Chapter 1

1. PROJECT BACKGROUND

1.1 INTRODUCTION

A review of recent literature in relation to the mental health needs of children in care, led to the rationale for providing training to foster carers and the network of professionals surrounding the child, as an integral part of the service provided by a Child and Adolescent Mental Health Service for Looked After Children (CAMHS/LAC) in the south of England. Individuals who are prepared to become foster carers need solid mental health training to successfully parent children who have experienced severe trauma and present with a range of emotional and behavioural difficulties (Dorsey et al, 2008). To date there has been little evaluation of how mental health training has been experienced by foster carers.

The aim of this research was to undertake an illuminative evaluation of the experiences of foster carers, receiving mental health training provided by a dedicated CAMHS/LAC to increase their knowledge, awareness and understanding of the mental health needs of looked after children. The objectives of this study were:

1. Explore the experience of foster carers receiving training during and after delivery.
2. Evaluate the knowledge gained from the training and explore their perception of how this affected their practice.
3. Identify areas of strengths and weaknesses of the training and assess the relevance of the training to foster care in practice.
4. To use the information gained from this research to influence the shape and direction of future training and support, as a way of targeting resources to meet the mental health needs of this vulnerable group of children in care.
To improve the quality of care that children and young people receive from foster carers by providing mental health training and understand the support foster carers need in order to prevent placement breakdown.

This introductory chapter will outline a profile of looked after children (LAC) in England and will consider the current international and national concerns regarding the high level of mental health needs in looked after children. An outline of the key policy initiatives and guidance introduced over the last decade, which aimed to prioritise the mental health needs of children in care, will be considered. The origins of the foster carer role and the Government legislation related to supporting foster carers in terms of mental health training will also be discussed. An analysis of the literature related to this field will include a review of the development of foster care training, an outline of the current training interventions provided by various CAMHS teams in the United Kingdom. A local description of the needs of children in care and a background to the development of this research project will then be explored.

Chapter 2 will describe in more detail this research project conducted in contemporary practice beginning with an outline of the methodological approach adopted. The research project utilised an illuminative evaluation approach using a mixed methodology which includes a combination of qualitative and quantitative data. This approach will be explored in relation to its strengths and weaknesses. Chapter 3 will describe the quantitative method of data collection, the analysis and will report and discuss the results. Chapter 4 will describe the qualitative method of data collection, the analysis and will report and discuss the findings in relation to current literature in this field. A conceptual framework will also be presented within which the information gained from foster carers, is placed. This will present their journey of understanding and illuminate experiences reported by foster carers as they travelled through the training. Chapter 5 will draw together a discussion of the process of an illuminative evaluation and will expand upon the limitations of the research. Chapter 6 will outline the professional relevance of this work and provide a personal reflection in relation to the undertaking of the Doctoral Programme in Nursing and developing a professional identity as a research practitioner. This chapter will also summarise the implications of this research study and will provide
suggestions for further research and practice implications. The participants who took part in this study will be referred to as foster carers throughout this research project.

1.2 LOOKED AFTER CHILDREN

The term ‘looked after children and young people’ was introduced and defined within the Children Act (1989) as those children under the age of 18 who reside under the care of a Local Authority, either as a result of a voluntary agreement with their parents or as a result of a court order. Once in care the state shares parental responsibility and in England 73% of looked after children (LAC) are cared for by foster carers, with 11% in residential care homes (Department for Education, 2010). Foster care is defined by Colton and Williams (1997) as substitute care/parenting provided to children or young people on a temporary or permanent basis through the mediation of a local authority. Foster carers are responsible for providing the day to day care for children placed with them.

1.2.1 PROFILE OF CHILDREN IN CARE

According to the Department for Education (DfE) statistical release for the year ending 31st March 2011 there were 65,520 children residing in local authority care in England (DfE, 2011). This is an increase of 2% since 2010 which was 64,410 and is the highest number of children in care since 1987. Within the United Kingdom (including Wales, Northern Ireland and Scotland) this figure rises to approximately 83,000. In England during the year ending March 2011, 27,310 children started to be looked after. Although this was a decrease of 3% since 2010 which was at 28,090 children this is still an overall increase of 14% since 2007 at 23,960 (DfE, 2011). There has been growing concern about the steady increase of children entering care and the impact of this upon a child’s social and emotional functioning. The legal status of children in care consists of 60% on care orders with 31% accommodated voluntarily. The gender profile of children in care in 2011 includes 56% male and 44% female and this figure has been the same since 2007 (DfE,
Overall the admission of all ages of children has increased since 2007 except within the 10 to 15 year old age group as shown in Table 1.

### Table 1: Age of children on first starting to be looked after, 2007 to 2011 (DfE, 2011)

<table>
<thead>
<tr>
<th>Age of entry into care</th>
<th>2007</th>
<th>2011</th>
</tr>
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<tbody>
<tr>
<td>Under 1 year</td>
<td>18%</td>
<td>19%</td>
</tr>
<tr>
<td>1-4 years</td>
<td>18%</td>
<td>21%</td>
</tr>
<tr>
<td>5-9 years</td>
<td>16%</td>
<td>17%</td>
</tr>
<tr>
<td>10-15 years</td>
<td>39%</td>
<td>31%</td>
</tr>
<tr>
<td>16 years and over</td>
<td>8%</td>
<td>12%</td>
</tr>
</tbody>
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NB: Percentages have been rounded to the nearest whole number and therefore may not equal 100%.

These figures highlight that there has been an increase in the one to four age group entering care and although the number of children aged between 10 to 15 years has reduced since 2007, there continues to be a high percentage of adolescents in care who need a substitute family to care for them. The main reasons children were taken into care were due to abuse and neglect (54%); family dysfunction (18%); absent parenting (7%); family in acute distress (11%); parent’s mental illness or child’s disability (7%) with only 3% taken into care because of their own ‘socially unacceptable behaviour’ (DfE, 2011). The percentage of family dysfunction as a need has risen since 2007 from 14% to the current 18%. It is, therefore, reasonable to assume that many children taken into care will be profoundly affected by prior experiences which are likely to have a detrimental effect upon their emotional development. In relation to ethic origin the highest percentage of children in care are from a white ethnicity as 77% are identified as White, 9% as Mixed, 5% as Asian, 7% as Black and 2% as other ethnic groups. However children from some Black and Minority Ethnic (BME) groups are known to be over-represented in areas
with BME populations (Thoburn, Choud & Proctor, 2004). There has also been a steady increase of children placed in foster care with 74% in 2011 which compares with 70% in foster care in 2007. With this in mind and with ever increasing numbers of children entering the care system year upon year, the need for more foster carers who are highly skilled is becoming a national priority.

1.2.2 OUTCOMES FOR CHILDREN IN CARE

Once children are under the care of a local authority they may be at risk of experiencing multiple placements and concerns have been raised in relation to the negative impact this may have upon many areas of their social and emotional functioning (Cantos, 1996). In 2004 the New Labour Government’s White paper Every Child Matters (ECM) established five outcomes for children. These were to be healthy, stay safe, enjoy and achieve, make a positive contribution and achieve economic well-being. Although the Conservative, Liberal Coalition Government (2010) changed the emphasis on ‘outcomes’ to helping children ‘achieve more’ the policy of collecting this information remained the same (Brown, 2011). One of the ways they measured that children residing in local authority care were achieving and making a positive contribution was through indicators such as educational achievements and comparisons were made with information gathered on the general population of children in England. The DfE (2010) published educational outcomes for children which identified that only 12% of children in care achieved 5 GCSEs or equivalent A* to C compared with 62% of all children. GCSE attainment increased to 18% when children had remained in the same foster placement for one year and this compares to 11% of children who return home to the care of their parents and 3% of those children who live in residential care. In addition only 12% of children in care go on to further education compared to 68% of the general population. Statistics show that 73% of school age children looked after continuously for one year have some form of special educational needs, and this figure compares to 2.7% of all children in the general population (DfE, 2011).
As well as problems with educational achievements other negative outcomes related to antisocial behaviour such as contact with the courts and substance misuse issues are also concerning. Statistics gathered show 8.7% of children in care over the age of ten years had either a conviction or were subject to final warning or reprimand, in comparison to 3.5% of the general population of children (DfE, 2011). Offending behaviour was higher in older male children with the statistic rising to 14.4% in the 16-17 age groups. In this group 30% were identified as having substance misuse problems. According to figures provided by the Department for Education (DfE) 2007, children in care are four times more likely to use alcohol, smoke and misuse drugs than the general population of children. In total 4.3% of children in care were identified as having substance misuse problems, with a high percentage of these being aged 16-17 with 30% of those refusing treatment. There are identifiable factors that are thought to contribute to these behavioural problems which include an early history of child maltreatment, socio-demographic characteristics, institutional environments and foster placement stability (Bellamy, Traube & Gopalan, 2010). This exposure to neglect early in childhood may lead to complex and multiple needs in terms of behavioural and educational development which compound their risk of developing mental health difficulties.

