocation concealment would not be applicable for case control studies).

In addition, the reviewer is requested to complete in detail the comments section of the quality appraisal form so that the grade awarded for each study aspect is as transparent as possible.

Each study is then awarded an overall study quality grading for internal validity (IV) and a separate one for external validity (EV):

++	All or most of the checklist criteria have been fulfilled, where they have not been fulfilled the conclusions are very unlikely to alter.
+	Some of the checklist criteria have been fulfilled, where they have not been fulfilled, or not adequately described, the conclusions are unlikely to alter.
–	Few or no checklist criteria have been fulfilled and the conclusions are likely or very likely to alter.

Checklist

Study identification (Include full citation details)		
Study design: Refer to the glossary of study designs (appendix D) and the algorithm for classifying experimental and observational study designs (appendix E) to best describe the paper's underpinning study design		
Guidance topic:		
Assessed by:		
Section 1: Population		
1.1 Is the source population or source area well described? Was the country (e.g. developed or non-developed, type of healthcare system), setting (primary schools, community centres etc.), location (urban, rural), population demographics etc. adequately described?	☐ ++ ☐ + ☐ – ☐ NR ☐ NA	Comments:
1.2 Is the eligible population or area representative of the source population or area? Was the recruitment of individuals/clusters/areas well-defined (e.g. advertisement, birth register)? Was the eligible population representative of the source? Were important groups under-represented?	☐ ++ ☐ + ☐ – ☐ NR ☐ NA	Comments:
1.3 Do the selected participants or areas represent the eligible population or area? Was the method of selection of participants from the eligible population well described? What % of selected individuals/clusters agreed to participate? Were there any sources of bias? Were the inclusion/exclusion criteria explicit and appropriate?	☐ ++ ☐ + ☐ – ☐ NR ☐ NA	Comments:

Section 2: Method of allocation to intervention (or comparison)		
2.1 Allocation to intervention (or comparison). How was selection bias minimised? Was allocation to exposure and comparison randomised? Was it truly random (++) or pseudo-randomised (+) (e.g. consecutive admissions)? If not randomised, was significant confounding likely (–) or not (+)? If a cross-over, was order of intervention randomised?	☐ ++ ☐ + ☐ – ☐ NR ☐ NA	Comments:
2.2 Were interventions (and comparisons) well described and appropriate? Were intervention/s and comparison/s described in sufficient detail (i.e. enough for study to be replicated)? Was comparison/s appropriate (e.g. usual practice rather than no intervention)?	☐ ++ ☐ + ☐ – ☐ NR ☐ NA	Comments:
2.3 Was the allocation concealed? Could the person(s) determining allocation of participants/clusters to intervention or comparison groups have influenced the allocation? Adequate allocation concealment (++) would include centralised allocation or computerised allocation systems.	☐ ++ ☐ + ☐ – ☐ NR ☐ NA	Comments:
2.4 Were participants and/or investigators blind to exposure and comparison? Were participants AND investigators – those delivering and/or assessing the intervention kept blind to intervention allocation? (Triple or double blinding score [++]) If lack of blinding is likely to cause important bias, score (–).	☐ ++ ☐ + ☐ – ☐ NR ☐ NA	Comments:

2.5 Was the exposure to the intervention and comparison adequate? Is reduced exposure to intervention or control related to the intervention (e.g. adverse effects leading to reduced compliance) or fidelity of implementation (e.g. reduced adherence to protocol)? Was lack of exposure sufficient to cause important bias?	☐ ++ ☐ + ☐ – ☐ NR ☐ NA	Comments:
2.6 Was contamination acceptably low? Did any in the comparison group receive the intervention or vice versa? If so, was it sufficient to cause important bias? If a cross-over trial, was there a sufficient wash-out period between interventions?	☐ ++ ☐ + ☐ – ☐ NR ☐ NA	Comments:
2.7 Were other interventions similar in both groups? Did either group receive additional interventions or have services provided in a different manner? Were the groups treated equally by researchers or other professionals? Was this sufficient to cause important bias?	☐ ++ ☐ + ☐ – ☐ NR ☐ NA	Comments:
2.8 Were all participants accounted for at study conclusion? Were those lost-to-follow-up (i.e. dropped or lost pre-/during/post-intervention) acceptably low (i.e. typically <20%)? Did the proportion dropped differ by group? For example, were drop-outs related to the adverse effects of the intervention?	☐ ++ ☐ + ☐ – ☐ NR ☐ NA	Comments:
2.9 Did the setting reflect usual UK practice? Did the setting in which the intervention or comparison was delivered differ significantly from usual practice in the UK? For example, did participants receive intervention (or comparison) condition in a hospital rather than a community-based setting?	☐ ++ ☐ + ☐ – ☐ NR ☐ NA	Comments:

2.10 Did the intervention or control comparison reflect usual UK practice? Did the intervention or comparison differ significantly from usual practice in the UK? For example, did participants receive intervention (or comparison) delivered by specialists rather than GPs? Were participants monitored more closely?	☐ ++ ☐ + ☐ – ☐ NR ☐ NA	Comments:
Section 3: Outcomes		
3.1 Were outcome measures reliable? Were outcome measures subjective or objective (e.g. biochemically validated nicotine levels [++] vs self-reported smoking [–]). How reliable were outcome measures (e.g. inter- or intra-rater reliability scores)? Was there any indication that measures had been validated (e.g. validated against a gold standard measure or assessed for content validity)?	☐ ++ ☐ + ☐ – ☐ NR ☐ NA	Comments:
3.2 Were all outcome measurements complete? Were all/most study participants who met the defined study outcome definitions likely to have been identified?	☐ ++ ☐ + ☐ – ☐ NR ☐ NA	Comments:
3.3 Were all important outcomes assessed? Were all important benefits and harms assessed? Was it possible to determine the overall balance of benefits and harms of the intervention versus comparison?	☐ ++ ☐ + ☐ ☐ NR ☐ NA	Comments:

3.4 Were outcomes relevant? Where surrogate outcome measures were used, did they measure what they set out to measure? (e.g. a study to assess impact on physical activity assesses gym membership – a potentially objective outcome measure – but is it a reliable predictor of physical activity?)	☐ ++ ☐ + ☐ – ☐ NR ☐ NA	Comments:
3.5 Were there similar follow-up times in exposure and comparison groups? If groups are followed for different lengths of time, then more events are likely to occur in the group followed-up for longer distorting the comparison. Analyses can be adjusted to allow for differences in length of follow-up (e.g. using person-years).	☐ ++ ☐ + ☐ – ☐ NR ☐ NA	Comments:
3.6 Was follow-up time meaningful? Was follow-up long enough to assess long-term benefits/harms? Was it too long, e.g. participants lost to follow-up?	☐ ++ ☐ + ☐ – ☐ NR ☐ NA	Comments:
Section 4: Analyses		
4.1 Were exposure and comparison groups similar at baseline? If not, were these adjusted? Were there any differences between groups in important confounders at baseline? If so, were these adjusted for in the analyses (e.g. multivariate analyses or stratification)? Were there likely to be any residual differences of relevance?	☐ ++ ☐ + ☐ – ☐ NR ☐ NA	Comments:

4.2 Was Intention to treat (ITT) analysis conducted? Were all participants (including those that dropped out or did not fully complete the intervention course) analysed in the groups (i.e. intervention or comparison) to which they were originally allocated?	☐ ++ ☐ + ☐ – ☐ NR ☐ NA	Comments:
4.3 Was the study sufficiently powered to detect an intervention effect (if one exists)? A power of 0.8 (i.e. it is likely to see an effect of a given size if one exists, 80% of the time) is the conventionally accepted standard. Is a power calculation presented? If not, what is the expected effect size? Is the sample size adequate?	☐ ++ ☐ + ☐ – ☐ NR ☐ NA	Comments:
4.4 Were the estimates of effect size given or calculable? Were effect estimates (e.g. relative risks, absolute risks) given or possible to calculate?	☐ ++ ☐ + ☐ – ☐ NR ☐ NA	Comments:
4.5 Were the analytical methods appropriate? Were important differences in follow-up time and likely confounders adjusted for? If a cluster design, were analyses of sample size (and power), and effect size performed on clusters (and not individuals)? Were subgroup analyses pre-specified?	☐ ++ ☐ + ☐ – ☐ NR ☐ NA	Comments:
4.6 Was the precision of intervention effects given or calculable? Were they meaningful? Were confidence intervals (CIs) and/or p-values for effect estimates given or possible to calculate? Were CIs wide or were they sufficiently precise to aid decision-making? If precision is lacking, is this because the study is under-powered?	☐ ++ ☐ + ☐ – ☐ NR ☐ NA	Comments:

Section 5: Summary		
5.1 Are the study results internally valid (i.e. unbiased)? How well did the study minimise sources of bias (i.e. adjusting for potential confounders)? Were there significant flaws in the study design?	☐ ++ ☐ + ☐ –	Comments:
5.2 Are the findings generalisable to the source population (i.e. externally valid)? Are there sufficient details given about the study to determine if the findings are generalisable to the source population? Consider: participants, interventions and comparisons, outcomes, resource and policy implications.	☐ ++ ☐ + ☐ –	Comments:

Appendix 5: Key Characteristics of Reviewed Studies

Table 1

Design and Sample of Reviewed Studies

	1.Golding & Picken, (2004) (study 2)	**2.Gurney-Smith et al., (2011)**	**3.Herbert & Wookey, (2007)**	**4.Holmes & Silver, (2010)**	**5.Laybourne et al., (2008)**	**6.MacDonald & Turner, (2005)**	**7.Minnis et al., (2001)**	**8.Robson & Briant, (2009)**	**9.Selwyn et al., (2009) (Prospective study)**	**10.Warman et al., (2006)**
Design	Non-comparative	Non-comparative	Unblinded RCT	Non-comparative	Non-comparative	Unblinded RCT	Single blinded RCT	Non-comparative	non-randomised control trial	Non-comparative
Control group type			Waiting-list			Waiting-list	Treatment as usual		Treatment as usual	
Assessment	-Pre -Post	-Pre -Post -3 months post	-Pre -Post	-Pre -Post	-Pre -Post	-Pre -Post -6 months post.	-Pre -Post -9 months post.	- Post	- pre -post	-Pre -Post
Sample size	6	13	117	(i)14 (ii)22-27	7	117	160 182 children	28	35	87
Sample type	Foster carers	5 foster, 7 adoptive parents 1 special guardianship order	Foster Carers	Adoptive parents foster carers (incl. therapeutic & kinship).	Foster carers	Foster carers	Foster carers	Foster carers (majority) Adoptive parents	Adoptive parents	Foster carers
Age of children	5-12 yrs Mean age NR	4-14 yrs. Mean age = 9 years.	NR	Less than 10 yrs Mean age NR.		NR	5-16 yrs. Mean=11.3 yrs	NR Children who attended primary and secondary school.	Age range NR Treatment group Mean age = 8.6 yrs Control group Mean age = 7.2 yrs	2- 17 yrs. Mean = 9.3 yrs.

Table 2

Parenting Group Programmes Evaluated by Reviewed Studies

	1.Golding & Picken, (2004)	**2.Gurney-Smith et al., (2011)**	**3.Herbert & Wookey, (2007)**	**4.Holmes & Silver, (2010)**	**5.Laybourne et al., (2008)**	**6.MacDonald & Turner, (2005)**	**7.Minnis et al., (2001)**	**8.Robson & Briant, (2009)**	**9.Selwyn et al., (2009)**	**10.Warman et al., (2006)**
Group size	13	15-16	12 +	NR	10	11	12	11-17	NR	7-10
Theoretical basis of group programme	Attachment Theory, SLT, (Fahlberg, 1996; Hughes, 1997; Delaney, 1998, Howe et al., 1999)	Attachment Theory, SLT, (Fahlberg, 1996; Hughes, 1997; Delaney, 1998, Howe et al., 1999)	CB, SLT, attachment theory.	SLT, attachment, PACE* (Hughes, 1997) and narrative* (Lacher et al., 2005) theories	Attachment Theory, SLT, (Fahlberg, 1996; Hughes, 1997; Delaney, 1998, Howe et al., 1999)	CB, SLT. Some consideration of individual relationships and attachment history	NR	Not explicitly reported - family attachment narrative, CB, SLT, TA.	NR	CB, SLT, attachment theories.
Training Method	P D I	P D I	P D I	P D I	P D I	D	P D	P D I	P D I	D I

Note: P denotes Presentation, D denotes Discussion, I denotes Interaction. NR denotes 'Not Reported'.
Both the descriptive format for detailing the training method, and the summaries of the training format for Minnis and colleagues (2001), Golding and Picken (2004) and Warman and colleagues (2006) were adapted from Everson-Hock and colleagues (2011).

Table 2 (continued)

	1.Golding & Picken, (2004)	**2.Gurney-Smith et al., (2011)**	**3.Herbert & Wookey, (2007)**	**4.Holmes & Silver, (2010)**	**5.Laybourne et al., (2008)**	**6.MacDonald & Turner, (2005)**	**7.Minnis et al., (2001)**	**8.Robson & Briant, (2009)**	**9.Selwyn et al., (2009)**	**10.Warman et al., (2006)**
Group Schedule	45hrs (18 x 2.5hrs)	45hrs (18 x 2.5hrs (approx)	20-25hrs (4 x 5hrs plus follow-up session)	Total hours NR 7 sessions	48hrs (16 x 3hrs)	15-20hrs (5 x 3hrs/ 4 x 5 hrs)	18 hrs (3 x 6hrs)	Approximately 28hrs (4 x full day)	30hrs (6 x 5hrs)	30 hrs (10 x 3hrs)
Group Facilitators	Social Worker Psychologist	Social work and clinical psychology professionals	Clinical Psychologist as lead facilitator	Psychologist	Psychologist Assistant Psychologist Fostering support worker	NR	Social Worker	Psychologist Team Manager of the 'Centre for Health Team'	'Professional trainers' who are adoptive parents.	NR

Table 3

Outcomes Assessed by Reviewed Studies

	1.Golding & Picken, (2004)	**2.Gurney-Smith et al., (2011)**	**3.Herbert & Wookey, (2007)**	**4.Holmes & Silver, (2010)**	**5.Laybourne et al., (2008)**	**6.MacDonald & Turner, (2005)**	**7.Minnis et al., (2001)**	**8.Robson & Briant, (2009)**	**9.Selwyn et al., (2009)**	**10.Warman et al., (2006)**
Attachment Outcomes	Pen Portrait & Symptom checklist	EFRQ			RPQ		RADS		EFRQ	
Child Outcomes	SDQ CQ	SDQ CQ	CBCL	(ii) CQ	SDQ CQ	CBCL	SDQ RSE		SDQ	SDQ Concerns about my child scale
Carer Outcomes	CQ	PSI/SF CQ Satisfaction Questionnaire MM	Satisfaction questionnaire KBPAC Course Task Evaluation questionnaire	(i) PSI/SF MBAM* (ii) CQ MBAM	PSI/SF CQ	Satisfaction questionnaire KBPAC		Likert scale of helpfulness	GHQ Description of management strategies	PSI
General Carer-Child Outcomes	CQ	CQ		CQ	CQ					
Service Outcomes			Number of unplanned placement breakdown			Number of unplanned placement breakdowns	Costs of foster care questionnaire			

Note: Reactive Attachment Disorder Scale (RADS); Relationship Problems Questionnaire (RPQ); Expression of Feelings in Relationships Questionnaire (EFRQ); Strengths and Difficulties Questionnaire (SDQ); Rosenberg Self-Esteem Questionnaire (RSE); Carer Questionnaire (CQ); Child Behavioural Checklist (CBCL); Parenting Stress Index (PSI); Parenting Stress Index / Short Form (PSI/SF); General Health Questionnaire (GHQ); Managing Behaviour with Attachment in Mind (MBAM); Mind-Mindedness interview (MM); Knowledge of Behavioural Principles as Applied to Children (KBPAC).

