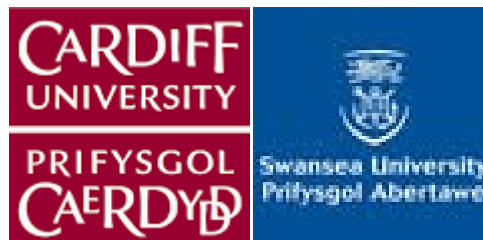




Children in Wales Plant yng Nghymru

In partnership with



FINAL REPORT

Contract number BIG001-0464

**Scoping Study: Transforming the Outcomes for Looked after
Children in Wales**

November 2013

CONTENTS

Page

1. Executive Summary	4
2. Background and Scope	8
3. Methodology	9
4. <u>Phase 1</u>	
Evidence Gathering Review	11
Stakeholder Engagement	20
5. <u>Phase 2</u>	
Evidence review of effective interventions to enhance well-being & outcomes for looked after children in Wales.	25
Young People's Engagement	46
Stakeholder Engagement	49
6. <u>Phase 3</u>	
Model 1	53
Model 2	60
Final Note	65
7. Appendices	67

FINAL REPORT

This report provides an overview of the activities undertaken by the project team in meeting the aims and requirements of the contract.

The period for this Final Report is **28/09/2013 – 22/11/2013**

This Final Report is for the Big Lottery Fund

This Final Report is supported and informed by the Children in Wales tender document submitted in response to the Big Lottery Fund, in addition to notes from the Inception Meeting between all partners

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Executive summary

1. Our task through the scoping study was to set out to gather robust evidence and draw on existing interventions and programmes from across the UK and beyond in the quest to identify effective ways of improving the life chances of looked after children and young people in Wales. The outcome from this work was to present two potential models for the Big Lottery Fund's consideration for long term pilot investment.
2. Activities were undertaken in just over eight weeks and were divided into a number of interrelated stages. Phase One of the study focused on evidence gathering as we undertook a 'rapid review' of the existing literature. The stages of the review and sources of evidence are set out in more detail in the report and firstly responded to the initial question which sought to identify the current state of knowledge around looked after children's needs. Our review revealed that looked after children have a wide variety of needs, are a heterogeneous group with diverse experiences, recognised strengths as well as deficits. Needs are related and interconnected, the most common of which can be broadly categorised into areas of health, emotional and behavioural issues, education and neurobiological needs. Our initial review concluded that interventions designed to boost placement stability through developing positive relationships and helping carers and looked after children manage behavioural and emotional difficulties could be priorities for investment.
3. We established a professional cross-sector stakeholder group to act as an expert advisory body for the project to discuss and consolidate thinking, support the evidence gathering stage and deliberate short-listed interventions once identified. This engagement was complemented by interaction with UK and international academic researchers and organisations with direct engagement with looked after children. We received a clear steer from our advisory group to identify and prioritise programmes which had the potential to make a positive difference to the greatest number of looked after children in Wales. Strengthening relationships, security and attachment between carers and children also emerged as clear priorities.
4. Phase Two of the project involved identifying a range of promising or robust interventions with the strongest evidence base that met the identified interrelated needs and had the potential to be applied in the Welsh context. The review was undertaken through a four stage approach detailed in the report which initially

yielded sixty papers put forward for more detailed analysis, further refined to thirty two, then eighteen. A total of six interventions were shortlisted.

5. We presented the six interventions to a group of looked after children in a facilitated workshop convened to capture their priorities and to consider each of the programmes in turn. The top priorities identified by the young people included positive relationships, stability, acceptance and being supported. Overall, the group recognised the strengths in each of the interventions and called for an element of direct work with children to be considered, and for the final selected model to be applicable for children and carers in all care settings. Their views were taken forward and fed back to the professional's expert group to aid their discussions.
6. The professional advisory group met again and deliberated each of the shortlisted interventions and two were at this stage eliminated. There was agreement amongst the group that whichever of the four remaining programmes were put forward for consideration for future funding, that they could support that decision. The four programmes were 'KEEP' (keeping foster and kinship parents trained and supported); 'Fostering Changes' (revised); 'Head, Heart, Hands' and the 'Fostering Healthy Futures Programme'.
7. We reflected further on each of the models, obtained additional information where this was possible, considered again the evidence base of each programme and each programmes capacity to deliver the priorities identified by the professional advisors and young people. We were also keen to consider the opportunities for utilising the strengths presented by each of the different interventions and how they could interact within a combined model composed of more than one programme. However we were mindful of the importance of ensuring that we retained the fidelity of the evaluated interventions and that we did not propose spreading future resources too thinly and potentially compromising outcomes.
8. We selected two evidenced based models to inform the Big Lottery Fund's pilot project.

The first proposed Model encompasses the following elements

- Fostering Changes Programme +
- Follow-up Support Group for Carers +
- Children/Young People's Group (social and skills base component) +
- Feasibility Study (mentoring component)

Model 1 proposes that the Fostering Changes Programme is rolled out on a phased basis across Wales for foster, residential and kinship carers. A second element is a follow up support and reinforcement group for carers trained through the Fostering Changes programme. A complementary group for looked after children could also be developed and piloted in a small number of local authorities in addition to a short feasibility study which would explore the potential for developing a mentoring programme for looked after children comparable to that provided by the Fostering Healthy Futures programme in Colorado. A rigorous evaluation of all aspects of the programme would be included.

The second proposed Model encompasses the following elements

- Fostering Changes Programme +
- Follow-up Support Group for Carers +
- Fostering Healthy Futures (feasibility study)+
- Piloting of the Fostering Healthy Futures or an adaption of this programme (determined by the recommendations of the feasibility study)

Model 2 also proposes that the Fostering Changes Programme is rolled out on a phased basis across Wales for foster, residential and kinship carers, and also includes a follow up support and reinforcement group for carers trained through the programme. We also propose that a feasibility study is carried out in Year 1 to explore in greater detail the process for implementing or adapting the Fostering Healthy Futures programme for the Wales context. The Fostering Healthy Futures programme could then be piloted in a small number of local authority areas. A rigorous evaluation of all aspects of the programme would be included.

9. We are both delighted and excited to present to the Committee the final two models which are outlined in more detail in the report. The journey may have been short and not without some lengthy and challenging deliberations, but we believe that the models selected will have the potential to improve the well being outcomes for looked after children in Wales.