A general health profile of the children and young people in care of the local authority includes those with complex medical and behavioural problems (Parker, Loughan & Gordon, 1992). They may have histories of abusive environments which can contribute to developmental difficulties and a delay in receiving the medical attention they require (Berridge, 1997). According to Blatt and Simms (1997), these children and young people present with a higher level of chronic health conditions in comparison to the general population of children. However it is important to note that they are also in receipt of more regular health assessments and this may contribute to this figure.
1.3 MENTAL HEALTH OF CHILDREN IN CARE

1.3.1 NATIONAL COMPARISONS OF THE MENTAL HEALTH NEEDS OF CHILDREN IN CARE

The Office for National Statistics (ONS) mental health surveys of looked after children (Meltzer, 2003; Meltzer, 2004a; Meltzer, 2004b) confirm that the rates of mental health difficulties are significantly higher for looked after children in comparison to the general population of children in the U.K (Ford, Vostanis, Meltzer & Goodman, 2007). They identified that 45% of looked after children experience mental health problems, a figure rising to some 72% when they live in a residential institutional setting and this is in comparison with 10% of the general population. According to Vostanis (2010), the mental health of children in care is affected by both acute and chronic trauma, loss and the secondary impairment of living in the care system, placement instability, risks of drug use and sexual exploitation. Many studies in the U.K have confirmed that the prevalence of mental health difficulties is significantly higher for children who reside in local authority care, in comparison with the general population as a result of coming into care when they are already emotionally traumatized, have suffered abuse and neglect and are from disadvantaged backgrounds (Mc Cann, James, Wilson & Dunn, 1996; Dimigen et al, 1999; Stanley, 1999; Stanley, Riordan & Alaszewski, 2005). The Royal College of Psychiatrists (2000) noted that this group of youngsters generally have more than one significant difficulty in their emotional and behavioural functioning (Richardson & Joughin, 2000). Studies have suggested there are strong links between disorganized attachment patterns in childhood and personality disorders and serious dissociative disorders in adulthood (Liotti, 1995; Johnston & McLeod-Claire, 2002). Further research indicates that a failure to address trauma related to attachment disorganization leads to serious enduring mental health problems. (Schore, 1994; Fonagy, 2001)

Over the last 10 years two main indicators relating to placement stability and placement moves have been recorded and measured by Local Authorities in
England in an attempt to gather information regarding the emotional health of children in care:

1. Placement stability is important when considering the stability of the emotional health and development of children in care. Data are available regarding the length of time a child resides within a stable placement: in 2010, 68% of children who had been looked after for a period of 2 ½ years or more had lived in the same placement. The latest figures show a 5% increase in stability of placement for children in care since 2006 when the percentage was 63.5%.

2. The stability of placement is also measured by frequency of changes in placement over a one year period: in 2010 10.9% of children in care had three or more placements during one year according to national figures. This figure represents a steady decline in frequency of changes in placement from that of 12.9% in 2006 (DfE, 2010). Again Local Authorities have used this information in the past to consider the stability in relation to the emotional and mental health of children residing in care.

Since 2008, the health of children in care has also been measured by Local Authorities through an additional national indicator regarding the emotional and behavioural health of looked after children. Data produced in 2009 and 2010 have now been published by the Department for Education (2011). Through the use of screening tools regarding the emotional health of children in care, they identified borderline mental health difficulties for looked after children (DfE, 2010).

Despite these overall indicators which show an improvement over the last two years there are regional variations and such statistics have their limitations in that they give us little information regarding the quality of the care received or an explanation as to why placements change.
1.3.2 INTERNATIONAL COMPARISONS OF THE MENTAL HEALTH NEEDS OF CHILDREN IN CARE

Similar concerns regarding higher rates of mental health issues for children in care have been identified within the growing body of international literature in this field. In the United States of America (USA) there are currently 500,000 children in care at any one time (Vostanis, 2010). In terms of prevalence of mental health difficulties it is estimated that 40-60% of children in the care system will need input from the mental health services (Clark et al, 1994). A USA study (Harman, Childs & Kelleher, 2000) found that children in care were more likely to be hospitalised for mental health difficulties than the general population. According to Golding (2010), 20% of children in care in Denmark have a psychiatric diagnosis and in Australia children in care are four times more likely to experience mental health problems.

As in England, given the high rates of mental health difficulties experienced by children in care, fostering has become more widespread in countries like the USA, Canada, Australia and New Zealand as the predominant type of care provided to children and young people in the western world (Vostanis, 2010). Improving the quality and stability of foster care is therefore of paramount importance internationally.

In many countries however with limited access to foster or family and friends care, the majority of children are placed in residential institutional care from an early age. Browne et al (2005) completed a WHO survey of 46 countries and as many 44,000 pre school children lived in institutions. This figure represents a high proportion in Russia, Eastern and Central Europe. In India 11 million children are estimated to not have a home (Vostanis, 2010). The risks in relation to the emotional and mental health of children residing in residential care have been found to increase (Meltzer, 2003).
According to Vostanis (2010), whatever the characteristics of different societies, children in care are at risk of developing multiple problems across their developmental and psychosocial functioning which are compounded by their environment. As a result there is an international drive for interagency commissioning and collaboration regarding service delivery and training for foster carers (United Nations, 1989; European Commission, 2005; Vostanis, 2005).

1.3.3 MENTAL HEALTH AND STABILITY OF PLACEMENT

According to Minnis, Bryce, Phin and Wilson (2010), the care setting in which children are raised and decisions about the kind of placement chosen, may have implications on the child’s emotional health and life course. They point to the recent increase in deaths of maltreated children highlighted by the Health Care Commission (HCC, 2009) as having demonstrated the challenges placed upon services of assessing and treating the mental health needs of children in care and finding suitable placements for them. Gean, Gilmore and Dowler (1985) and Cantos (1996) highlighted an increased risk of children developing mental health problems with the number of previous foster placements they experienced. Stanley et al (2005) also identified that high levels of mental health need were associated with placement disruption and therefore providing suitable stable foster placements given the recent statistics, is one key area in terms of targeting resources in the form of training to promote the health of looked after children (LAC). Lindhheim and Dozier (2007) also indicate that the commitment of foster carers to children over the long term aids their ability develop a secure attachment and also identifies that instability of placement has a detrimental effect upon the child’s mental health and wellbeing. Ainsworth and Eichberg (1991) referred to the risk of repeated separation from caregivers or a history of repeated trauma leading to a greater risk of multiple problems for individuals with their own children within future generations.

Macdonald and Turner (2005) also suggest that there is a strong correlation between behavioural problems and placement breakdown (Borland, O’Hara & Triselioyis, 1991). They suggest that such behavioural difficulties need addressing alongside a government objective of ensuring that children who cannot be cared for in their
family of origin are securely attached to foster carers capable of providing safe and effective care during the duration of childhood (DH, 1999 as cited by Macdonald & Turner, 2005). The importance of supporting placements to prevent secondary trauma from moving was explored by Barth, Yeaton and Winterfelt (1994) who identified that the perception of self efficacy in reducing stress for foster carers is a protective factor against the replacement of a child.