Table 4

Key Findings of Reviewed Studies

	1.Golding & Picken, (2004)	**2.Gurney-Smith et al., (2011)**	**3.Herbert & Wookey, (2007)**	**4.Holmes & Silver, (2010)**	**5.Laybourne et al., (2008)**	**6.MacDonald & Turner, (2005)**	**7.Minnis et al., (2001)**	**8.Robson & Briant, (2009)**	**9.Selwyn et al., (2009)**	**10.Warman et al., (2006)**
Significant improvement in Treatment Group, relative to baseline / control	SDQ'S (peer difficulties, hyperactivity & total difficulties) CQ (Child's problems and combined score) Satisfaction Questionnaire	Post-3m -SDQ total -EFRQs disinhibition subscale CQ CQs PSU & CRC Pre-3m - Hyperactivity subscale -CQ -CQs PSU & CRC -PB 1 & 2 -MM caregiver mental attribute High satisfaction ratings	Satisfaction Questionnaire Confidence in managing children's behaviour, belief in efficacy of group at improving children's behaviour.	(i)PSI/SF (difficult child & total stress) (ii) CQ (8 of 12 items)	PSI/SF (Parenting distress and total)	Satisfaction Questionnaire		High helpfulness ratings	Confidence in managing behaviour. over time	SDQ (emotional problems & total difficulties) PSI/SF(carer distress, difficult child & total stress) Concerns about my child scale,

Table 4 (continued)

	1.Golding & Picken, (2004)	2.Gurney-Smith et al., (2011)	3.Herbert & Wookey, (2007)	4.Holmes & Silver, (2010)	5.Laybourne et al., (2008)	6.MacDonald & Turner, (2005)	9Minnis et al., (2001)	7.Robson & Briant, (2009)	8.Selwyn et al., (2009)	Warman et al., (2006)
Non-significant improvements in group	SDQs remaining scales Pen portrait and symptom checklist	SDQ total and remaining subscales(pre-post) PSI-SF EFRQ CQ's PCR subscale/ PB 3 MM –child mental attributes and rupture question	CBCL Number of unplanned placements KBPAC	CQ remaining items	SDQ PSI/SF(child) RPQ CQ	CBCL Number of unplanned placements KBPAC	SDQ Costs of foster care. RAD at follow-up Self-esteem		SDQ Management of Behaviours EFRQ	SDQ (conduct / hyperactivity / peer problems / pro-social behaviour)PSI/SF (difficult interaction)
Deterioration in Treatment Group, relative to baseline	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Note: The results of analyses of the GHQ were not clearly reported within Selwyn and colleagues (2009) publication, and consequently are not detailed here.

EMPIRICAL PAPER APPENDICES

Appendix 1: Process Questionnaire

Date . . . . . .

FOSTERING ATTACHMENTS WITH CHILDREN WHO ARE LOOKED AFTER AND ADOPTED
A group for foster carers and adoptive parents

Please circle the number on the scale that reflects how much you agree with the following statements. The statements are about your experiences of the fostering attachments group.

The facilitators acknowledged parents' contributions to the group discussions

0 1 2 3 4 5 6 7 8 9 10

Strongly Disagree — Not Sure — Strongly Agree

The facilitators were sensitive to parents' contributions to the group discussions

0 1 2 3 4 5 6 7 8 9 10

Strongly Disagree — Not Sure — Strongly Agree

The other group members were sensitive to parents' contributions to the group discussions

0 1 2 3 4 5 6 7 8 9 10

Strongly Disagree — Not Sure — Strongly Agree

The facilitators were critical of parents' contributions to the group discussions.

0 1 2 3 4 5 6 7 8 9 10

Strongly Disagree — Not Sure — Strongly Agree

The other group members were critical of parents' contributions to the group discussions.

0 1 2 3 4 5 6 7 8 9 10

Strongly Disagree — Not Sure — Strongly Agree

The facilitators were empathic to parents' contributions to the group discussions.

0 1 2 3 4 5 6 7 8 9 10

Strongly Disagree — Not Sure — Strongly Agree

The other group members were empathic to parents' contributions to the group discussions.

0 1 2 3 4 5 6 7 8 9 10

Strongly Disagree — Not Sure — Strongly Agree

It did not feel safe to share personal information with the group.

0 1 2 3 4 5 6 7 8 9 10

Strongly Disagree — Not Sure — Strongly Agree

I felt that I was able to contribute to the group discussions if I wanted to.

0 1 2 3 4 5 6 7 8 9 10

Strongly Disagree — Not Sure — Strongly Agree

I did not feel able to ask the facilitators questions.

0 1 2 3 4 5 6 7 8 9 10

Strongly Disagree — Not Sure — Strongly Agree

The facilitators encouraged group members to think about how the information presented could be applied to their own situations.

0 1 2 3 4 5 6 7 8 9 10

Strongly Disagree — Not Sure — Strongly Agree

The information was not presented clearly.

0 1 2 3 4 5 6 7 8 9 10

Strongly Disagree — Not Sure — Strongly Agree

Thank you for telling us about your experience of the group

Appendix 2: ‘Fostering Attachments’ Curriculum Checklist.

FOSTERING ATTACHMENTS WITH CHILDREN WHO ARE LOOKED AFTER AND ADOPTED
A group for foster carers and adoptive parents

Treatment Fidelity Assessment: Theoretical Component

Module 1: Attachment Theory

Introduction to Attachment Theory			
Theoretical Topic	*Fully covered, as detailed in manual*	*Partially covered (Please detail which parts not covered)*	*Not covered, and reason for not covering it.*
A brief overview of Attachment Theory.			
Why attachment theory might be a useful framework for foster carers			
Why attachment relationships are important for children			
What is good and poor nurturing?			

Caregiving and the Attachment System			
Theoretical Topic	*Fully covered, as detailed in manual*	*Partially covered (Please detail which parts not covered)*	*Not covered, and reason for not covering it.*
Attachment behaviour and how it relates to exploratory behaviour			
How attachment behaviour changes through childhood			
Caregiving behaviours and their influence on attachment and exploration.			

The Internal Working Model and Patterns of Attachment			
Theoretical Topic	*Fully covered, as detailed in manual*	*Partially covered (Please detail which parts not covered)*	*Not covered, and reason for not covering it.*
What is an internal working model and how			

does it influence the child.			
Introduction to the patterns of attachment.			

The Organized Attachment Patterns			
Theoretical Topic	*Fully covered, as detailed in manual*	*Partially covered (Please detail which parts not covered)*	*Not covered, and reason for not covering it.*
Secure attachment and its impact on a child's development.			
Exploration of the ambivalent attachment pattern.			
Exploration of the avoidant attachment pattern.			

The Disorganized Attachment Pattern			
Theoretical Topic	*Fully covered, as detailed in manual*	*Partially covered (Please detail which parts not covered)*	*Not covered, and reason for not covering it.*
Comparison of ambivalent and avoidant patterns.			
How children show combinations of ambivalent and avoidant behaviours.			
What is a disorganized pattern of attachment?			
Disorganized or organized? The move to controlling behaviours			
Developmental difficulties that can result from difficulties with attachment.			