Brief overview of each of the main programmes

The **Fostering Changes Programme** is a flagship course developed for foster carers that provides them with the practical skills to manage placements. The programme was developed by the Adoption and Fostering National Team at the Maudsley Hospital, South London, in conjunction with King's College London. The revised manualised programme has been updated to take into account the advanced understanding of what the impacts of neglect and abuse are on children, with a greater emphasis on how to help carers implement techniques to enable children to identify, acknowledge, express and manage their feelings more effectively. The revised programme includes more about the importance of developing secure and positive attachments and ways in which carers can help improve the educational outcomes of children and get involved in their foster children's school life. The programme has an emphasis on effective communication and problem solving skills and aims to provide carers with both knowledge and practical skills to positively impact upon behaviour and security. The Programme is behaviourally based and derives from research into parenting skills, attachment, educational attainment and the academic progression of looked after children who are in foster care. The evidence based programme is underpinned by social learning theory, attachment theory and cognitive-behavioural therapy.

The **Fostering Healthy Futures Programme** was developed in Colorado, USA and targets risk and protective factors that have been identified as strong predictors of risk behaviours and associated outcomes. The Programme has been developed to work directly with looked after children and has two central components. The first element is a weekly skills based group work which follows a detailed manualised programme that combines cognitive-behavioural strategies with activities designed to help children process experiences related to placement in out-of-home care. The interventions focus on emotion recognition, problem solving, anger management, cultural identity, change and loss, and peer pressure. Multicultural stories and activities are integrated throughout. The second element is that of mentoring, as looked after children are paired with graduate student mentors and receive 30 weeks of one-to-one mentoring. The role of the mentor is to work to create relationships with children that serve as positive examples for future relationships; help children put into practice the skills learned in the skills group; engage children in educational, social, cultural, and recreational activities, and to promote positive future outlooks and resilience.

Background and scope

Children in Wales, in partnership with Cardiff University and Swansea University were appointed by the Big Lottery Fund to research and develop two potential models for a long term pilot investment that will transform the life chances of Looked after Children in Wales.

The extent of the project is to undertake a scoping study to gather robust evidence and identify effective ways of improving the life chances of looked after children and young people in Wales. The study could lead to a further £5 million investment aimed at dramatically improving the outcomes of looked after children in Wales.

Supported and informed by an Expert Advisory Group, the project will draw on existing interventions and programmes from across the UK and beyond. By December 2013, the project will have identified two options for a potential pilot project worth up to £5 million for up to 10 years.

The legacy from this study has the potential to have a lasting impact on the lives of children and young people in care in Wales and the services they receive. The interventions supported by the Big Lottery Fund will be additional to the services provided as part of existing statutory duties in Wales.

Methodology

Review Type

The evidence gathering phase review has followed a 'rapid review' process (*Shaw and Holland, forthcoming*). A rapid review streamlines processes and takes less time to complete than a full systematic review. A rapid review can share many of the procedures of a full systematic review, such as setting inclusion, exclusion and quality criteria and a clear and traceable methodology for database searching and analysis of findings (*Collins and Fauser, 2004*). Unlike many systematic reviews, this review has included evidence drawn from non-experimental research studies and non-peer reviewed publications. This broader interpretation of research evidence is commonplace in social care and other complex interventions (*SCIE, 2009, Gough et al., 2012*).

Review research questions

The review has aimed to respond to the following questions. These questions were outlined in the submitted tender and were subject to consultation with the dedicated Expert Advisory Group (*see section on Engagement*)

- a) What is the current state of knowledge of looked after children's **needs**? What are the most common additional needs, and which have the most impact on well-being and outcomes?
- b) What is the range of **effective** interventions for looked after children that meet needs and enhance wellbeing and outcomes? How many of these are targeted at specific areas, such as education or health, and which are more holistic?
- c) What interventions have the strongest evidence base?
- d) Which of the interventions with the strongest evidence base may be applicable to the Welsh context?¹

¹ e.g. some interventions with strong research evidence have only been tested in specific contexts such as native American populations or in juvenile detention centres in north America. The Welsh context also includes a social policy agenda that promotes children's rights under the framework of the UNCRC and avoids a deficit narrative of looked after children's needs.

- e) Do interventions which are said to be effective and have a strong evidence base also have common elements? If so, what are these elements?

Stages of review

The stages of review were agreed as follows

- a) Refinement of evidence review research questions with stakeholders
- b) Development of search terms and identification of databases and other potential sources (including expert recommendations)
- c) Identify inclusion and exclusion criteria (relevance to research questions and research type and quality)
- d) Conduct searches and exclude studies that do not meet inclusion criteria
- e) Read abstracts / research summaries and develop shortlist of most promising studies
- f) Shortlisted studies read in full and assessed for (i) practice relevance (ii) academic quality.
- g) Analysis of findings
- h) Synthesise and report on findings

Phase 1

1.1 Evidence Gathering Review

Cardiff University has undertaken a rapid evidence review, in partnership with Swansea University. This process has informed and complimented the work of Children in Wales and formed the basis of discussions and engagement with members of a dedicated Expert Advisory Group.

The post doctoral research team located in both Cardiff and Swansea Universities comprises of the following

Dr Sally Holland (Cardiff University)

Dr Paul Rees (Swansea University)

Dr Nina Maxwell (Freelance Researcher)

Dr Nicholas Forbes (Honorary Research Associate, Swansea University)

Ms Louise Roberts (Final Year doctoral candidate, Cardiff University).

Sources of evidence: inclusion and exclusion criteria

The project team utilised Cardiff University's extensive databases to conduct a thorough search for evidence. Social sciences, social work, psychology, education and medical databases were searched. These included Social Care Online, Web of Science, PsycInfo, Medline, ASSIA, Cochrane Library, Campbell Collaboration, National Research Register.

These searches were supplemented by internet searching and hand searching of journals with additional suggestions from the Expert Advisory Group, other stakeholder organisations and from fellow academics. Grey literature (i.e. not published in peer reviewed academic publications), which may include important evaluations by government or third sector agencies were included if they met the inclusion criteria. Systematic search terms were used, including Boolean parameters (e.g. AND/OR, NOT).

Search terms included: looked after, in care, foster care, residential care, kinship care, care leaver, health, mental health, education, resilience, wellbeing, skills, intervention, support, outcomes, success, progression, achievement.

Inclusion and exclusion criteria was set and included DATE (e.g. published since 1989 – date of the Children Act), QUALITY (reports empirical findings based on one or more clear research method), RELEVANCE (must concern looked after or separated children and describe an intervention), LOCATION (UK and international studies published in English).

Phase one of the Evidence Gathering stage focused on the following research question

- a) What is the current state of knowledge of looked after children's needs? (aged 0-18) What are the most common additional needs, and which have the most impact on well-being and outcomes?

Scope of the review

Searches for recognition of Looked after Children needs were primarily concentrated on systematic and non-systematic review literature. The papers analysed referenced studies which incorporated both quantitative and qualitative research designs and reflected a range of ages and placements. Studies referenced within the reviews were conducted predominantly in the UK but also internationally. Throughout the review, the appropriateness of the literature has been considered in relation to the Welsh context and additional considerations highlighted where necessary.