Reducing or minimizing the number of foster placement breakdowns remains an important objective for Local Authorities and therefore the ability of foster carers and residential staff to work consistently to manage behaviour is significant. There is some evidence that disruptions in placements can undermine the child’s capacity for developing meaningful attachments, disrupt friendships and contribute to difficulties at school (Macdonald & Turner, 2005).

Minnis and Devine (2001) developed and tested a questionnaire, the Reactive Attachment Disorder scale, in which they found that children placed within the care system presented with significantly higher scores for attachment disorders than a comparison group of school children. They used a Modified Rosenberg Scale (MRS), which showed that children in care experienced lower self-esteem scores in comparison to their peers. Kretchmar, Worsham and Swenson (2005), conducted a qualitative study of an at-risk mother’s experience in an alternative foster care programme, which provided therapeutic input to enable the mother to care for her child. They identified that the mother’s attachment related trauma in early childhood had a high impact on her mental health and in turn she experienced the parenting of her own child as challenging.

Foster carers have reported how parenting a looked after child can lead to a sense of insecurity which leads to feelings of inadequacy (Ironside, 2004). Other foster carers struggle to manage challenging behaviour and feel isolated until placements break down (Hill-Tout, Pithouse & Lowe, 2003). Issues of helplessness occur when foster carers are faced with the high levels of challenging behaviour (Herbert & Wookey, 2007). This leads to placement breakdown which affects mental well
being and increases vulnerability to developing problems in the future (McCarth,
2004).

Foster carer group work has been found to be beneficial to foster carers supporting
them with knowledge and reducing stress (Laybourn, Anderson & Sands, 2008). Quality
Protects guidance (DH, 1999) placed emphasis on placement stability and
support from dedicated teams regarding mental health, however according to
Mount, Lister and Bennun (2004), fewer than half of those that needed support from
Child and Adolescent Mental Health Services (CAMHS) accessed it. This may be
due to failure in identifying difficulties, placement moves or uncertainty, reluctance
to engage and a paucity of provision (Sargent & O'Brien, 2004). Access to CAMHS
and the effectiveness of CAMHS, in meeting the needs of children in care, remains
questionable (Rushton & Dance, 2006). Nationally targeted CAMHS services for
looked after children are providing multi systemic therapy and treatment foster care
which involves a level of foster parent training (Vostanis, 2010). There is a need to
adapt behavioural management interventions to meet the specific needs of foster
carers in relation to children in care. Some researchers have linked beliefs held by
foster carers as having a direct influence upon how they subsequently care for the
foster child (Taylor, Swann & Warren, 2008). The importance of refocusing
existing services, developing more flexible systems for vulnerable groups of
children and using scarce resources for consultation and training is vital (Golding,
2010; Vostanis, 2010).

1.4 GOVERNMENT POLICY

Over the last decade there has been a steady increase in Government legislation,
initiatives, policies and consultation papers targeting the health needs of looked
after children, as a response to poor outcomes for children in care as highlighted
earlier. There has been a drive to narrow the gap in health outcomes between
children in care and children in the general population. It is important to briefly
describe the key legislation related to supporting an improvement in the health of
looked after children as it indicates the current situation and describes the initiatives
that have been brought in to address the failings or shortcomings of the past. Key
legislation also reflects changes over time, amendments and developments in policy
and practice which in turn impacted on the quality and stability of foster care placements.

In 1998 research collating the views of children in care was presented in a paper published by the Department of Health ‘Caring For Children Away From Home’: Messages from Research (DH, 1998). This research based paper provided evidence of the experiences of children in care and made recommendations to Local Authorities in relation to the quality of care offered to children. The Quality Protects programme produced by the Department of Health also commenced in 1998 and outlined the role and responsibilities of local councils. This initiative was a three year improvement programme which aimed to ensure that Local Authority children’s services were well managed and effective. The initiative emphasised the need for greater life chances for children in care and recommended the focus of resources upon carrying out the parental role to promote improved outcomes for them. This was supported by a financial grant for interagency collaboration based on research (DH, 1998b). The CAMHS mental illness specific grant in 1999, led to the development of dedicated posts focusing on the mental health needs of this vulnerable group of children.

The Adoption and Children Act (2002), went further to provide guidance on promoting the health of children in care and developed a framework for health councils and social services departments to work together closely to meet the health needs of children in care (DH, 2002). Strategic planning, specific responsibilities on senior managers in social care for health and designated health practitioners who specialised in the health needs of children in care were developed. Health professionals began to take on an increasingly important role in training foster carers.

In 2003 the Green Paper, Every Child Matters was published by the Department for Education & Skills (DfES) and created an agenda which applied to all children irrespective of their circumstance and began to define what was needed in order for children to live healthy lives, to achieve economic wellbeing and make a positive contribution towards society. In 2004 the National Service Framework (NSF) set in place a 10 year programme developed by the Department of Health (DH) and the
DfES which aimed to stimulate improvements in children’s health. This programme aimed to provide high quality integrated health and social care and set standards to reduce inequality. The programme also emphasised the need to locate mental health services in non-stigmatising settings. Standard 2 of the NSF focussed upon supporting foster carers through the provision of training in order to equip them with the skills to reduce health inequalities and poor outcomes. In addition, the Children Act (2004) made amendments to the Children Act (1989) and recommended changes in child protection and placed emphasis on high risk groups of vulnerable children.

In 2007 the White Paper, Care Matters: Time for a change (DfES, 2007), made more explicit the need to maintain improved outcomes and support further improvements in the care system. One initiative related to this was the Children’s Workforce Development Councils (CWDC) creation of the Training, Support and Development Standards for foster care. This highlighted the need for the provision of excellent parenting for children in care and this became central to the agenda. There was also general agreement that no single agency could meet the complex needs of this group of children (DfES, 2003). As a result of the guidance and legislation as described over the last 10 years, a joint commissioning of services panel that specialised in the needs of children in care was set up in health, education and social care. In some geographical locations, higher performing councils began to develop specialist multi-agency teams to provide dedicated health professionals for children in care. This led to an increased role for health professionals in relation to supporting foster carers to care for looked after children in the provision of additional assessment, training and consultation. By 2008 within the U.K, pilot integrated and targeted CAMHS services were developed and sustained through dedicated funding streams generally located within statutory social care or mental health organisations alongside some non-statutory agencies (Taylor, Stuttaford & Vostanis, 2007). The CAMHS review (2008) however, identified that access to these services varied regionally and too many CAMHS teams continued to use referral criteria that reflected more traditional diagnosis which, it argued, can limit the provision of mental health support to high risk groups only.
Despite this drive to improve outcomes there continues to be concerns about whether services are meeting the needs of the most vulnerable. The current statutory guidance, Promoting health and wellbeing of looked after children (DH, 2009), replaced the 2002 guidance and provides a summary of outcomes from statistics gathered since 2008 on the health needs of looked after children. This identified that health risks for children in care continue to be greater than for children in the general population. One of the most important findings to emerge from these statistics was that there were continuing failures within the care system and this led to stronger recommendations for collaborative working between Local Authorities (LA), the Primary Care Trusts (PCT) and the Strategic Health Authorities (SHA) to co-operate with each other and improve and target these health inequalities.