Parenting Children with Attachment Difficulties			
Theoretical Topic	*Fully covered, as detailed in manual*	*Partially covered (Please detail which parts not covered)*	*Not covered, and reason for not covering it.*
How can an understanding of these patterns influence our parenting – brief introduction to parenting children with attachment difficulties.			
How can we increase feelings of safety for the child?			
Parenting that takes into account attachment patterns of relating: • Parenting the child with an ambivalent attachment pattern of relating: • Parenting the child with an avoidant attachment pattern of relating. • Parenting the child with a disorganized/controlling pattern of relating.			
Adverse parenting as trauma			
Managing timeholes.			

FOSTERING ATTACHMENTS WITH CHILDREN WHO ARE LOOKED AFTER AND ADOPTED
A group for foster carers and adoptive parents

Treatment Fidelity Assessment: Theoretical Component

Module 2: A model for parenting the child with attachment difficulties.

Part One: Providing a Secure Base

Introduction to the model and creating a Secure Base			
Theoretical Topic	*Fully covered, as detailed in manual*	*Partially covered (Please detail which parts not covered)*	*Not covered, and reason for not covering it.*
An overview of the house model of parenting			
Revision of attachment theory and the idea of a secure base			
How to create a secure base for the child.			

Empathy and support from the Secure Base			
Theoretical Topic	*Fully covered, as detailed in manual*	*Partially covered (Please detail which parts not covered)*	*Not covered, and reason for not covering it.*
Helping the child to manage emotion			
What can carers do when they have no more empathy left?			
Understanding the impact of early experience on parenting.			
What can carers do when the child rejects the empathy and support?			

Attunement and empathy			
Theoretical Topic	*Fully covered, as detailed in manual*	*Partially covered (Please detail which parts not covered)*	*Not covered, and reason for not covering it.*
What is meant by Attunement and Interactive Repair?			
How to help the child experience attunement through relationship based play.			
Managing difficult behaviour within attuned relationships.			
Reflection about feelings.			

Protecting the family atmosphere			
Theoretical Topic	*Fully covered, as detailed in manual*	*Partially covered (Please detail which parts not covered)*	*Not covered, and reason for not covering it.*
What is a family atmosphere?			
Maintaining a positive family atmosphere.			
How this parenting approach helps the development within the brain of the capacity to regulate emotions.			

Creating a feeling of belonging for the child			
Theoretical Topic	*Fully covered, as detailed in manual*	*Partially covered (Please detail which parts not*	*Not covered, and reason for not covering it.*

		covered)	
The use of family rituals and claiming behaviours to help the child feel that they belong.			
Helping children who are angry.			

Looking after yourself			
Theoretical Topic	*Fully covered, as detailed in manual*	*Partially covered (Please detail which parts not covered)*	*Not covered, and reason for not covering it.*
Making time for reflection and for relaxation.			
Understanding and managing feelings evoked by the child.			
Stress and coping			

FOSTERING ATTACHMENTS WITH CHILDREN WHO ARE LOOKED AFTER AND ADOPTED
A group for foster carers and adoptive parents

Treatment Fidelity Assessment: Theoretical Component

Module 3: A model for parenting the child with attachment difficulties.

Part Two: Building Relationships and managing behaviour.

Helping the child to enjoy being part of the family			
Theoretical Topic	*Fully covered, as detailed in manual*	*Partially covered (Please detail which parts not covered)*	*Not covered, and reason for not covering it.*
Reminder of the house model of parenting: Where are we now?			
Helping the child to enjoy and be part of the family.			
Socialisation and shame			

Learning to parent with PACE			
Theoretical Topic	*Fully covered, as detailed in manual*	*Partially covered (Please detail which parts not covered)*	*Not covered, and reason for not covering it.*
What is meant by PACE (playfulness acceptance, curiosity, and empathy).			
The use of PACE with discipline.			

Building relationships with stories.			

Providing structure and supervision			
Theoretical Topic	*Fully covered, as detailed in manual*	*Partially covered (Please detail which parts not covered)*	*Not covered, and reason for not covering it.*
How to use structure and supervision to help the child feel secure.			
What is an appropriate level of supervision for the child?			
Children and young people who self-harm.			

Managing confrontation and coercive interactions			
Theoretical Topic	*Fully covered, as detailed in manual*	*Partially covered (Please detail which parts not covered)*	*Not covered, and reason for not covering it.*
How to step aside rather than getting pulled into confrontation.			
Coercive interactions.			
Helping children learn to problem solve.			

Thinking, feeling and behavioural choices			
Theoretical Topic	*Fully covered, as detailed in manual*	*Partially covered (Please detail which parts not covered)*	*Not covered, and reason for not covering it.*
Thinking, feeling and behaving.			
The use of choices and logical consequences.			
Helping the child who lies and steals.			

Managing behaviour whilst maintaining a secure base			
Theoretical Topic	*Fully covered, as detailed in manual*	*Partially covered (Please detail which parts not covered)*	*Not covered, and reason for not covering it.*
The ABC of behaviour.			
What is rewarding for the child?			
Review of the house model of parenting: The House Complete			

Appendix 3: Self-Efficacy Scale, Parenting Sense of Competence Questionnaire

Parenting Sense of Competence: Self-efficacy subscale

For each of the 7 statements below, please consider if it applies to you. Then for each statement please tick **one** box only from **A** to **F** to indicate how much you agree or disagree with it.

Strongly Agree. Agree. Slightly agree. Slightly disagree. Disagree. Strongly disagree.

A **B** **C** **D** **E** **F**

	A	**B**	**C**	**D**	**E**	**F**
1. The problems of taking care of a foster / adoptive child are easy to solve once you know how your actions affect the child. I have acquired this understanding.	☐	☐	☐	☐	☐	☐
2. I would make a fine model for a new foster/adoptive parent to follow so that she/he could learn to be a good foster / adoptive parent.	☐	☐	☐	☐	☐	☐
3. Being a good foster /adoptive parent is manageable, and any problems are easily solved.	☐	☐	☐	☐	☐	☐
4. I meet my own personal expectations in my ability to care for my foster / adopted child.	☐	☐	☐	☐	☐	☐
5. If anyone can find the answer to what is troubling my foster /adopted child, I am the one.	☐	☐	☐	☐	☐	☐
6. Considering how long I've been a foster/adoptive parent, I feel thoroughly familiar with this role.	☐	☐	☐	☐	☐	☐
7. I honestly believe that I have all the skills necessary to be a good foster /adoptive parent to my foster /adopted child.	☐	☐	☐	☐	☐	☐

Appendix 4: Carer Questionnaire

Carer Questionnaire

Please answer the following questions by reflecting on yourself and the child/young person you care for during the past few weeks. Try not to be influenced by single incidents when answering but base your answers on how you think things are generally

How much do you feel you understand the child's difficulties?	10 9 8 7 6 5 4 3 2 1 Very Not at all
How much do you think your child's difficulties relate to his or her early experience?	10 9 8 7 6 5 4 3 2 1 Very Not at all
Do you feel you understand why the child behaves as he or she does?	10 9 8 7 6 5 4 3 2 1 Very Not at all
Do you feel confident that you can manage the challenges that the child presents?	10 9 8 7 6 5 4 3 2 1 Very Not at all
Do you feel that you have the necessary skills to manage the specific challenges the child presents?	10 9 8 7 6 5 4 3 2 1 Very Not at all
Do you feel that you have a good relationship with the child?	10 9 8 7 6 5 4 3 2 1 Very Not at all
How easily can you and the child communicate with each other?	10 9 8 7 6 5 4 3 2 1 Very Not at all
Do you feel that the child responds to your attempts to help him/her?	10 9 8 7 6 5 4 3 2 1 Very Not at all
How difficult is the child to care for?	1 2 3 4 5 6 7 8 9 10 Very Not at all
How difficult is it to build a relationship with the child?	1 2 3 4 5 6 7 8 9 10 Very Not at all
How rewarding do you find the child?	10 9 8 7 6 5 4 3 2 1 Very Not at all
How secure do you feel the placement is at the moment?	10 9 8 7 6 5 4 3 2 1 Very Not at all

Appendix 5: Mind-Mindedness (MM) Interview scoring manual

MM Interview Scoring Manual: An extract from Meins and Fernyhough (2010)'s *Mind-mindedness coding manual, Version 2.0.*

" 4. Representational Measures of Mind-Mindedness In Preschool and Older Children

In caregivers of children of preschool age and above, we have assessed MM using a brief interview (Meins, Fernyhough, Russell, & Clark-Carter, 1998). Caregivers are first informed that there are no right or wrong answers to the questions in the interview and that they should feel free to talk about the first things that come into their heads. The caregiver is simply given an open-ended invitation to describe the child: *Can you describe [child's name] for me?* If caregivers seek guidance on how to answer the question, the researcher should repeat that no specific type of description is required, and that the caregiver should talk about whatever comes into his/her head. We usually include two further follow-up questions in the MM interview (*What's the best thing about [child's name]?* and *What do you try to teach [child's name]?*), but the answers to these questions are not analysed as part of the MM assessment.