Needs and well-being

A wide variety of needs associated with Looked after Children are recognised within the literature. However before these are summarised, it is important to acknowledge the following caveats:

- Looked after Children are a heterogeneous group with diverse experiences and needs.
- The looked after population is a dynamic group. In March 2013 there were 5,743 looked after children in Wales. Of these, 1,980 had started to be looked after in the last 12 months and a similar number ceased to be looked after (1,938).
- Looked after Children are recognised as having largely the same needs as all children. However the prevalence and / or severity of the needs is likely to be greater for the looked after population.

- Looked after Children's needs may have developed prior to their entry into the care system but may also be connected to, or exacerbated by, their looked after experience.
- There is evidence that there are sizeable numbers of Looked after Children who are performing well in key domains such as mental health, emotional literacy and education.

The most common needs of Looked after Children can broadly be categorised into areas including health, emotional and behavioural issues, education and neurobiological needs. While categorisation is helpful in terms of explaining and summarising range and scope, it is important to note that Looked after Children's needs are not separate and distinct from each other, but rather related and interconnected. For example, the emotional and behavioural needs of Looked after Children can impact on educational needs, relational needs can impact on mental health needs, mental health needs can impact on physical health needs and so on. These different areas of need may be seen as together constituting aspects of well-being.

As Samuels (2011:19), discussing Looked after Children in the United States comments:

The domains comprising well-being are self-reinforcing, meaning that as well-being improves, permanency and safety become more likely. So too do physical and mental health, educational success, and positive lifelong connections.

Statham and Chase (2010:6) note that there are many different approaches to understanding children's well-being but:

Despite the differences in emphasis and approach, there is some degree of consensus emerging from these different studies/indices. All measure multiple dimensions of children's lives, and most include domains which relate to their physical, psychological and social wellbeing in one form or another. They also incorporate, to varying degrees, measures of socio-economic and environmental wellbeing such as educational attainment, economic and material resources, housing and the local environment, quality of school life and access to leisure activities.

Although, as we have noted so far, needs can be seen to be inter-related and impacting overall on well-being, the next section examines some of the most common needs individually before commenting on positive exceptions and the individual nature of children's needs and strengths.

Physical health needs

At entry into care, Looked after Children have greater health needs than non Looked after Children (Meltzer et al. 2004, DCSF 2009). However the long-term outcomes remain poor for Looked after Children and have been described as evidence of health inequality (DCSF 2009). For example, whilst looked after, Looked after Children's health needs have been adversely affected by lost and incomplete records as well as disrupted or changeable contacts with health services (NICE guidance 2010). When compared to peers, Looked after Children have higher levels of poor oral care, dental neglect and disease, are less likely to have visited a dentist regularly and more likely to need treatment when they do (Scott and Hill, 2006, Sarri et al., 2012). Looked after Children are less likely to be fully immunised than their non-looked after peers (NICE, 2009).

The health of Looked after Children in foster care has been perceived more positively by carers than those in residential care (Meltzer *et al.* 2004). Research has also suggested that Looked after Children are disproportionately involved in behaviours that could negatively impact on their health. This includes smoking and drug and alcohol misuse. Looked after Children also have higher rates of teenage pregnancy and obesity than the general population (DCSF 2009).

In Wales, two-thirds of looked after children were reported by one study to have at least one physical health complaint, the most common of which were eye and/or sight problems (18%), asthma (14%), speech or language problems (13%), bed wetting (12%), difficulty with co-ordination (12%) and eczema (12%) (Meltzer *et al.* 2004). Levels of asthma and eczema were not higher than the general population. As with education (see below), physical health appears to improve the longer children are looked after (Meltzer et al., 2004).

Mental health, emotional and behavioural needs

The mental health of Looked after Children has been highlighted as poorer than that of the general population (Sempik 2010). Mental health needs can be influenced by a number of factors which include experiences prior to becoming looked after, age at entry to care and type of placement. For example, the mental health of Looked after Children in residential care has been observed as poorer than that of Looked after Children in foster care (Sempik 2010). Looked after Children and care leavers are

thought to be at much higher risk of suicide and self-harm than the general population (Meltzer, 2004, Furnivall, 2013). One Canadian study found that while suicide and attempted suicide were more prevalent among looked after children, suicide attempts were higher *before* entry to care than after (Vinnerljung, 2012).

The prevalence of Looked after Children with recognisable mental health disorders has been estimated at 45% and 49% (Sempik 2010, Meltzer *et al.* 2004), rising to 72% amongst children in residential care. This compares to 10% of the general population (Mooney *et al.* 2009). Sempik *et al.* (2012) using a different methodology (children looked after for at least 12 months) further estimated that between 70-80% have recognisable mental health problems or conduct disorders and 20% of Looked after Children aged five and under display mental health, emotional or behavioural difficulties. Based on the Wales numbers of Looked after Children for 2012 / 2013 (5743), this would equate to between 2584 and 2814 children in Wales with a diagnosable disorder and between 4020 and 4594 children with recognisable difficulties (Welsh Government 2013). However, these figures must be treated with caution due to sampling weaknesses in these studies.

Looked after Children's emotional needs have been related to both their experiences prior to, during and following their entry into care. Experiences of trauma, dysfunction, abuse and neglect as well as feelings of loss, anger and /or a lack of control can manifest in emotional and behavioural difficulties. For example, in Wales approximately 60% of the children and young people that became looked after in the last three years, did so as a result of abuse or neglect (Welsh Government 2013). It has been asserted that 80% of children who experience abusive or neglectful parenting will develop disorganised attachment styles, which involve emotional and behavioural difficulties (Ward and Brown 2012). In the longer term, children who do not develop secure attachments perform less well on a range of measures including social and emotional development (NICE 2013).

There is a perceived shortage of community child and adolescent mental health services for Looked after Children and this may discourage carers and social workers from making referrals. A study by Bonfield *et al.* (2010) in the east of England found that out of a sample of 108 children in foster care, 49% of children were found to have an apparent mental health problem and were not receiving a service from CAMHS, despite relatively high mental health literacy amongst carers.

Neurobiological needs

Neuroscientists have been exploring the relationship between early childhood deprivation and brain development for a considerable period of time. It is thought that the acquisition of an in-depth understanding of this association may be of particular help in understanding of the needs of Looked after Children. For example Leve et al. (2012) highlight pre-natal exposure to drugs and alcohol as an increased vulnerability affecting large numbers of children in foster care. Rutter (2005) has pointed out, however, that psychosocial deprivation often co-occurs with malnutrition and this could reasonably account for neurobiological abnormalities in many cases. Therefore, it is very difficult to determine whether malnutrition or psychosocial deprivation has given rise to the presenting difficulties and needs. Neuroscientists who are familiar with the evidence base are generally circumspect in drawing conclusions in individual cases or even more generally. Rutter, 2005 (p310), for example, comments “..the notion that particularly high-quality experiences in early life will make for ‘better’ brain development does not have empirical support.” Recent developments in already sophisticated neuroimaging techniques such as computed tomography (CT), magnetic resonance imaging (MRI) and positron emission tomography (PET) as well as metabolic medicine has certainly added to a sense of renewed optimism; that the neuropsychological processes that result from neglect will be visible in some way. Yet Woolgar (2013) having reviewed relevant literature on the practical implications of neurobiological research notes that the research is still in its infancy. He also notes there does not appear to be evidence to suggest that the needs of Looked after Children warrant unusual treatments. It is clear that, as in the general population, some Looked after Children may present with needs that stem from structural brain abnormalities, atypical brain functioning, genetic irregularities or other neurological complications, but there is a lack of evidence to suggest that these needs are any different to those found in other children.