Finally in October 2010, further guidance produced by the National Institute for Clinical Evidence (NICE) and Social Care Institute of Excellence (SCIE) entitled ‘Promoting the quality of life of looked-after children and young people’ (NICE & SCIE, 2010) highlighted the mental health needs of this group of children and young people and their requirement for multi-agency evidence based support. This focused upon ensuring that organisations, professionals and foster carers work together to provide high quality care, stable placements and nurturing relationships. They identified that looked after children as a group are vulnerable to psychological difficulties and are often denied access to services. This guidance together with the updates on the Children and Young Person Act (2008), places a responsibility upon professionals working with children in care, to ensure that good quality placements are provided to children. This latest reform of the children services provides Local Authorities with more flexibility to create the support packages needed for foster carers to provide stable placements for children in care. Berridge and Cleaver (1987), highlight that foster carers are clearly unprepared for the sorts of demands that severely emotionally deprived children would make on them. More recently researchers have confirmed this when exploring why placements fail (Sinclair, Wilson & Gibbs, 2005). The consequence of delays in assessments of children has been identified as an important factor in exposing children to risks of maltreatment or placement breakdown (Farmer, Sturgess & O’Neill, 2008). Turner, Macdonald and Dennis (2007) also noted that unplanned terminations of placements have the potential of undermining the foster carer’s ability to provide stable care.
1.5 FOSTER CARE IN THE UNITED KINGDOM

1.5.1 FOSTER CARE

Foster carers are responsible for the day to day care of children placed with them. A search of the pertinent literature identified evidence that the recruitment of foster carers remains difficult, with foster carers dropping out at alarming rates (Turner, Macdonald & Dennis, 2007). In 1994, the Audit Commission concluded that welfare agencies were unable to offer the support and guidance that is needed to sustain recruitment and retention of foster carers. They concluded that factors such as parents working, liability insurance, lack of training, support and respite care and the increasing severity of risks associated with the children placed with them all contributed to placement breakdowns. A report was published by Utting in 1997 which reviewed the safeguards for children living away from home. He found that many foster carers were unprepared to meet the needs of this very vulnerable group and this in turn led to many placement breakdowns. Utting’s report supported the need for increased reimbursements and increased training for foster carers

1.5.2 ORIGINS OF FOSTER CARE TRAINING

Training for foster carers, which is usually referred to as foster parent training, refers to an educational process which is offered to foster carers to provide information and skills in order to fulfil their responsibility. Pasztor and Evans (1992) note that the origins of parent training were in the 1800’s, however the development of foster carer and residential staff training since the 1960’s is relatively recent. They suggested that the need to train foster carers was not seen as a priority as it was assumed that foster carers had gained sufficient parenting skills by caring for their own children. Many studies have identified that training is associated with enhanced foster caring attitudes, skills reducing behaviour problems and improving relationships (Boyd & Remy, 1978; Lee and Holland, 1991; Sinclair, Wilson & Gibbs, 2005). Runyan and Fullerton (1981) linked the lack of training with failed foster care placements. Zusoski (1999) refers to a vast amount of published and unpublished parent training, which has now been developed by the state and private welfare agencies. However this is based on the vast evidence of the
success of training groups with birth parents and is not confirmed in the context of foster care.

Many foster care training programmes have built on existing parenting training by combining social learning and attachment theory in order to enable foster carers to care for children and gain knowledge regarding trauma and a child’s presenting behaviours (Vostanis, 2005; Golding, 2007). Their impact on the quality of care, children’s outcomes and the sustainability of placement is according to Dorsey et al (2008) yet to be confirmed. The effectiveness of training offered to foster carers and residential staff may need to be evaluated alongside additional specialized support (Turner et al 2007).

Clarkson and Whistlecraft (1987) reviewed the adequacy of current training for foster carers and residential staff and called for Local Authorities to purchase in specialist staff such as CAMHS with a training brief to undertake and prioritise this work. Clark et al (1996), referred to this as the need for wraparound service strategies that included mental health training in order to improve permanency in placement, youth offending and absconding behaviours.

According to Golding and Picken (2004), research has identified that parenting practice and child behaviour is connected and they have effects upon each other (Kazdin, 1997). Parent training can have lasting effects and is central to improving outcomes for looked after children in terms of placement stability and enabling foster carers to tackle and manage challenging and distressing behaviour (Scott, 2001; Webster-Stratton, 1997). Ongoing evaluations continue to demonstrate benefits to the foster carer in terms of satisfaction however, there is very little evidence based research to identify that this leads to a significant change in their child’s emotions or behaviour (McAuley & Davies, 2008). The aim of such training programmes are to encourage healthier attachment behaviours within the child, share knowledge and awareness of more sensitive parenting skills and increase reflective practice (Marvin, Cooper, Kent & Powell, 2002). Various models of training have been put forward to contribute to the evidence base (Patterson, 1969; Skinner, 1953; Webster –Stratton, 1984). A combination of a skills based approach
alongside an element of support is recommended by Golding and Picken (2004). Warman et al (2006) also discussed the need for providing a range of opportunities for foster families to access education but also to support each other and work through challenging times. Studies by Minnis and Devine (2001) and Hill-Trout et al (2003), both found positive experiences reported by foster carers but no measurement of significant effects upon the behaviours of fostered children.

1.5.3 STANDARDS FOR FOSTER CARE

The Care Standards Act (CSA) (DH, 2000), introduced a National Care Standards Commission in England and produced independent regulatory and inspectorate procedures for social care and private and voluntary health care services. Under section 23 and 49 of the CSA Act (DH, 2000) the National Minimum Standards were published and covered the current guidance for training and development of social care professionals working with children. Standard 6.1 refers to the provision of foster carers who can provide a safe, healthy and nurturing environment for children under Local Authority care. Standard 7.3 refers to the need for social workers and foster carers to cooperate to enhance the child’s emotional health. Standard 12 refers to the foster carers having access to services for support and training.

The Department for Education and Skills (DfES, 2005b) published Training for Foster Carers, which raised issues regarding the quality and uptake and impact of post approval training. The report identified that there was no national framework and no national, easily transferable, qualification for foster care according to Warman et al (2006). The report also identified that negative experiences of training had an impact on the take-up and there were significant differences in the quality and structure of foster carer training in relation to emotional health training. In May 2007 the Children’s Workforce Development Council (CWDC) consulted with foster carers and developed standards for the Training, Support and Development (TSD) of foster carers in England. They outlined key areas of learning and development that every foster carer should undertake pre and post approval to form national minimum standards of good practice. Fostering services implemented these
standards from April 2008 which stated that every foster carer should evidence their skills by completing a portfolio workbook of training by April 2011.

This has lead to a change in terms of how foster carers’ competences are measured. Seven standards are now in place nationally to enhance education development and support for foster carers. The Children Act (2004) legally under-pins this process which requires a multi-agency approach to the development of effective and accessible services for vulnerable children.

1.5.4 CHARTER FOR FOSTER CARE

The Children’s Workforce Development Council (CWDC) hope that by accessing clearer guidance and new training resources provided to supervising social workers there will be a reduction of bureaucracy, the provision of consistency across services and an improvement in the support offered to foster carers (DfE, 2011). In addition to these minimum standards published for the conduct of fostering services, a charter for foster carers has also been published by the Department for Education (DfE, 2011) which acknowledges the extraordinary job that foster carers do every day. The charter highlights that the needs of the child must come first and foster carers should treat their children as they would their own to help them form an identity. The charter aims to develop foster carers as role models. It discusses the notion of support and development in the context of being part of a team with access to training through the Fostering Changes training programme which is designed for mainstream foster carers. This training programme aims to increase parenting skills and improve child health outcomes. The CWDC also support the Multi Dimensional Treatment Foster Care (MDTFC) project in England which has promoted multi disciplinary health and social care teams through the funding of projects in eight Local Authorities. These MDTFC projects aim to support foster carers of seven to 11 year olds who are at risk, presenting with anti-social and high risk behaviours and have experienced numerous placement breakdowns. Outcomes of such projects are imminent and support high levels of supervision, intensive positive parenting, an increase in recreational activities, and an increase in input at school and provide structured therapeutic living environments (DfE, 2011)
Chamberlain, Moreland and Reid (1992), supported the view that retention rates of foster carers in the foster care system could be increased, by providing foster parents with enhanced training and support services together with a monthly pay incentive. In their study they identified that this support package reduced the drop out rate of foster carers by two-thirds. This enabled the holding of more foster carers in the system and increasing their overall level of skill. Numerous studies including Webster-Stratton (1984) have demonstrated that it is possible to teach parents skills to improve their child management and that this had a dampening effect on the amount of oppositional behaviour that a child or young person presents. Chamberlain et al (1992) recommended extending the training to include all foster children and continuation of the training on a less intensive basis.