"If the MM interview is the only measure that the caregiver will be completing in the testing session, it is useful first to put the caregiver at ease by asking general questions (e.g., whether the target child has any siblings, whether they attend preschool, their precise age, etc.) before asking the caregiver to describe the child. Caregivers' answers to the *describe your child* question are transcribed verbatim, and each attribute mentioned *that refers to the child* is classified into one of the four

exhaustive and exclusive categories described below (Meins et al., 1998, 2003). Implicit descriptions **are** coded. For example, if the caregiver said 'he wears us out' without explicitly mentioning the relevant attribute (e.g., high activity level), this would be classed as an attribute of the child (and coded as behavioural – see 4.3 below).

"Note that, unlike in the observation-based MM coding scheme, precise repetitions of specific attributes mentioned during the interview are **not** coded separately, so each attribute can only be coded once. For example, if a caregiver described the child as *happy* twice in the interview, this would only be coded as one attribute, but if the caregiver described the child as *happy* and then as *content*, this would be coded as two attributes. The rationale for treating repetitions differently in the observation and interview MM schemes is that caregivers' interview-based descriptions of their children are purely representational, so repeating the same mentalistic attribute does not entail a more diverse representation of the child as an individual with a mind. In contrast, mind-related comments in the observation-based scheme are in response to the infant's behaviour, so repetitions of such comments are meaningful because they index whether the caregiver is reading the infant's internal states appropriately or in a non-attuned manner over time.

"4.1. Mental Attributes

Any comment that refers to the child's mental life, relating to will, mind, interests, pretence, imagination, intellect, knowledge, memory, metacognition (as detailed under Mind-related comments in Section 3.1 above). The following are also classified

as mental:

(a) Willful, opinionated, bright, intelligent, clever, mind of his/her own, wellorganised, dedicated, conscientious, committed

(b) Comments about the child's desires or wishes. For example:

a. She wants to be a teacher

b. She'd like a baby brother or sister

(c) Comments about the child's likes and dislikes *as long as they do not merely indicate things the child likes* ***doing*** (comments such as 'he likes playing football' are coded as behavioural – see 4.3 below). For example:

a. He likes animals

b. She doesn't like her sister playing with her stuff

c. He loves schoolwork

(d) Comments about the child's emotions, but **not** the behavioural manifestations of emotions. For example:

a. Happy (but not 'always smiling'), loving (but not 'cuddly'), content, good sense of humour, caring, drama queen, considerate, manipulative

"4.2. Attributes That May or May Not Be Mental

Occasionally, it is difficult to establish whether a comment should be coded as mental or behavioural. In these circumstances, the preceding or succeeding context may assist in clarifying how the caregiver is intending the term to be used.

Helpful

If *helpful* is used in isolation, then it should be coded as behavioural (see 4.3

below). However, if the caregiver elaborates on the way in which the child is helpful to suggest that this is in response to him or her recognising other people's needs, then this should be coded as mental. For example: "When I've had a hard day and I'm really pushed for time, she's very helpful" would be coded as mental.

"Funny

If *funny* is used in isolation, then it should be coded as behavioural (see 4.3 below). However, if the context shows that *funny* is being used to index the child's sense of humour rather than behaviour, then it should be coded as mental. For example: "She's really funny. She knows exactly what to say to make me laugh" would be coded as mental.

"4.3. Behavioural Attributes

Any comments that refer to the child's behaviour, such as games and activities the child is involved in, and interactions with others on a behavioural level. The following descriptions are also classified as behavioural:

Lively, talkative, chatty, boisterous, aggressive, passive, friendly, restrained, out-going, naughty, chatterbox, sporty, well/badly behaved, full of fun.

"4.4. Physical Attributes

Any physical attributes, such as the child's physical appearance, age, or position in the family. For example:

(a) *He's my second son*

(b) *Blond*

(c) *Three feet tall*

(d) *He's cut all his teeth now*

4.5. General Attributes

Any comment relating to the child that does not fit into the above categories.

"4.6. Indices of Mind-Mindedness Used in Analyses

The index of MM is the score for mental attributes, calculated as a proportion of the total number of attributes produced by the caregiver during the interview in order to control for differences in verbosity (Meins et al., 1998, 2003). As before, researchers may decide that frequency measures are more appropriate, controlling for overall verbosity in analyses." (Meins & Fernyhough (2010, p14-18)

Appendix 6: Strengths and Difficulties Questionnaire P4-16

Appendix 7: Sense of Security Scale

What I Am Like With My Foster / Adoptive parent

This questionnaire asks about how you act and feel around your foster / adoptive parent. The researcher will tell you which foster / adoptive parent this questionnaire is asking you about.

Before we get to those questions, please try the practice question. Each question talks about two kinds of kids, and we want to know which kids are most like <u>you</u>.

Decide first whether you are more like the kids on the left side or more like the kids on the right side, then decide whether that is sort of true for you, or really true for you, and circle that phrase. For each question you will only circle <u>one</u> answer.

Practice Question:

Some kids would rather play sports in their spare time.		**BUT**		Other kids would rather watch T.V.
Really true for me	Sort of true for me		Sort of true for me	Really true for me

Now please answer the rest of the questions. Please ask the researcher if you don't understand any of the questions. Take as much time as you need to finish the questionnaire.

1. Some kids find it easy to trust their foster / adoptive parent		**BUT**		Other kids are not sure if they can trust their foster / adoptive parent.
Really true for me	Sort of true for me		Sort of true for me	Really true for me

2. Some kids feel like their foster / adoptive parent butts in a lot when they are trying to do things

Really true for me | Sort of true for me

BUT

Other kids are feel like their foster / adoptive parent lets them do things on their own

Sort of true for me | Really true for me

3. Some kids find it easy to count on their foster / adoptive parent for help

Really true for me | Sort of true for me

BUT

Other kids think it's hard to count on their foster / adoptive parent

Sort of true for me | Really true for me

4. Some kids think their foster / adoptive parent spends enough time with them

Really true for me | Sort of true for me

BUT

Other kids think their foster / adoptive parent does not spend enough time with them.

Sort of true for me | Really true for me

5. Some kids do not really like telling their foster / adoptive parent what they are thinking or feeling

Really true for me | Sort of true for me

BUT

Other kids do like telling their foster / adoptive parent what they are thinking or feeling.

Sort of true for me | Really true for me

6. Some kids do not really need their foster / adoptive parent for much

Really true for me | Sort of true for me

BUT

Other kids need their foster / adoptive parent for a lot of things.

Sort of true for me | Really true for me

7. Some kids wish they were closer to their foster / adoptive parent

Really true for me | Sort of true for me

BUT

Other kids are happy with how close they are to their foster / adoptive parent .