Educational needs

Looked after Children have been shown as more likely to be waiting for the allocation of a school place and more likely to be excluded than children not looked after (Axford 2008). Previous interventions have aimed to improve attendance, numeracy, literacy and attainment while decreasing exclusion (Liabo, Gray and Mulcahy 2013). In a survey of Looked after Children in Wales, two-thirds were reported as having officially recognised special educational needs and just under two-thirds described as having some difficulty with reading, mathematics and spelling (Meltzer *et al.* 2004).

Educational outcomes for Looked after Children in Wales have improved over the last decade, but still remain much lower than the general population. For example, the rate of care leavers who had 5 or more GCSEs (any subjects) at grades A*-C fell slightly to 9%. In the general population 51% of 16 year olds achieved at least five Grade A*-C GCSEs (including English/Welsh and maths). Much of the attainment gap is thought to be related to pre-care experiences, with children on average achieving better the longer they are in care (Berridge, 2012).

In North America and the UK, placement stability and the provision of specialist and general support have been associated with educational success (Pecora 2012, Welbourne and Leeson 2012). Looked after Children and carers have also identified a range of measures that would help meet the additional needs. These include the needs for financial and practical assistance, emotional support and encouragement, as well as specialist educational interventions (NICE guidance 2010, Dickson, Sutcliffe and Gough 2009).

Relational needs

Looked after Children have repeatedly raised the importance of being loved within research and the provision of a loving and nurturing environment has been associated with self-esteem and well-being (Dickson, Sutcliffe and Gough 2009). The relationship between a Looked after Child and their carer has particular relevance to considerations of well-being as it has been asserted that “Children’s happiness and well-being goes up or down with their relationship with the people currently looking after them” (Sinclair 2008:5).

Looked after Children have highlighted continuity, consistency, being listened to and ‘feeling someone was there for them’ as important relationship characteristics (Dickson, Sutcliffe and Gough 2009). The need to belong has also been identified and this can refer to achieving a sense of belonging within a foster family, managing belonging to two families and / or maintaining belonging with their cultural, ethnic background (Dickson, Sutcliffe and Gough 2009). Placement stability has been positively associated with a range of outcomes, including physical and mental health, emotional and behavioural issues (Jones et al., 2011; Rock *et al.* 2013). However the achievement of permanency has been heavily focussed on legal orders, which may be unsuitable for many Looked after Children (Boddy 2013).

In addition to relational needs with carers, birth family and professionals, Looked after Children's wider social needs are also recognised within the literature. This includes acknowledgement that Looked after Children's ability to make and/ or sustain friendships may be impeded (NICE guidance 2010). When appropriately supported, the participation of Looked after Children in community contexts has been linked to the achievement of meaningful and sustainable relationships and has impacted positively upon Looked after Children's sense of belonging, identity and connectedness (Hicks *et al.* 2012).

Placement needs

Looked after Children have differential needs in relation to their placement. Within the literature the type of placement, quality of care provided and the stability of the placement have been highlighted. For example, it has been noted that children in residential care may have additional needs related to sexual harassment, bullying, inadequate supervision, isolation and stigma (Axford 2008). Kinship care is reported as being positively associated with a number of outcomes related to stability and maintaining continuity of schools, neighbourhoods and contact with birth families (Jones *et al.*, 2011). However, caution needs to be applied to comparing outcomes for residential, foster and kinship care as the needs and circumstances of children living in different types of placement are known to have different characteristics and baseline risks (Jones *et al.*, 2011). An important placement, secure care, has little evidence on outcomes, probably due to the very small number of children living in this setting (Jones *et al.* 2011).

Individual / Personal needs

The looked after status of a Looked after Children constitutes just one aspect of their identity (Boddy 2013). Consequently, Looked after Children may have a range of individual needs that are not necessarily connected to their care experience. These may include needs related to age and stage of development, heritage, disability, sexuality, culture, religion and language (NICE guidance 2010). There is little robust evidence on outcomes for minority groups with the Looked after Children population, including BME young people, unaccompanied asylum seeking children, and disabled young people (Jones *et al.*, 2013).

Positive exceptions and individual needs

Despite the notably high level of need among the Looked after Children population there is evidence that large numbers do perform well in many areas of their lives. A large multidimensional and multiple-rater study with a sample size of 193 undertaken within Wales ($n=193$), for example, found between 34% and 76% of Looked after Children to be performing within the average to above average range on measures of mental health, emotional literacy, cognitive functioning, literacy and literacy achievement (Rees, 2013). On a standardised measure of reading, for example, the scores of 44% fell within the average to above average range. Similarly the emotional literacy of 63% was rated by teachers as within the average to above average range. As many as 16% of the Looked after Children in this study met stringent multi-dimensional 'success' criteria. Positive performance in key domains does not imply, of course, that the Looked after Children do not have needs, but that caution does need to be taken in identifying the profile and precise nature of an individual's needs. The findings also suggest that in addition to needs most, and probably all, Looked after Children have areas of personal strength.

Conclusion

We have emphasised in this review the inter-relatedness of Looked after Children's needs and the importance of recognising strengths and resilience as well as deficits. It is clear that some needs and factors have greater impacts on outcomes than others. Jones et al. (2011) in a review of 92 studies mapping associations between different factors associated with Looked after Children outcomes noted that placement stability, age at first placement and behavioural problems appear to be the key factors associated with outcomes. Leve et al. (2012) in a review paper reach similar conclusions, noting that placement disruptions are associated with many difficulties for children. In terms of the types of enhancing interventions that may be supported by the Big Lottery Fund it may therefore be suggested that interventions designed to boost placement stability through developing positive relationships and helping carers and children manage behavioural and emotional difficulties would be priorities for investment.

1.2 Stakeholder engagement

A key component of the project was for engagement to take place with a range of appropriate stakeholders. Children in Wales agreed to bring together key professionals to establish an Expert Advisory Panel, to discuss and consolidate thinking, and to support the evidence gathering stages and deliberate each of the short-listed models.

The process for establishing the Expert Advisory Group was as followed

➤ **Identifying stakeholders**

The identification and engagement of appropriate stakeholders built upon our knowledge and well established relationships with our member organisations and other key personnel with expertise in the area of Looked after Children.