“Foster parents expressed satisfaction, accomplishment, and appreciation for being seen as experts or professional people who were contributing for the greater good.” (Chamberlain et al, 1992 p.400)

1.5.5 DEDICATED CAMHS FOR CHILDREN IN CARE

The importance of well integrated dedicated teams who have protected time to dedicate to vulnerable at risk groups of children and young people such as children in care continues to have a limited evidence base in terms of what works (McAuley & Young 2006; Street & Davies, 2002, cited by Vostanis, 2010, p. 561). There are limited data to support improved outcomes for these services and a need for increased evaluation of interventions (Dorsey et al, 2008). The focus tends to be on providing multi systemic treatment, consultation and training and developing specialist knowledge within dedicated teams which can support the general CAMHS teams to understand the needs of this at risk population of children (Golding, 2010). Vostanis (2010) recommends rebalancing existing services to provide flexible and accessible services to vulnerable groups such as children in care. Those teams with scarce resources should provide consultation and training which is underpinned by theoretical frameworks and begin to evaluate interventions in order to build up the evidence base and disseminate findings to other teams within their country and build on international examples of good practice (Stanley et al, 2005; Minnis et al, 2010).
1.6 LITERATURE REVIEW OF TRAINING INTERVENTIONS:

1.6.1 SEARCH STRATEGY

In order to discover suitable evidenced based papers to assist in designing this research project, time was spent considering the information resources needed. The format needed was one which would lead to both a comprehensive search of the literature covering the most appropriate search engines. A search of 15 electronic research and professional bibliographic databases was chosen and these databases were available through the NHS library service and University Library. This included Medline, Cumulative Index to Nursing and Allied Healthcare Literature (CINAHL), Applied Social Sciences Index and Abstracts (ASSIA), SCIRUS, British Nursing Index (BNI), Allied and Complementary Medicine (AMED), PsychINFO, Cochrane Library, Social Care online, Social Science Citation Index (SSCI), SOC Index, ERIC, International Bibliography of the Social Sciences (IBBS), ISI of science and TRIP database plus. In addition to regular searches of databases, manual searches of relevant journals and bibliographies of retrieved papers were also undertaken.

According to (Bell 1993), it is important to identify the parameters of the search. Some of the headings used to aid this process throughout the searches are described below:

- **Select the topic**: Foster carers and children with emotional and behavioural difficulties.
- **Define the terminology**: All children in local authority care who come under the remit of CAMHS services below the age of 18 years.
- **Language**: Materials in English.
- **Geography**: Two searches conducted: (1) A UK specific search in order to compare similar populations (2) A wider international search.
- **Time period**: 1950–2011
- **Types of material**: Journal articles.
- **Sector**: Local Authority Care
A thesaurus mapping led to a ranked list of most commonly used subject headings related to the research topic. A scope note was used in checking the way in which the term is used and therefore whether its use was appropriate to the search. Descriptors used initially were performed on separate searches and included: Looked after children, foster care, foster carers, mental health, group training, education, attachment disorders, and child behaviour disorders. The search was finally reduced to a combination of relevant search terms with Boolean terms used such as OR to broaden the search and the use of AND to narrow search and retrieve records containing all the words.

The selections of papers were then read thoroughly (Crombie and Davis, 1998). Boswell and Cannon (2007, p.239) identify a process for formatting and documenting relevant evidenced based papers which was also used to aid this process through use of PICOT (Population, Intervention of interest, Comparison of interest and Outcome of interest and Time.) An example of the search strategy on one occasion is highlighted in the mind map in Appendix 1. In addition an example of the formatting process is also included in Appendix 2. This process of searching relevant literature continued until April 2011.

1.6.2 TRAINING INTERVENTIONS

The purpose of this review of the literature was to locate pertinent papers to answer the focused questions: What mental health training is on offer for foster carers and what does it consist of? Is mental health training for foster carers effective in increasing the skills and confidence of foster carers in managing the emotional and behavioural difficulties of children in care? Can mental health training increase the level of knowledge regarding mental health needs? Does mental health training lead to a reduction in perceived stress for foster carers? Do foster carers identify a perceived change in the presenting behaviours of children in care as a result of attending mental health training? Can the provision of mental health training reduce placement instability?

A review of the literature revealed that mental health training offered to foster carers used numerous formats with a broad range of training methods. The evidence found
revealed two systematic reviews which identified 11 key primary studies and seven other research studies using mixed methods approaches. Three broad categories were revealed. A review and comparison of these three categories of training which includes 18 studies are discussed and cover studies in relation to this research over the last 15 years.

These three broad categories of studies are listed below and are included in the references section of this thesis:

1. **Training Groups: Cognitive Behavioural Programmes:** These programmes were skill based training which focused upon the developmental needs of children and child management techniques. A systematic review of these skill based foster care training groups using the Cognitive Behavioural Model identified a review of all training prior to 2005 (Turner, Macdonald & Dennis, 2007). This review identified six key studies between 1992 and 2004: Chamberlain (1992); Barth et al (1994); Minnis (2001); Pithouse (2002); Edwards (2002); McDonald (2004).

2. **Training Groups: Treatment Foster Care Programmes:** These programmes were treatment foster care training which used an individualised programme consisting of a strong network of support in combination with training and therapeutic input for children. A systematic review of treatment foster care in 2008 (Macdonald & Turner) revealed five key studies between 1991 and 2005: Chamberlain (1991); Chamberlain (1992); Chamberlain (1998); Clarke (1994); Leve (2005).

3. **Training Groups: Mixed Model Programmes:** These programmes consisted of studies since 2004 that have aimed to identify strategies best suited to respond to challenging behaviour by using a combination of approaches such as cognitive problem solving techniques, parent management training, family therapy and multi-systemic training, focused upon information sharing and support to assist foster carers in understanding their role and responsibilities (Hill-Trout, 2003). These studies used a combination of theoretical models including learning theory and attachment theory. They use theoretical perspectives to promote positive relationships by combining existing parent training informed by social learning.
theory and attachment theory (Warman et al, 2006). Social learning theory was
developed in the 1940’s through observations of animal behaviour. It is an active
approach to learning which explains human behaviour by exploring relationships
between cognitive thoughts, the environment and behaviours (Bandura, 1977).
Attachment theory refers to the unique affectional tie between two people enacted
within the initial relationship between the child and the primary care giver (Bowlby,
1973). Early styles of attachment are also linked to child behaviours. Between 2005
and 2010 an additional seven key studies of training groups were found through the
literature search: Golding and Picken (2004); Warman et al (2006); Herbert and
Wookey (2007); Laybourne (2008); Robson and Bryant (2009); Gurney Smith et al
(2010); Holmes and Silver (2010).

1.6.2.1 TRAINING GROUPS: COGNITIVE BEHAVIOURAL
PROGRAMMES

A Cochrane systematic review of Cognitive Behavioural Training (Turner et al,
2007) included an analysis of current national and international research with regard
to training for foster carers. Cognitive Behavioural Therapy (CBT) seeks to identify
and correct problematic thinking associated with dysfunctional behaviour by
challenging adaptive thoughts and beliefs. There is an extensive research evidence
base for this psychotherapeutic treatment which has led to professionals in the field
of social care to devise CBT training programmes. The role of Cognitive
Behavioural Therapy (CBT) based training can be broadly categorised as training
which provides foster carers with skills to think (cognitive) and act (behavioural) in
relation to the care they provide their children. The principles of CBT are orientated
towards problem solving. These skills based training formats then, have aimed at
enabling foster carers to understand and manage the behaviour of their child through
techniques that have a preventable problem solving solution. This systematic review
provided extensive searching for relevant literature across 10 relevant databases and
contacted experts in this field to identify a total of 34 studies. These studies
highlighted that training provision continues to play a significant role in
contributing to foster care placements for children and young people. (Turner et al,
2007).
Within the systematic review, a meta-analysis of cognitive behavioural training interventions occurred, which selected six eligible randomised control trials which were researched in terms of effectiveness in assisting foster carers in the management of difficult behaviour. Two of the studies took place in the USA; Barth et al (1994) and Chambelain et al (1992). Four of the studies took place in the U.K; Minnis and Devine (2001), Pithouse et al (2002), Edwards and Talbot (2002), McDonald, Burgess and Smith (2003). All of these studies dealt with the effectiveness of training on the child’s emotional health and behaviour and behaviour management methods. All the studies were single two group experiments, two of which were based upon the Webster-Stratton ‘Incredible Years’ (1997) model of parent training. This programme has lead to evidence based success with birth parents in terms of effectiveness of training on children’s’ emotional health and behaviour management (Webster-Stratton, 1998a; Webster-Stratton 1998b). Only three of the studies had sufficient data to calculate effect sizes and confidence intervals.