Sort of true for me | Really true for me

8. Some kids worry that their foster / adoptive parent does not really love them

Really true for me | Sort of true for me

BUT

Other kids are <u>really</u> sure that their foster / adoptive parent loves them.

Sort of true for me | Really true for me

9. Some kids feel like their foster / adoptive parent really understands them

Really true for me | Sort of true for me

BUT

Other kids feel like their foster / adoptive parent does not really understand them.

Sort of true for me | Really true for me

10. Some kids are really sure their foster / adoptive parent would not leave them

Really true for me | Sort of true for me

BUT

Other kids sometimes wonder if their foster / adoptive parent might leave them

Sort of true for me | Really true for me

11. Some kids worry that their foster / adoptive parent might not be there when they need her

Really true for me | Sort of true for me

BUT

Other kids are sure their foster / adoptive parent will be there when they need her.

Sort of true for me | Really true for me

12. Some kids think their foster / adoptive parent does not listen to them

Really true for me | Sort of true for me

BUT

Other kids do think their foster / adoptive parent listens to them.

Sort of true for me | Really true for me

13. Some kids go to their foster / adoptive parent when they are upset

Really true for me | Sort of true for me

BUT

Other kids do not go to their foster / adoptive parent when they are upset

Sort of true for me | Really true for me

14. Some kids wish their foster / adoptive parent would help them more with their problems

Really true for me | Sort of true for me

BUT

Other kids think their foster / adoptive parent helps them enough.

Sort of true for me | Really true for me

15. Some kids feel better when their foster / adoptive parent is around

Really true for me | Sort of true for me

BUT

Other kids do not feel better when their foster / adoptive parent is around.

Sort of true for me | Really true for me

Thank you for doing this questionnaire. It will be really helpful for our project.

Appendix 8: Participant Information Sheet for participating foster/adoptive parents

Evaluation of an attachment-based parenting group for foster and adoptive parents

Participant Information Sheet for participating foster/adoptive parents. Version 1, p1.

Sarah Wassall & Dr. Helen Rostill, University of Birmingham
Dr. Kim Golding, Integrated Service for Looked After Children (ISL), Worcester

The role of a foster/adoptive parent can be challenging, and so it is important that they have access to good quality interventions and support when they need it. To help this happen, we want to research if support programmes, like *(name of health and social care service)'s* attachment based parenting group, are helpful, and how they do or don't help foster/adoptive parents and children. We hope that by finding this out, we can help services to improve the well-being of fostered/adopted children and support their caregivers.

We understand that you will be attending the attachment based foster-parenting group in *(county name).* We are very interested to find out what you learn through attending the group and if it affects you and your relationship with your child. We would therefore like to invite you to take part in this research.

Before you decide it is important that you understand what taking part would involve. Please take time to read the following information. Ask us if there is anything that is not clear or if you would like more information. Please take your time to decide if you want to take part or not.

1. Do I have to take part?

It is up to you to decide whether or not to take part. If you decide not to participate, or wish to withdraw at any time you can do so, without giving a reason, and your decision will not affect your medical/social care or legal rights, or of the children under your care.

2. What will happen to me if I take part?

You will be invited to complete three questionnaires about being a foster / adoptive parent and your fostered/adopted child's behaviour. These would be done once in December 2009/January 2010, March 2010, July 2010, November 2010 and February 2011. In total, the questionnaires should take up to an hour to complete.

During the December 2009/January 2010, July 2010, and February 2011 visits, you will also be invited to participate in a 15 minute interview asking you about your foster/adopted child, and your relationship with the We hope that the interview will feel like a relaxed conversation, with questions that you feel easily able to answer. With your permission, the interviews will be audio-recorded so that the researcher can accurately record your answers.

Evaluation of an attachment-based parenting group for foster and adoptive parents

With your permission, you will complete the questionnaires and interview during home visits by the researcher. If you would prefer, the appointment can take place at *(Service Location).* The researcher will visit either on their own, or with another researcher. To ensure your privacy and the accuracy of the information we collect, we would recommend that the tasks are completed when other household members are not present.

3. Are there any risks or benefits to taking part?

We do not anticipate that participants will experience any risks, discomforts or inconvenience. With your permission, the questionnaires and interviews will take place within your home so you should not have to do any travelling for the project. It is possible that some participants might find talking about their relationship with their foster / adoptive child in the interview emotional. If you find this, you will be directed to appropriate sources of support through *(Service name)* or the voluntary sector.

To say thank you for taking part, each participant will be given a free raffle ticket for a prize draw that will take place after the information collection part of the project. The prize will be a £40 cinema voucher.

4. Will my information be kept confidential?

All information collected about you and your child during the course of the research will be kept strictly confidential. The only exception to this is if the information suggests that you, your child or another party are at risk of harm, or being harmed. If this happens, the information will be shared according to local safeguarding procedures.

5. What will happen to the results of this study?

We hope to publish the results of the study in a peer reviewed journal and through other routes to ensure that fostering/adoptive parents and supporting services are also aware of the findings. You and your child will not be identified in any report/publication arising from this study.

6. What if I want any further information?

If you want any further information or have any questions, please ask the researcher or telephone Sarah Wassall on [redacted].

Appendix 9: Consent form for participating foster/adoptive parents

UNIVERSITY OF BIRMINGHAM

CONSENT FORM for participating foster/adoptive parents

Participant Identification Number:.....

Title of Project: Evaluation of an attachment based parenting group for foster and adoptive parents.
Investigators: Sarah Wassall, Dr. Helen Rostill, Dr. Kim Golding

Please initial box

1. I confirm that I have read and understand the information provided 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 a reason and that this will not affect my medical/social care or legal rights, or those of others. ☐

3. I understand that the interview will be audio recorded to accurately record my responses. ☐

4. I understand that the data collected during this study will be looked at by researchers and relevant others at the University of Birmingham to ensure that the analysis is a fair and reasonable representation of the data. Parts of the data may also be made available to the social or health care teams responsible for me or my family member's care, but only if any previously undisclosed issues of risk to me or my family member's safety should be disclosed. ☐

5. I agree to take part in the above study ☐

Name of Participant	Date	Signature
……	……	……
Name of Researcher	Date	Signature
……	……	……

Appendix 10: Ethical Approval

Appendix 11: Participant Information Sheet for those with parental responsibility of children whose foster carers are participating

Evaluation of an attachment based parenting group for foster and adoptive parents

Participant Information Sheet for those with Parental Responsibility of children whose foster parents are participating. Version 1, p1.

Sarah Wassall & Dr. Helen Rostill, University of Birmingham
Dr. Kim Golding, Integrated Service for Looked After Children (ISL), Worcester

To help make sure that fostered/adopted children have the best care possible, it is important that foster/adoptive parents have access to good quality support when they need it. We want to research if support programmes, like *(health and social care service)'s* attachment based parenting group, are helpful, and how they do or don't help foster/adoptive parents and children. We hope that by finding this out, we can help services to improve the well-being of fostered/adopted children and their caregivers.

We understand that [insert child's name]'s foster carer will be attending the attachment based foster-parenting group in *(county name).* [insert child's name] foster carer is being invited to take part in this research project because we are very interested to find out if foster carers' attendance of the group affects their relationship with [insert child's name]. To do this we would like to ask [insert child's name]'s foster carers some questions about their relationship with [insert child's name], and [insert child's name]'s behaviour.

Before you decide whether [insert child's name] foster carer can give us this information about [insert child's name] is important that you understand what this will involve. Please take time to read the following information. Ask us if there is anything that is not clear or if you would like more information.

1. Do I have to agree for [insert child's name] foster carer to give this information?

No. You can decide that [insert child's name]'s foster carer will not give us information about their relationship with your child, or their behaviour. You can also withdraw your consent at any time, and you will not have to give a reason for doing this. Not taking part will not affect your, or [insert child's name]'s, or their foster carers' medical or social care or legal rights or the services and support received.