➤ **Membership of the Expert Advisory Group**

Giving consideration of the need to ensure that the Expert Advisory Group was sufficient balanced and managed in terms of numbers, the following organisations were approached with a request to become members.

Fostering Network

Voices from Care Cymru

Prospect Care

Children in Wales

Cardiff & Vale Health Board / BAAF Medical Advisors Group

Welsh Local Government Association

Care Leavers Network

National Society for the Prevention of Cruelty to Children (NSPCC Cymru)

Big Lottery Fund

All-Wales Heads of Children's Services Group

All-Wales Looked after Children Nurses Group Cymru

Action for Children

Welsh Government (DHSS)

Tros Gynnal Plant

British Association of Adoption and Fostering (BAAF)

Cardiff University

Barnardo's Cymru

Public Health Wales – Safeguarding looked after children

National Youth Advocacy Service (NYAS Cymru)
Children's Commissioner for Wales
Association of Directors for Social Services Cymru (ADSS Cymru)
Swansea University

➤ **Invitation**

A briefing paper was produced and circulated which provided both a short introduction to the scoping study and a formal approach to become part of the Expert Advisory Group. This paper also included a request for some initial comments in relation to the draft research questions which were to define the scope of the evidence gathering phase of the project. Responses to both the invitations and to the questions were collated. Follow up correspondence (email and telephone) was required to ensure that all responses were received in a timely manner.

➤ **First Meeting**

The first meeting of the Expert Advisory Group took place on 18th October 2013 at Children in Wales. 14 organisations were in attendance and apologies were received from 5 representatives in advance.

The meeting provided for members of the Expert Advisory Group an opportunity to have a fuller understanding of the purpose and parameters of the scoping study and of their role and expectations in supporting and informing the work programme.

The project team delivered a presentation which supported a brief report which outlined the work plan and the evidence gathering activities to date.

Members gave a considered response to the work undertaken to date, further assisted in identifying and showcasing interventions and practice considered notable and worthy of further exploration, and began the process of aiding the project team in beginning to identify the priorities going forward.

The breadth and richness of the initial discussion amongst participants culminated in members giving focused consideration to the following points and issues. (*list not exhaustive*)

- The need to give consideration to both specific/narrow/targeted interventions and to more general interventions, models and approaches.
- Which intervention(s) will have the biggest impact and make a profound change.

- An appreciation of the diverse needs and backgrounds of the Looked after Children population and the interaction between those needs.
- The complex relationship between looked after children and the care system, including placement stability and support, movement in and out of care, placement breakdown etc.
- Pre-care experiences and in-care experiences – and the impact of this on the outcomes for looked after children.
- The commonalities between Looked after Children and children/young people from their peer group.
- Chronological age and developmental realities – need to give full consideration to this.
- There is a need to consider the priorities which looked after children identify and hear their voices. The message from many serious case reviews is that the child wasn't listened to.
- Consider how looked after children have, or have not, been involved in the development of interventions and models, and in what way.
- The 'golden thread' of relationships.
- Mentoring (peer and professional support) and positive relationships.
- Social pedagogy approaches – learn from pilot projects in the UK and the experiences from European countries e.g. Denmark.
- Variability of service provision in Wales e.g. mental health services.
- Foster Care, Kinship Care and residential care – the former is where the majority of looked after children are placed.
- Consider 'promising' approaches and interventions which may not be subject to robust evaluation techniques.
- Secure based model approaches, attachment theory.
- Consider children on the edge of the care system. Could this be an opportunity for us to focus on supporting children and families at risk of entering the care system?

Members were provided with clarity in terms of the ways in which they could directly engage with the scoping exercise between meetings and more specifically to help further identify and share models of good practice virtually. Members also welcomed the opportunity to meet for a further meeting to examine and discuss a number of potential models to put forward to the Big Lottery Fund for consideration.

Next Steps

The Project Team agreed to give consideration to the main discussion points, comments and suggestions outlined above and to take account of the main points as the work moves forward. The Project Team agreed.

- To convene a second meeting on the 8th November 2013 which would provide an opportunity to examine in more detail a number of potential models and interventions to put forward to the Big Lottery Fund for potential future funding (*the exact number of models was not known at this stage and would be informed by the quality appraisal stage*)
- To circulate the shortlisted models in advance of the above meeting
- To engage directly with a group of young people with experience of the care system. A provisional date of 6th November was agreed with the support of Children in Wales member organisation Voices from Care Cymru
- To collate any additional information received virtually from the Expert Advisory Group and/or other stakeholders engaged (*see below*)
- To begin and complete the quality appraisal and analysis stage (*see below*).

Wider Engagement

In addition to establishing the Expert Advisory Panel, Children in Wales and our partners have engaged with appropriate stakeholders outside of the panel and Wales. This has included.

- Cascading information about the scoping work amongst our networks and contacts, including those within academia;
- Ensuring that members of the Expert Advisory Panel have been asked to engage with other experts within their organisation and/or sector to help ensure maximum coverage
- Publicising the scoping work through our extensive contact database.

More specifically, this has included the following activities.

- A list of experienced 14 UK and international academic researchers has been written to, asking for recommendations of interventions that may be missed by the search. This is to supplement the policy and practice experience of the advisory group.

- Publicity for the project together with a request for stakeholders to help identify and share models of good practice virtually has been undertaken through a dedicated page on the Children in Wales website. This page, which includes the Big Lottery Fund's Press Release has been promoted through social media channels e.g. Twitter, and amongst internal staff members and externally through our strategic contacts e.g. the Children in Wales Policy Council
- Organisations throughout Europe as members of the Eurochild Thematic Working Group on Alternative Care have also been engaged in the scoping study through a dedicated mail-shot. This has been further supported by information on the project and a call for notable interventions cascaded across the entire Eurochild membership through the Eurochild weekly e-bulletin.
- Interest emanating from the Big Lottery Fund media publicity and press release was also received and shared with the project research team.

Phase Two

2.1 Evidence review of effective interventions to enhance well-being and outcomes for looked after children in Wales.

Phase Two focused on the following research questions

- b) What is the range of **effective** interventions for looked after children that meet needs and enhance wellbeing and outcomes? How many of these are targeted at specific areas, such as education or health, and which are more holistic?
- c) What interventions have the strongest evidence base?
- d) Which of the interventions with the strongest evidence base may be applicable to the Welsh context?
- e) Do interventions which are said to be effective and have a strong evidence base also have common elements? If so, what are these elements?

METHOD

The literature review was undertaken in four stages in order to identify as many potential interventions as possible, differentiate the most promising, identify those with the strongest evidence base, and assess each intervention in terms of quality and potential impact based upon independent ratings of two reviewers in order to produce a shortlist of interventions for recommendation to the Young People's Group and Expert Advisory Panel.