Turner et al (2007) reported upon evidence in terms of outcomes for the psychological changes in children and young people, but there was no evidence of significant change despite the use of numerous validated tools which included the Child Behaviour Check List (CBCL), the Strength and Difficulties Scale (SDQ), a Reactive Attachment Disorder scale (RAD). In terms of foster carer outcomes, through the measurement of skills, again there was no evidence of significant change. There was however evidence of an increase in knowledge and an increased use of a specific cognitive behavioural strategy. In terms of their psychological functioning various tools were used, such as self evaluation questionnaires and a General Health Questionnaire (GHQ) however, no significant changes were identified despite a long follow up period of nine months. In one study the qualitative findings highlighted an increase in confidence and high satisfaction in terms of format and content.

Unfortunately, despite the success of these programmes with birth parents, researchers have found very little evidence that training provision alone would lead to an improvement in caring attitudes and skills for foster carers. Data results relating to foster carer outcomes also show no evidence of effectiveness. Due to the
relatively small number of trials found they recommended further research in this area (Turner et al, 2007). They also considered these findings in relation to other groups offered to parents which have evidence of effectiveness. They identified that the baseline characteristics of children in care are very different in comparison to the general population of children. The long term effects of early trauma, disadvantaged backgrounds and experiences of serious abuse and neglect may manifest themselves in a psychopathology that foster carers have little direct effect on in the short term.

Of the 28 studies not included in the systematic review, five cited research of training directed at children, 12 were not randomised control trials focussing on models of training or individualised case studies and 11 were too small or non-randomised.

Turner et al (2007) also recommended the need for more evaluative research in this field as training interventions appear to have very little effect on outcomes relating to looked after children, as assessed in relation to psychological functioning, extent of behavioural problems and interpersonal functioning.

The review highlighted that many of the Randomised Control Trials (RCT) included within this review were too small. Pithouse et al (2002) conducted one of the studies included in the systematic review and they acknowledged the limitations of their study:

“For that reason we do not advance a view of training in behavioural management as somehow ineffective’ in foster care on the basis of this small and imperfect investigation when what is needed is training as part of a broader strategy of support.” (Pithouse et al, 2002, p.213)

To conclude, it is important to note that Cochrane Systematic Reviews provide a ‘gold standard’ in that they are well conducted and quality assessed. However, they reveal a dearth of evidence (Tanner 2007). As a result of this review, Turner et al (2007), recommended value in encouraging future researchers to employ more sensitive outcome measures over longer periods of time, to increase the number of
participants and offer a combination of training alongside additional intensive support by specialized agencies.

1.6.2.2 TRAINING GROUPS: TREATMENT FOSTER CARE PROGRAMMES

This whole systems approach to training for foster carers (recommended above in the systematic review) is demonstrated within treatment foster care programmes. Macdonald and Turner (2008), carried out a systematic review of treatment foster care which they defined as care provided by paid professional foster carers in the family home which includes a strong community support network, provision of training and therapeutic input for children who are at risk of being cared for in an institutional setting. As such, foster carers are offered additional resources to training such as clinical case management, and follow along support services. The term ‘treatment foster care’ was also referred to in the literature as ‘specialised foster care’ or ‘therapeutic foster care’. Macdonald and Turner (2008) searched 634 citations and five studies met their criteria, four of which included studies from the Oregon Social Learning Centre in the USA (Chamberlain, 1991; Chamberlain, 1992; Chamberlain, 1998; Leve, 2005).

In their systematic review MacDonald and Turner (2008) identified that treatment foster care may be a useful intervention for children and young people with complex emotional, psychological and behavioural needs. Data collected within the five studies were collected from a total of 390 participants. Treatment foster care provided individualized support which led to some improvements with regard to children’s emotional and behavioural difficulties; results indicated some clinically meaningful reduction in antisocial behaviour, absconding, involvement in criminal activities as well as improvements in school attendance and obtaining employment. MacDonald and Turner (2008) also found that these American studies provided some evidence that treatment foster care indicated a promising intervention. Targeted selection, support and training combined together, showed some evidence of placement stability. Four of the studies included the Multidimensional Treatment Foster Care (MTFC) developed by Chamberlain (1988) in the Oregon Social Learning Centre and were of sufficient size to indicate statistically significant
findings. The study conducted by Chamberlain in 1991 provided findings on only seven children and was not sufficient to calculate effect size. Recommendations from the review included further research of this model in Sweden and the U.K as the generalisability of these studies was limited (Hanson, 2007; Farmer, 2008). The issue of bias was also raised in that the programme was designed by the same people who carried out the research and therefore a replicate study was also recommended using an independent research team.

Within one research study, Clark et al (1994) used outcome measuring tools such as the Child Behaviour Checklist (CBCL), client and foster carers records and six monthly interviews in order to demonstrate that individualized support led to improvements with regard to the emotional and behavioural difficulties that children and young people present. Children were found to be more able to internalize actions of their foster carers, were less likely to run away from placements and presented with less criminal activity.

“The positive impact of an intervention that focuses on creating an emotionally supportive environment for children by strategic family and system interventions makes clinical sense.” (Clark et al, 1994, p.215)

1.6.2.3 TRAINING GROUPS: MIXED MODEL PROGRAMMES

Since the publication of the two systematic reviews outlined above, there have been various other research studies which have explored what works in terms of foster care training over the last five years. With limited resources these foster parent training programmes, using a combination of theoretical approaches, have been developed within the UK (Holmes & Silver, 2010; Robson & Bryant, 2009). This mixed models approach to training programmes and a pragmatic combination of inter-agency training and indirect intervention is on the increase (Mount et al, 2004). These behaviour management programmes aim to help foster carers develop skills in communication, increase their confidence, share information and research in order to increase the foster carer’s knowledge and ability to cope with their child’s emotions and behaviour.
In 2004, Golding and Picken carried out routine practice based evaluations of two groups they developed regarding attachment training for foster carers. The first was a psycho-educational group involving 41 foster carers using the Incredible Years Parent Training Programme (Webster-Stratton, 1984). This programme is based on strengthening parenting competences and reducing children’s aggressive behaviour. The second was a programme developed by Golding which focused on children’s attachment difficulties using ideas from a number of authors including Fahlberg (1996), Hughes (1997) and Delaney (1998). Six foster carers completed this group which involved linking attachment theory with presenting behaviours of children in care using a parenting model PACE (Hughes, 1997). Playfulness, Acceptance, Curious and Empathic (PACE) refer to the attitude or stance from which the foster carer parents the child. The mixed method approach to the evaluation process included the use of several quantitative measures and regular qualitative feedback. They concluded from the qualitative data that the training groups provided an opportunity for foster carers to increase their understanding of the needs of children in terms of developing behavioural management techniques and gaining awareness of children who present with attachment difficulties. They found small improvements in quantitative measures, however no differences reached statistical significance.

The ‘Fostering Changes Program’ was set up in 1999, to provide foster carers with practical advice and skills for managing difficult behaviour. The training consists of a range of strategies designed to promote positive relationships between foster carers and their children. Warman et al (2006) used a mixed methods approach to evaluate six years of the ‘Fostering Changes Program’ (Pallet, Scott, Blackeby, Yule & Weissman, 2005) through the use of quantitative measures such as the Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997), Parenting Stress Index (PSI) (Abidin, 1995), satisfaction questionnaires and qualitative measures such as weekly interviews with the foster carers taking part in the study. The quantitative results demonstrated that the training programme had a significant effect upon foster carers’ levels of stress and a positive effect on children’s behaviour. However through interviews with foster carers, the qualitative research findings highlighted that the perceived usefulness of the training outweighed the quantitative evidence. That is, foster carers themselves valued the training and
perceived it as having a beneficial effect in terms of their self esteem and confidence. Foster carers also valued the benefits of listening to the experience and skills of their peers. Warman et al (2006) drew interesting links within the field of education and the impact of co-operative learning. The role of peers and social learning is a very powerful way of gaining skills. They argue that the ‘Fostering Changes Programme’ format has as a central component social learning; emphasising the role of co-operative learning and shared experiences. The role that foster carers play within the training of their peers may be useful to consider in future research.