2. What will happen to [insert child's name] if their foster carer takes part?

[insert child's name]'s foster carer will be asked to complete questionnaires about your child's behaviour. They will be asked to do these in December 2009/January 2010, March 2010, July 2010, November 2010 and February 2011.

[insert child's name]'s foster carer will also be invited to participate in a 15 minute interview asking them about you about [insert child's name] and their relationship together. They will be asked to do these in December 2009/January 2010, July 2010 and February 2011. With their permission, the interviews will be audio-recorded.

Evaluation of an attachment based parenting group for foster and adoptive parents

The foster carers will not be asked to give any information regarding you or [insert child's name]'s birth family.

3. If [insert child's name]'s foster carer takes part, are there any risks or benefits to me, my child or their foster carers?

We do not think that taking part would cause any problems or harm to [insert child's name], their foster carer or those with parental responsibility.

If they participate they will be entered into a raffle. The raffle will be drawn after all the assessments are completed, and the prize will be a £40 cinema voucher.

4. Will information about me, [insert child's name] and their foster carer be kept confidential?

All information that is collected about [insert child's name], their foster carers and those with parental responsibility will be kept confidential. The only exception to this is if the information suggests that [insert child's name] or another party are at risk of harm, or being harmed. If this happens, the information will be shared according to local safeguarding procedures.

When recording the information from the questionnaires and interviews, the research team will <u>not</u> record your child's name, or any personally identifying details.

5. What will happen to the results of this study?

We hope to publish the results of the study in a peer reviewed journal and other places to make sure that birth, foster carers, adoptive parents and services that support parents find out about the findings of the study. You, [insert child's name] and their foster carer will not be identified in any report/publication about this study.

6. What if I want any further information?

If you want any more information or have any questions, please ask the researcher or telephone the Sarah Wassall on [redacted].

Appendix 12: Consent form for those with parental responsibility of children whose foster carers are participating

UNIVERSITY OF BIRMINGHAM

CONSENT FORM for those with Parental Responsibility of Children whose Foster Parents are participating.

Participant Identification Number:.....

Title of Project: Evaluation of an attachment based parenting group for foster and adoptive parents
Investigators: Sarah Wassall, Dr. Helen Rostill, Dr. Kim Golding

Please initial box

1. I confirm that I have read and understand the information provided 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 child's foster carers' participation regarding giving information about my child is voluntary and that I am free to withdraw my consent at any time, without giving a reason and that this will not affect the medical/social care or legal rights of me, my child or others. ☐

3. I understand that the data collected during this study will be looked at by the researchers and relevant others at the University of Birmingham to ensure that the analysis is a fair and reasonable representation of the data. Parts of the data may also be made available to the social or health care teams responsible for my child's or their family members' care, but only if any previously undisclosed issues of risk to my child or others should be disclosed. ☐

4. I agree for my child's foster carers to take part in the above study by complete questionnaires and interviews regarding their relationship with my child and my child's behaviour. ☐

Name of child whose foster carer will participate	Date	Signature
……	……	……
Name of person with parental responsibility for participating child	Date	Signature
……	……	……
Name of Researcher	Date	Signature
……	……	……

Appendix 13: Participant Information Sheet for those with Parental Responsibility of Participating 9-14 year olds

Evaluation of an attachment based parenting group for foster and adoptive parents

Participant Information Sheet for those with Parental Responsibility of Participating 9-14 year olds. Version 1, p1.

Sarah Wassall & Dr. Helen Rostill, University of Birmingham
Dr. Kim Golding, Integrated Service for Looked After Children (ISL), Worcester

To help make sure that fostered/adopted children have the best care possible, it is important that foster/adoptive parents have access to good quality support when they need it. We want to research if support programmes, like *(health and social care service's name)*'s attachment based parenting group, are helpful, and how they do or don't help foster/adoptive parents and children. We hope that by finding this out, we can help services to improve the well-being of fostered/adopted children and their caregivers.

We understand that [insert child's name]'s foster carer will be attending the attachment based foster-parenting group in *(county name).* [insert child's name] is being invited to take part in this research project because we are very interested to find out if foster carers' attendance of the group affects their relationship with [insert child's name].

Before you decide whether [insert child's name] can participate it is important that you understand what taking part will involve. Please take time to read the following information. Ask us if there is anything that is not clear or if you would like more information. Take time to decide if [insert child's name] can take part or not.

7. Does [insert child's name] have to take part?

No. You can decide that [insert child's name] will not take part. You can also withdraw [insert child's name] from the study at any time, and you will not have to give a reason for doing this. Not taking part will not affect you or [insert child's name]'s medical or social care or legal rights, or the services and support received.

8. What will happen to my child if they take part?

[insert child's name] will be asked to complete a questionnaire asking them about their relationship with their foster carer. This should take no longer than 30 minutes. They will be asked to do these in December 2009/January 2010, March 2010, July 2011, November 2010 and February 2011.

Evaluation of an attachment based parenting group for foster and adoptive parents

Participant Information Sheet for those with Parental Responsibility of participating 9-14 year olds. Version 1, p2.

With your permission, [insert child's name] will complete the questionnaire during home visits by the researcher. If they would prefer, the appointment can take place at *(Service Location)*. The researcher will visit either on their own, or with another researcher. To ensure [insert child's name]'s privacy and the accuracy of the information we collect, we will ask [insert child's name] and their foster carers permission for the questionnaire to be completed under the supervision of the researcher only, when other household members, including their foster carer are not in the same room as the child.

9. Are there any risks or benefits to taking part?

We do not think that taking part would cause any problems or harm to [insert child's name] or their foster carer. With their permission we will visit their house to do the activities so that they will not have to travel anywhere.

If they participate they will be entered into a raffle. The raffle will be drawn after all the assessments are completed, and the prize will be a £40 cinema voucher.

10. Will information about me be kept confidential?

All information that is collected about [insert child's name] during the study will be kept confidential. The only exception to this is if the information suggests that [insert child's name] or another party are at risk of harm, or being harmed. If this happens, the information will be shared according to local safeguarding procedures.

11. What will happen to the results of this study?

We hope to publish the results of the study in a peer reviewed journal and other places to make sure that foster/adoptive parents and services that support parents find out about the findings of the study. You, [insert child's name] and their foster carer will not be identified in any report/publication about this study.

12. What if I want any further information?

If you want any more information or have any questions, please ask the researcher or telephone the Sarah Wassall on [redacted].

Appendix 14: Participant Information Sheet for those with Parental Responsibility of Participating 9-14 year olds

UNIVERSITY OF BIRMINGHAM

CONSENT FORM for those with parental responsibility for participating 9-14 year olds.

Participant Identification Number:.....

Title of Project: Evaluation of an attachment based parenting group for foster and adoptive parents
Investigators: Sarah Wassall, Dr. Helen Rostill, Dr. Kim Golding

Please initial box

5. I confirm that I have read and understand the information provided for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

6. I understand that my child's participation is voluntary and that I am free to withdraw my consent at any time, without giving a reason and that this will not affect the medical/social care or legal rights of me, my child or others. ☐

7. I understand that the data collected during this study will be looked at by the researchers and relevant others at the University of Birmingham to ensure that the analysis is a fair and reasonable representation of the data. Parts of the data may also be made available to the social or health care teams responsible for my child's or their family members' care, but only if any previously undisclosed issues of risk to my child or others should be disclosed. ☐

8. I agree for my child to take part in the above study. ☐

Name of Participating child	Date	Signature
……	……	…….……
Name of person with parental responsibility for participating child	Date	Signature
……	……	…….……
Name of Researcher	Date	Signature
……	……	…….……

Appendix 15: Participant Information Sheet for participating 9-14 year olds

A research project about whether or not parenting groups are helpful for fostered and adopted children and their caregivers.