First, the search strategy involved the use of multiple key word searches using the three main domains of education (table 1), health (table 2), and mental health (table 3) across thirteen academic databases and seven relevant websites (Appendix 2).

In total, 1200 separate key word searches were performed. This included 260 key word searches for each of the three domains across the thirteen databases, and 140 key word searches for each domain across the seven websites. Judgements as to whether to retain a potential reference were made on title only, in order to ensure that all potential interventions were included. The search was supplemented by including interventions within systematic reviews, contacting experts in the field and

recommendations from the Expert Advisory Panel. This yielded a total of 60 papers retained for further examination.

Table 1: Search terms for 'Education'

GROUP	"Looked after children", "foster care", "kinship care", "residential care" (NOT older people OR elderly OR older adults OR adults), "out of home care"
AND	Education
AND	Intervention, support, child welfare, outcomes

Table 2: Search terms for 'Health'

GROUP	"Looked after children", "foster care", "kinship care", "residential care" (NOT older people OR elderly OR older adults OR adults), "out of home care"
AND	Health
AND	Intervention, support, child welfare, outcomes

Table 3: Search terms for 'Mental health'

GROUP	"Looked after children", "foster care", "kinship care", "residential care" (NOT older people OR elderly OR older adults OR adults), "out of home care"
AND	Education
AND	Intervention, support, child welfare, outcomes

The second stage of the search involved reviewing the abstract of each of the retained references (if available) to determine relevance to the aims of the literature review. For the purposes of this report, papers were included on promising or robust interventions with looked after children who were under 18 years of age and had the potential to be applied in the Welsh context. Papers were excluded if they were published before 2000, were not written in English, involved interventions which came under the auspices of statutory care or would only impact on a small number of this population. This first sift resulted in 32 papers (Appendix 3).

The third stage involved reading and evaluating each paper using a Quantitative or Qualitative Appraisal Checklist (NICE, 2012a; b) where each intervention's methodology was rated as strong, moderate or weak against 1 of 5 potential responses relating to the robustness of the evidence presented about each

intervention (see Appendix 4 for further details). This third stage resulted in 18 potential interventions identified.

For the final stage, each of the 18 papers were re-read and summarised with an overall rating assigned. At this stage, the reviewer was invited to consider the quality of the intervention in terms of its potential impact, ability to reach a wide audience of looked after children and applicability to Wales even in cases where the evidence base was not established or where results had been moderate. In order to check these ratings, each intervention was read and rated by a second reviewer. This process of inter-rater reliability ensures that raters agree on overall scores given. In cases where disagreement occurs, the raters detail how they have reached their decision and discuss the intervention with the aim of reaching agreement. If no agreement can be made, a third reviewer reads and rates the intervention in question. For this study, whilst reviewers disagreed on 4 of the 18 interventions (22%) agreement was reached following discussion. No intervention required a third review.

A total of 8 papers were retained at this stage relating to 6 interventions. Incredible Years (IY) appeared as three separate interventions as one had added a behavioural component and one had piloted its use with biological-foster parent dyads. However, all three were based upon the main IY intervention and as such, IY was retained as one intervention collating the results from each of the three papers. A total of 10 interventions were excluded.

For the 6 interventions identified as suitable for recommendation to the Advisory Panel (see Appendix 5 for rationale) each of the programme developers has been contacted via email (Appendix 9) and, in most cases, by follow-up telephone conversation. They have been informed about the purposes and rationale of the review and asked about whether the programme has been implemented in the UK, (or more specifically Wales for the UK-developed programmes), costs of the intervention, on-going or unpublished evaluations and their willingness to be involved in implementing and evaluating the programme in Wales.

Introduction to the shortlisted studies

Prior to outlining the shortlisted 6 interventions, it is important to note the following features of intervention evidence in the field of looked after children.

Firstly, there are some limitations on the scope of the published data. There is a tendency in academic publishing to publish successful results rather than the unsuccessful. Nonetheless we did find several examples of interventions that showed no significant positive effect compared to a comparison group. Of course we did not shortlist any of these. Some types of interventions are easier to measure, especially when they are group or individual programmes delivered by manual with high levels of fidelity. New programmes have yet to establish an evidence base and therefore are not shortlisted here (with the exception of *Head, Heart, Hands*, which we have shortlisted with caveats about the evidence base.) Some types of evidence are regarded more highly than others in intervention science, particularly results from randomized controlled trials that can help distinguish between changes that might have happened anyway and those that are the result of the intervention. Although we support the principle of this 'gold standard' of evidence, we note that this does not necessarily value the qualitative experiences of children and carers and may exclude measuring the impact on groups that may 'confound' the results, such as disabled children (Jones et al., 2011). Finally, much of the best evidence comes from the USA (Leve et al., 2012), which has a system that is comparable in some aspects (child protection orientation, for example) but is different in other notable ways such as the lack of a universal, free health service. We are pleased to include two interventions that have been tested by randomised control trial in the UK: *Incredible years* and *Fostering Changes*.

Secondly, it should be noted that interventions vary considerably in their scope and aims. Two major ways in which interventions may be self-limiting are in the age-groups and the areas of need they are aiming to assist. For some, they have been specifically designed for a particular age group but have more recently been extended to include older or younger children. With the exception of *Fostering Healthy Futures*, which currently is aimed at 9-11 year olds but is developing work with older children, we have short-listed interventions that would be helpful for children and young people form a wide age range. We have also selected programmes that are aimed at helping with a wide range of issues, bearing in mind the discussion in Part 1 about the inter-relatedness of various needs and sources of strength.

A third important point is that this review has been shaped by a number of important factors beyond objective, library-based literature reviewing. Young people, the advisory group, academic advisors, limitations imposed by the Big Lottery Fund's public purpose (i.e. to fund projects that are additional to statutory provision) and the review team's own knowledge of policies and practices for looked after children in Wales have all had an impact on the final shortlist.

Fourthly, it is interesting to note that there appear to be more evidence based interventions for carers rather than directly with children. This was also found by Jones et al (2011) in their systematic review conducted for NICE. Four of the following six interventions are for carers and (in one case) social workers. It is possible that some of the most promising ways in which we could directly work with looked after children are with programmes designed for *any* child facing extra challenges or with additional needs. The length and depth of our searching meant that we did not examine any interventions that were not specifically designed for looked after children or at least reported results for looked after children. Jones et al. (2011: 619) distinguish between these two as describing interventions with carers as aiming to enhance 'quality of care' and those with children as 'additional services' designed to enhance normal service provision.

Finally, it should be noted that the evidence base for interventions will be strengthened if evaluation of effectiveness is built in at planning stage. It is suggested that if any of these interventions are funded for Wales, then the implementation should be carried out using the methodology of a randomised controlled trial.