Herbert and Wookey (2007) devised a ‘Child Wise Programme’ which is a Cognitive Behavioural Programme which includes elements of the ‘Incredible Years’ behavioural programme (Webster-Stratton, 1984). They used a randomised control group and identified that foster carers’ confidence increased when managing challenging behaviour, their knowledge of behavioural principles was significantly higher than that of the control group, however they recommended that foster carers were given sufficient opportunities for further supervision and support to develop their skills further. As was found in other studies included in the systematic review (Turner et al, 2007), they found disappointing results in terms of failure of statistical findings to reach significance in relation to changes in the presenting behaviours of the children.

Laybourne and Sands (2008) adapted existing social learning theories and attachment theories within their training. They evaluated the 18 session programme that had been developed by Golding (2004) entitled ‘Fostering Attachments in Young People who are Looked After and Adopted’ (Golding, 2006) with 8 foster carers. They also used a mixed methods approach to evaluation using the PSI (Abidin, 1995), the SDQ (Goodman, 1999), the Relationship Problems Questionnaire (Minnis, Devine & Pelosi, 1999), the Intervention Questionnaire (Golding, 2004) and qualitative exploration via a semi-structured interview six weeks post training. As in other studies there were no statistical significant decreases in scores relating to children’s behaviours, however there was movement in the right direction. There were statistical decreases in foster carers’ stress levels. The authors considered a reduction in self blame within foster carers for this
decrease. They suggested that, in addition to objective measures, the qualitative aspect provided rich information regarding foster carers’ views and recommended further exploration from future research.

Robson and Briant (2009) evaluated the satisfaction and helpfulness of a training programme developed as an indirect intervention for foster carers. They developed a comprehensive programme that ran over four days and included a range of theories techniques and models regarding self care techniques, anxiety and anger management, improving emotional literacy, attachment theory and mental health disorders. They collected quantitative data on usefulness and satisfaction and qualitative data by providing opportunities for regular feedback. They concluded that important themes arose which included the importance of sharing experiences, the value in meeting new foster carers, an awareness of deep emotional issues for foster carers, an increase in perceived personal reflection and growth and confirmation of existing skills while also providing new ones. Robson and Briant (2009) also highlighted that the training had an impact upon foster carers’ partners who did not participate in the training. The quantitative data provided information regarding a reduction in stress for foster carers. The authors also raised six issues regarding the training of foster carers. These related to the facts that the trainers had no prior knowledge of who is attending the course, the group of foster carers were not prepared educationally through standards or competencies, the content was wide and busy, the theory was hard for people to grasp and a group of more experienced foster carers felt they did not need further training.

Holmes and Silver (2010) reported their findings after they developed a training group that combined aspects of parenting groups with attachment theory in order to provide support to foster carers and adoptive parents. They also combined the use of attachment theory, social learning theory and the principles of Playfulness, Acceptance, Curiosity and Empathy (PACE) (Hughes, 1997). They used the principle of attachment theory to inform ways of increasing foster carers’ empathy for their child which in turn aimed to improve the foster carer child attachment relationship. They used a mixed methods approach to the evaluation of data provided by 58 parents and foster carers and found that the training enabled foster carers to gain more confidence, stress levels within foster carers decreased, all
stressed the benefit of realising they were not alone, they had a desire for more information and reported that they perceived the training of foster carers had a positive effect on the behaviours of the children they cared for. Again without a control group the findings have to be treated with caution. They concluded that through training, an environment can be provided where adult and child relationships are perceived as more positive and problem behaviours are observed to be less severe.

Gurney-Smith, Granger, Randle and Fletcher (2010), also evaluated the ‘Fostering Attachments in Young People who are Looked After and Adopted’ (Golding, 2007) for 10 adoptive parents and five foster carers. They gained feedback for 13 participants in total and found that participants’ feedback was positive in terms of satisfaction but there were no statistical differences in scores for SDQ, PSI, mind-mindedness or intervention.

In summary then a review of the literature has revealed three broad categories of foster care training over the last 15 years and has shown mixed findings. Many of the researchers identified that foster carer training has been received positively by foster carers. The qualitative findings highlight that foster carers gained confidence in their ability to care for their children and the training went some way to enable them to contain behavioural problems which led to a perception of improved mental health in the children (Street & Davies, 2002). In addition, foster carers reported a significant reduction in levels of stress following training (Laybourne & Sands, 2008). Overall there was movement in a positive direction as training was perceived as helpful and foster carers reported a perceived change in the presenting behaviours of children in care as a result of attending mental health training. Unfortunately, the quantitative data in many of the studies showed little statistical significance in terms of measurable change in the emotional and behavioural difficulties presented by children in care. However there was evidence regarding an increase in knowledge and a consistent use of strategies to manage behaviour (Turner et al, 2007) Recommendations for future researchers included the need to take into account that the baseline characteristics of children in care are very different to those of children in the general population. Given this, the outcome tools may need to be used over longer time frames, using more sensitive measures and increase the number of
participants with more evaluative research in this field. Many of the research studies focused upon how to provide successful foster care through further understanding of the foster carer experience (Wilson, 2006).

1.7 BACKGROUND TO RESEARCH PROJECT

In 2000 a Local Authority in the south of England aimed to improve access to the Child and Adolescent Mental Health Services (CAMHS) and improve placement stability for children residing within the social care system. They funded the development of an Advanced Community Mental Health Nurse Specialist for Looked after Children. The creation of this initial nurse post in the CAMHS service has led to the development of a dedicated mental health team. An understanding of the local demographics of this Local Authority is needed prior to describing the service in order to provide a contextual backdrop to this project.

1.7.1 DEMOGRAPHICS OF A LOCAL AUTHORITY IN THE SOUTH OF ENGLAND

The population of the Local Authority in the south of England is 197,700 of which 13% are from BME communities (PCC, 2009). This includes 48,000 children and young people (0-18), 8,500 of which are living in low income households. The Index of Multiple Deprivation (IMD) framework identifies four wards which are amongst the 20% most deprived in the country. GCSE attainment is low, obesity high in reception year children, physical activities are minimal with poor dental health and high numbers of teenage pregnancies according to a health profile published (DH, 2009a). There are higher numbers of young people not living with their family and in income deprived families (DAAT, 2009). Alcohol related crimes and sexual offences are all significantly worse than is average for England. The mental health needs of the 24,818 school aged children who reside in this Local Authority include 1315 children (5.3%) who have conduct disorder, 1,067 children (4.3%) who have emotional disorders, 347 children (1.4%) who have symptoms of hyperactivity (ONS, 2007).
1.7.2 CHILDREN IN CARE IN A LOCAL AUTHORITY IN THE SOUTH OF ENGLAND

In July 2010, there was a sharp rise in the number of children and young people in local care from just fewer than 300 to 346. This accounts for 3% of the local population of children and young people. Gender, ethnicity and age profiles suggest, that there are slightly more males than females, that there has been a recent increase in the numbers of unaccompanied asylum seekers and that there has been an increase within the under five and five to nine age groups. Residential provision provides accommodation for 7% of children in care with the majority residing in foster placements that include family and friends. There is a shortage of foster care placements with approximately 140-150 foster carers employed by the local authority. The use of the independent fostering agencies has increased from 43 in 2008 to 84 in 2010. The use of out of area foster care is higher than the national average. The Local Authority’s expenditure on children in care in 2009/2010 is £10.8 million, a rise of £2 million from the previous year (Kitchman, 2010). This has led to a current review of the placement strategy locally which aims to strengthen prevention and early intervention for children on the edge of care, to invest in the growth of a pool of Local Authority foster carers, to reduce expenditure on Independent Fostering and reconfigure residential provision by closing one of the four units by April 2011 (PCC, 2010). Within the UK, the Association of Directors of Children’s Services has reported that this increase in numbers of children in care is reflected within 92 of the 105 Local Authorities nationally (Kitchman, 2010).