Participant Information Sheet for participating 9-14 year olds. Version 1, p1.

Sarah Wassall & Dr. Helen Rostill, University of Birmingham
Dr. Kim Golding, Integrated Service for Looked After Children (ISL), Worcester

To make sure that children have good care, it is important that their foster/adoptive parents get help and support when they need it. To do this, we need to find out what helps for foster/adoptive families.

We are doing a project to find out if the parenting group that your foster/adoptive parent will be going to is helpful. We would like to invite you to take part in the project. This is because we would like to find out if your foster/adoptive parent going to the group helps you too.

Please read this sheet. It tells you what you will be asked to do if you want to take part in the project.

1. Do I have to take part?

No, you do not have to take part.
If you do decide to take part, you can stop at any time. You will not have to give a reason for stopping.
If you decide not to take part, this will not change the support that you or your foster/adoptive parents' get.

2. What will happen to me if I take part?

You will be asked to answer some written questions. The questions are about how you get on with your foster/adoptive parent. This should take 30 minutes. You will be asked to do the questions five times in 2010.

A researcher will be with you when you answer the questions. We can help you if the questions are hard to understand.
If you say it is ok, your foster/adoptive parent will wait outside the room while you do the task. This is to make sure that your answers are kept private.

A research project about whether or not parenting groups are helpful for fostered and adopted children and their caregivers.

Participant Information Sheet for participating 9-14 year olds. Version 1, p2.

3. Are there any risks or benefits to taking part?

We do not think that taking part would cause any problems for you or anybody else.

If you take part you will get a raffle ticket for a prize draw. The prize draw will happen on the January 11th 2011. The person with the winning raffle ticket will get a £40 cinema voucher.

4. Will information about me be kept confidential / private?

Yes it will. We won't tell anybody what your personal answers to the questions were. We won't even tell your foster / adoptive parents. We won't put your names on your question sheet. Your answers will be kept in a locked cabinet.

If we tell people about children's answers to the questions, we won't use your name. This means no one will be able to tell who you are.

The only time we will tell people your information, is if we learn things about you or someone else getting hurt. If this happens we will tell someone who helps keep people safe, like your social worker.

9. What will happen to the findings of this project?

We will write what we learn from the project in places where foster/adoptive parents, social services and people interested in foster / adoptive families can read about it. When we write about what we have learnt, we won't use your name, and no one will be able to tell who you are.

10. What if I want any further information?

If have any questions about the project, please call Sarah Wassall on [redacted].

Appendix 16: Consent form for participating 9-14 year olds

UNIVERSITY OF BIRMINGHAM

CONSENT FORM for 9-14 year olds

Participant Identification Number:.....

Evaluation of an attachment based parenting group for foster and adoptive parents
Investigators: Sarah Wassall, Dr. Helen Rostill, Dr. Kim Golding

Please initial box

1) I have read and understand the information sheets about the study. ☐

2) I understand that I do not have to take part if I do not want to.
I understand I can stop taking part at any time.
I understand that if I decide not to take part, the support that I and my foster/adoptive parents' get will not change. ☐

3) I understand that the information I give the researchers about me will be looked at by people working on the research.
I understand that the only time other people will be told information about me is if the researchers learn something that makes them worried that I or someone else might get hurt.
If this happens they will tell someone who helps keep people safe, like my social worker. ☐

4) I agree to take part in the study ☐

My name	Date	My Signature
……	……	…….……
Researcher's name	Date	Researcher's Signature
……	……	…….……

Appendix 17: Participant Information Sheet for those attending the parenting group for foster and adoptive parents: Consent to sessions being video-recorded

Evaluation of an attachment-based parenting group for foster and adoptive parents

Participant Information Sheet for those attending the parenting group for foster and adoptive parents. Version 1, p1.

Sarah Wassall & Dr. Helen Rostill, University of Birmingham
Dr. Kim Golding, Integrated Service for Looked After Children (ISL), Worcester

The role of a foster/adoptive parent can be challenging, and so it is important that they have access to good quality interventions and support when they need it. To help this happen, we want to research if support programmes, like the attachment based parenting group, are helpful or not. We hope that by finding this out, we can help services to improve the well-being of fostered/adopted children and their caregivers.

This research project will evaluate if and in what ways *(health and social care service name)'s* attachment based parenting group is helpful for fostering and adoptive families. An important part of this evaluation is to find out how the parenting group is delivered by *(region's name)* social services. We want to find out if they present the group programme in a consistent way for each group programme.

To assess the people facilitating the group programme we would like to video them during the group sessions. They have agreed to do this. We would also like to know if you would be happy for us to do this.

Before you decide it is important that you understand what having the sessions being videoed would involve. Please take time to read the following information. Ask us if there is anything that is not clear or if you would like more information. Please take your time to decide if you want to take part or not.

1. Do I have to consent to the sessions being videoed?

No. If you, or anyone in your group, decides that they do not want the sessions videoed then they will not be videoed. If this is your decision it will not affect your medical/social care or legal rights or service support, or that of the children under your care. You would remain very welcome at the parenting group.

2. What will happen if I consent to the sessions being videoed?

If you and everybody in your group consents, the group facilitators will set up a video camera at the beginning of each session. The whole session will be recorded. If you wanted the video recording to be stopped at any time, for any reason, the facilitators would turn the video off immediately.

Evaluation of an attachment-based parenting group for foster and adoptive parents

The video would be focused on the facilitators. The facilitators would try to set it up so that where possible only they can be seen by the camera. This is because **the video is only used to look at what the facilitators are doing**. **The video will not be used to look at what the foster and adoptive parents are doing.**

The videos will be watched by the researchers who will record whether the programme is delivered in a consistent way. **The researchers will not be assessing what you say and do.**

3. Are there any risks or benefits to consenting to the sessions being videoed?

We do not anticipate that videoing the group will cause any risk, discomfort or inconvenience to the group members. Videoing the group will support the research which aims to help services improve the support they offer foster and adoptive parents.

4. Will my information be kept confidential?

The video tapes will be kept strictly confidential. They will be securely stored. The researchers will not be told the names of the people who attend each group. Once the researchers have rated the videos they will be destroyed.

5. What will happen to the results of this study?

We hope to publish the results of the study in a peer reviewed journal and through other routes to ensure that fostering/adoptive parents and supporting services are also aware of the findings. You and the children in your care will not be identified in any report/publication arising from this study.

6. What if I want any further information?

If you have any questions, please ask the researcher or call Sarah Wassall on [redacted].

Appendix 18: Consent form for those attending the parenting group for foster and adoptive parents: Consent to sessions being video-recorded

UNIVERSITY OF BIRMINGHAM

CONSENT FORM for videoing the parenting group sessions

Research site: .....
Study Number & Title:.....
Participant Identification Number:.....

Title of Project: Evaluation of an attachment based parenting group for foster and adoptive parents.
Investigators: Sarah Wassall, Dr. Helen Rostill, Dr. Kim Golding

Please initial box

1) I confirm that I have read and understand the information provided 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 consent to the group sessions being videoed is voluntary and that I am free to withdraw this consent at any time and ask for the video recordings to be stopped, without giving a reason. I understand that this will not affect my medical/social care or legal rights or service support, or those of others. I understand that I will still be welcome at the parenting group. ☐

3) I understand that the videos of the sessions will be looked at by the researchers at the University of Birmingham to ensure that the analysis is a fair and reasonable representation of the data. ☐

4) I consent to the sessions I attend at the attachment based parenting group for foster and adoptive parents to be video-recorded. ☐

Name of Participant	Date	Signature
……	……	……
Name of Researcher	Date	Signature
……	……	……

Thank you for your help

Appendix 19: Instructions for authors for submission to The Journal of Child Psychology and Psychiatry