Shortlisted interventions

Six interventions were shortlisted in advance of the Young Person's group meeting and the Expert Advisory Group meeting. These were (in no particular order):

- 1. Incredible Years for foster carers**
- 2. KEEP:** Keeping foster and kinship parents trained and supported
- 3. Fostering Changes:** Revised programme
- 4. Head, Heart, Hands:** social pedagogy
- 5. Paired Reading Literacy Scheme**
- 6. Fostering Healthy Futures Programme**

The interventions are outlined according to the following format:

- 1. Name of intervention**
- 2. Description of intervention**
- 3. Assessment of evidence base**
- 4. Policy and practice implications for Wales²**
- 5. Costs**
- 6. Key sources of information.**

² This section will be revised following advice from the advisory group before the report is presented to big Lottery Fund Wales.

1. Incredible Years for foster carers

Description of intervention

The intervention is delivered in a group format over 12 weekly 2-hr sessions with up to 12 carers and 2 facilitators. The sessions involve facilitator led group discussions, videotape modelling and rehearsal of intervention strategies. The sessions emphasise the importance of play, use of incentives, ways to help children learn, effective praise and other ways to deal effectively with adverse behaviour.

The intervention is primarily designed for 2-8 year olds but the course trialled in Wales included carers of young people up to the age of 16. One study, conducted in New York, trained birth and foster carers together, where there was a plan for children to return home.

A recent adaptation in Wales is to provide the model on a one-to-one coaching basis with an option of also joining group sessions. These are useful for carers who are geographically isolated or who are experiencing specific problems.

Assessment of evidence base

This intervention has a very strong evidence base as a parenting programme. Professor Webster-Stratton of the University of Seattle developed, and has led on, the testing of the programme over several decades. It has been shown to be effective as a preventative programme and to treat conduct disorders. The programme is endorsed and promoted by the Welsh and English governments and is in use world-wide. It is one of very few parenting programmes that has been subject to randomised control trials in Wales and has been successfully trialled as a general parenting programme in Wales as well as with foster carers. It is one of only eleven "Blueprint" programmes identified by the Center for Violence Prevention at the University of Colorado, from over nine hundred programmes that they have reviewed. To attain "Blueprint" status, programmes require high standards of evidence, independent replication (ideally in service settings), long-term follow up and tools to enable effective dissemination (www.colorado.edu/cspv/blueprints/) (Hutchings, 20112). It is also endorsed by NICE for the treatment of conduct disorders.

For the purposes of this review we assessed the evidence in three papers where the intervention had been used with foster carers. All three papers were assessed positively in terms of scientific appraisal. The Wales study was rated as '**strong**'.

The research in Wales involved a randomised control trial. There was a relatively small sample: (Number (n) =46; intervention n=29, control n=17). Follow up was 3 months after the intervention was completed (6 months from baseline), after which the control group were offered the intervention. A significant reduction was observed in Eyberg Child Behaviour Inventory scores (at baseline 50% of intervention carers rated their looked after child above the clinical cut-off, this reduced to 35% at follow up. For the control group it increased from 25% of children to 30% at follow up). A significant reduction was observed in SDQ total score for the intervention group (62% of children rated over the cut off at baseline vs 35% at follow up. For controls 56% of children were above the cutoff at baseline falling to 36% at baseline, but this was not significant. There was a 40% drop in carer depression levels for the intervention condition only.

Policy and practice implications for Wales

The programme has been adapted for foster carers across several contexts, but most importantly for this review is has been tested in Wales, with promising results. While qualitative experiences of taking part in the programme were largely positive, some carers noted that they would have liked trainers with more knowledge of the legal and social context of foster care.

The intervention does not work directly with children and young people and their views on the programme are not reported in the published papers.

The Wales-based study was a pilot, which showed promising results. Authors recommend a roll out and larger study which could run alongside an implementation programme in Wales. Modifications to measures are suggested in the Bywaters paper and foster carers suggested an extension to 14 weeks to include more emphasis on play and on problem-solving.

A home-based individual intervention has been piloted in Wales.

The programme has been widely implemented in north Wales and Powys (7 out of 22 local authorities in Wales).

Costs

In the 2011 paper it is reported that delivery costs were £1741 per foster carer.

Key sources of information

1. Nilsen, W. (2007). Fostering futures: a preventive intervention program for school-age children in foster care. *Clinical Child Psychology & Psychiatry*, 12(1), 45–63.
2. Linares LO, Montalto D, Li M, & Oza VS. (2006). A promising parenting intervention in foster care. *Journal of Consulting & Clinical Psychology*, 74(1), 32–41.
3. Bywater T, Hutchings J, Linck P, Whitaker C, Daley D, Yeo ST, Edwards RT. (2011) Incredible Years parent training support for foster carers in Wales: a multi-centre feasibility study. *Child Care Health Dev.* 2011 Mar;37(2):233-43
These papers report research on transferring the evidence based parenting programme Incredible Years to foster care.
4. Hutchings,J . (2012) The Incredible Years Programme in Wales, IJCV : Vol. 6 (2) 2012.
5. Personal communication with Professor Judy Hutchings on roll out and on-to-one coaching developments.

2. KEEP: Keeping foster and kinship parents trained and supported

Description of intervention

KEEP is a 16-20 week programme for foster and kinship carers. Sessions last 90 minutes. It aims to increase positive parenting skills, improve child outcomes, increase positive placement changes (reunification, adoption) and reduce disruption. KEEP aims to accomplish these goals by:

- Promoting the idea that foster parents can serve as key agents of change for children.
- Strengthening foster parents' confidence and skills so they can change their child's behaviours.
- Helping foster parents use effective parent management strategies and provide them with support to do so.

There are three programmes for carers of age groups 3-6, 5-12 and 12-17. Catch up sessions are delivered at home for missed sessions. In the UK a monthly support group led by KEEP facilitators is offered as follow-up.

KEEP originated in Oregon, USA in 1996 from Multidimensional Treatment Foster Care (MTFC), a programme developed by Chamberlain and colleagues as a family-based alternative initially for teenagers with chronic problems. KEEP utilises the same principles as MTFC but is designed for foster carers and family and friends (kinship) carers. The main theoretical basis is social learning theory (i.e that children will learn from the world around them, that carer and parents are the key agents for change and the quality of these interactions can help improve outcomes.). The KEEP 3-6 programme additionally includes a combination of Social Learning Theory, Attachment and Brain Science.

The KEEP programmes have been available in England since 2009 supported by the Department for Education (DfE) and local authority partnerships have been funded to set up and deliver the programmes through the evidence based intervention programme (EBIP) initiative. BAAF is one of the organisations delivering the programme in London and the North-east of England.

All three KEEP programmes are now offered in England with facilitators trained and supported by OSLC Community Programme Consultants in Oregon or UK Consultants.