The majority of LAC locally came into care due to abuse and neglect. There has been a steady increase in placement stability reflected in the Annual Performance Assessment for Local Authorities which measures progress against national indicators, from 65.3% in 2009, to a 2010 figure of 73.4% remaining in a placement continuously for 2.5 years (DfE, 2010). This compares with the national figure of 68% in 2010. Stability of placement is measured in terms of how many children have three or more placements in one year. This Local Authority had 6.4% of their children in care moving more than three times in one year in 2010 compared with 8.5% in 2009. This compares nationally with 10.9% of children in care (DfE,
This collation and publication of national and local statistics relating to looked after children has been useful in identifying year upon year improvements (McAuley & Davis, 2009). This increase may be to do with a variety of initiatives, resources and practices and it is not possible to be more specific as to the actual benefits of the group training.

1.7.3 ROLE OF A CHILD AND ADOLESCENT MENTAL HEALTH SERVICE FOR LOOKED AFTER CHILDREN (CAMHS/LAC) IN THE SOUTH OF ENGLAND

The role of the local dedicated CAMHS/LAC team, involves working with foster carers, residential workers, social workers, family placement workers and senior managers to support the emotional health needs for this population of children. As in other parts of the UK, the CAMHS/LAC team began to explore the value of group training as a way of utilising scarce resources to reach as many professionals as possible. Four CAMHS/LAC specialists currently work within the Child and Adolescent Mental Health Service (CAMHS) to address the complex emotional and behavioural needs of this group of youngsters and to forge strong networks with professionals in education, social work and youth offending teams as in other parts of the country (McAuley & Young, 2006; McAuley & Davis, 2009).

The CAMHS/LAC team currently assess and deliver treatment to approximately 30% of the all the children looked after within the Local Authority in the South of England. These children often present with a combination of extreme behaviours which put subsequent placements at risk. Research suggests that without additional training the usual parenting strategies seem to have little impact upon their behaviour (Macdonald & Turner, 2005). Reducing or minimising the number of foster placement breakdowns remains an important objective for both the Local Authority and CAMHS/LAC and therefore the ability of foster carers to work consistently to manage behaviour and provide consistent care for children is a priority.
In 2001-2004, two nurse specialists in the CAMHS/LAC identified that there were many placements at risk of breakdown. During a consultation process with foster carers and residential staff, many of the foster carers asked for more information and support to improve their understanding, and therefore their care of children who presented with severe emotional and behavioural difficulties. This consultation process led to the development and provision of training to foster carers, as well as residential staff, social workers and senior managers and a review of the Safe Care Policy in 2005. This new policy now underpins the practice of the foster carers and residential staff. The previous guidelines were viewed as undermining the foster carers’ ability to develop a secure attachment with the child or young person: in contrast the current policy now incorporates a practical application of the principles of attachment theory (Bowlby, 1988).

1.7.4 CAMHS/LAC FOSTER CARER TRAINING

Between 2004 and 2007 as a local attempt to address the gap in current mental health training provision for foster carers, attachment training has been delivered to the professional network surrounding children residing within the care system. The training comprised of a three hour attachment training programme offered once a week over a period of six-weeks or a consecutive two-day seven hour attachment training programme. A total of 146 social care professionals attended the programme over a three year period of which 95 were foster carers. The content of the training was developed by two nurse specialists who combined aspects of social learning theory, attachment theory and a parenting approach which included the principles of Playfulness, Acceptance, Curiosity and Empathy (PACE) (Hughes, 1997). The content of the two day training programme can be found in Appendix 3.

The two day training course entitled ‘Helping Children to Form Good Attachments’ was developed, designed, provided and facilitated by the researcher of this study and a mental health nurse practitioner. The training is accessed through a foster care training calendar provided by the City Council. The training aims to increase foster carers’ knowledge base regarding the mental health needs of children, who are looked after within local authority care, provide opportunities for mental health
supervision, consultation and support the process of networking. This is crucial according to Descombe (1998) since the overall objective of foster care training is to support the quality of care that children and young people receive from foster carers, residential staff and professionals.

The attachment training workshops currently provide 19 competences to post approval training and so have become fundamental to the ongoing development of foster carers. This multi-agency training was driven by the Every Child Matters Agenda (DfES, 2003), to improve accountability and integration across the services. This Green Paper consulted on measures to tackle recruitment and retention in foster care to ensure the foster carers have the support they need to care for vulnerable children. Again this training contributes to a calendar of training which targets the mental health needs of this group.

To date, evaluation of the training offered has been conducted using a satisfaction questionnaire. A summary of the satisfaction questionnaires completed immediately after the groups revealed positive responses from a mixture of professional groups and can be found in Appendix 4. Foster carers completed satisfaction feedback questionnaires at the end of each training group. Over a three year period, a summative evaluation of this data provided feedback regarding the satisfaction of participants in relation to the content, organisation and delivery of the training. A summative evaluation can be defined as a retrospective procedure used to evaluate a training program once it has been completed. This led to changes in the format of the training. With a 94% response rate for completing the satisfaction questionnaire on the two day training a high percentage found: the training helpful (95%), gave greater understanding of children they cared for (98%) and was relevant to their role as foster carers (92%). The feedback was limited however in terms of presenting simple levels of satisfaction from attending the programme. The CAMHS/LAC were surprised by the overwhelmingly positive responses and wondered about the perceived usefulness of the training in terms of the effects upon foster carers. This feedback was limited however to presenting a simple summative audit of satisfaction gained at the end of the training.
In 2006, the CAMHS Strategic group which is made up of key senior managers from health, social services, education and voluntary services identified that:

“…. There is a paucity of British research to demonstrate improved outcomes for this vulnerable group and their foster carers.” (CAMHS Strategic Business Plan 06/07, 2006)

As part of the Business Plan (2006/2007) they highlighted an area of service improvement for the CAMHS/LAC. They proposed the need for a more in-depth evaluation of the current rolling programme of attachment training workshops offered to residential carers, foster carers and the wider network. This would address the overall objective of demonstrating service user involvement in the evaluation of current services and lead the way to shape and develop the service in the future. This research was seen as crucial in order to develop future services to meet the mental health needs of this group of children.

1.8 CONCLUSION

In conclusion, a review of the current literature has revealed there is widespread national and international philosophical support for the training of foster carers regarding the mental health needs of children in care. However, there is little empirical support for the use of even the most common programmes, which are included within this literature review (Dorsey et al, 2008). Recommendations from recent research have focused on the need for further exploration of the foster carer experience of the training programmes in order to identify the contributory factors that ensure both process and summative feedback are perceived as successful and whether any positive changes are retained over time (Laybourne et al, 2008). In order to achieve this outcome a mixed methods approach, combining both qualitative and quantitative methodology may be useful since existing quantitative measures on small samples fail to provide evidence of change in terms of a child’s behaviour. In addition given the nature of the psychiatric difficulties, more long term research needs to take place together with the use of more sensitive tools (Turner et al, 2007). Qualitative research, on the other hand, may provide an opportunity to consider how foster carers learn. An exploration of feedback
regarding the benefits of listening to others and building on existing skills may be a way of contributing further knowledge of the training needs of this group. The evaluation of satisfaction questionnaires between 2004 and 2007 highlighted that foster carers were building upon existing understanding of their experiences and with the aid of training were making sense of what they know. For this reason this research is considered in light of theoretical perspectives of learning such as the principles of Gestalt psychology of learning which identifies that knowledge is constructed from experience and that learning is a personal interpretation of the world (Burns, 2002). Learning is an active process in which meaning is developed on the basis of past and present experience. This humanist approach considers learning as a natural process as people are curious. Sinclair et al (2005) identified that there has been little exploration of the features of training programmes that are helpful. The need then for further research is justified and a more in-depth qualitative exploration of the experience of mental health training for foster carers may contribute to existing knowledge.