Assessment of evidence base

KEEP has been evaluated by a large (n=700) randomised control trial in the USA. The intervention was found to increase placement stability and also increase 'positive exits' (ie moves for permanency). There was a reduction in child behaviour problems and an increase in positive parenting techniques. The study was rated as 'strong' by our research team.

Like Incredible Years, this is a Blueprints model programme (see above).

Policy and practice implications for Wales

KEEP is currently being implemented in several local authorities in England. There is no implementation in Wales.

It is a programme specifically developed for foster and kinship carers.

This programme works with carers and does not include direct work with children
It was developed in the US context.

There is an adapted version for residential carers.

It covers age ranges 2-17.

Costs

£1500-1800 per carer for a 16 week group

Key sources of information

1 Price, J. M., Chamberlain, P., Landsverk, J., Reid, J. B., Leve, L. D., & Laurent, H. (2008). Effects of a foster parent training intervention on placement changes of children in foster care. *Child Maltreatment*, 13(1), 64–75.

2. Price, J. M., Chamberlain, P., Landsverk, J., & Reid, J. (2009). KEEP foster-parent training intervention: model description and effectiveness. *Child & Family Social Work*, 14(2), 233–242.

3. Leathers, S. J., Spielfogel, J. E., McMeel, L. S., & Atkins, M. S. (2011). Use of a parent management training intervention with urban foster parents: A pilot study. *Children and Youth Services Review*, 33(7), 1270–1279.

Intervention's UK web-site: <http://www.mtfce.org.uk/keep.html>

BAAF KEEP programme: <http://www.baaf.org.uk/ourwork/keep>

Personal communication with Hannah Collyer, South London and Maudsley NHS Trust.

3. Fostering Changes (Revised Programme)

Description of intervention

Fostering changes was developed by the Adoption and Fostering National Team at the Maudsley Hospital, South London, in conjunction with King's College London. The Revised Fostering Changes intervention is an adaptation of the Fostering Changes programme (Pallett et al 2005). Despite previous positive evaluations and roll-out, the programme has been revised in accordance with new knowledge related to attachment, education and communication.

The intervention aims to provide foster carers with both knowledge and practical skills to positively impact upon behaviour and security. Elements of the programme: social learning theory, attachment theory and cognitive behavioural techniques are similar to the Webster-Stratton/Incredible Years programme. The learning is delivered via weekly, three hour group sessions over twelve weeks (full description of the programme is available on the DfE report cited below). Although the programme was developed for carers of 2-12 year olds it can be adapted for 12+ and the 'train the trainer' 4 day programme has an additional day for 12+ issues. It has mainly been implemented with foster carers but has also included kinship carers in the groups. It has recently been successfully adapted for residential carers in Austria.

Assessment of evidence base

The intervention was subject to a randomised control trial in the London area, reporting in 2011. The sample was relatively small: (34 in intervention group, 29 in control (waitlist) group). Results of the trial were summarised as:

Statistically significant improvements in indices of behaviour were found in the children of carers who had been allocated to the Fostering Changes arm of the trial, compared to children of carers in the control group. There was a large effect on carer-defined problems (effect-size 0.95 sd, p Value =0.003) and a small-to-moderate effect on emotional and behavioural difficulties (Total Problems on Strengths and Difficulties Questionnaire (effect-size 0.3 sd, p=0.03). The quality of attachment between looked after child and carer was significantly improved in the intervention group compared to controls (effect-size 0.4 sd, p=0.04).

There was no long term follow up to assess whether positive effects were maintained. The research team rated this trial as **strong**.

Policy and practice implications for Wales

Programme was developed and evaluated in the UK context.

It is specifically aimed at the needs of carers of looked after children

The research evidence is promising. Evaluators note that it is the only programme of its type in UK to demonstrate improved attachment following training.

Since 2011 it has been widely rolled out in England (trainers trained in 107 LAs reaching nearly 600 carers)

There is little use of this programme currently in Wales (Two independent providers in Wales are training their foster carers, including TACT).

The intervention does not work directly with children and young people and their views on the programme are not reported.

Implementation in Wales would ideally be accompanied by a rigorous evaluation of effectiveness.

Costs:

'I can confirm that the typical cost per foster-carer trained in the Fostering Changes programme two years ago was £800. This does not include hire of a venue (a lot of courses are run in community rooms without charge to the Local Authority) or provision of a crèche to look after other children. If these were added, and inflation at 2.5% per year were factored in, the cost per carer might go as high as £1,200. In general, the costs are relatively low as it is a not-for-profit charity running out of the University, so for example do not have to pay for fees back to the program developer as is the case in Incredible Years and in KEEP, where getting supervision from the USA is not without extra cost.' Professor Stephen Scott.

Key sources of information:

Dept of Education, Research Report DFE-RR237

Briskman, J., Castle, J., Blackeby, K., Bengo, C., Slack, K., Stebbens, C., 2010.

Leaver W. and Scott, S. *Randomised Controlled Trial of the Fostering Changes Programme*

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/183398/DFE-RR237.pdf

Plus: personal communication with K. Blackeby, M. Wollgar and S. Scott from the Fostering Changes team.

4. Head, Heart, Hands

Description of intervention

Head, Heart, Hands is a newly developed programme for foster carers and social workers based on the principles of social pedagogy. It is currently being piloted in six sites in England and Scotland by Fostering Network. It involves systemic and cultural changes to support the new approach, which will involve an intensive training programme for their foster carers and social workers, and continued on-going support from trained social pedagogues.

As Fostering Network's Chief executive states: 'social pedagogy is an approach with a theoretical and ethical basis rather than an intervention'. Information from Fostering Network about the approach is as follows:

'Social pedagogy blends the use of knowledge from academic research and established child development theories (head), with an important emphasis on emotions, recognising that everyone has their own emotional and ethical needs (heart), in combination with a focus on using practical tasks and every day activities as vital opportunities for learning (hands).

Individuals trained in social pedagogy work with the whole child, aware that children think, feel, have a physical, spiritual, social and creative existence, and that all of these characteristics are in interaction in the person and have an important bearing on their development.

For foster care in the UK, this approach promises to herald a shift away from following procedures to a system that supports foster carers to help fostered children build positive relationships that lead to stability, better outcomes and long-term well-being.

Social pedagogy will put foster carers at the heart of the child care team, recognising and supporting the pivotal role they play in the development of fostered children. It gives more authority to foster carers and encourages all those who work with fostered children to take a more sensible approach to risk so the children can experience happy and fulfilling lives.

Assessment of evidence base

Research evidence is mostly descriptive. This is partly because social pedagogy is a

very broad approach rather than a manualised programme and it is difficult to evaluate its effectiveness using conventional measures. Outcomes for looked after children in countries where social pedagogy is used are generally much better than in the UK, but social pedagogy is not the only difference in provision in these cases. An independent evaluation of the Head, Hearts, Hands programme is currently being undertaken and the report will be available in 2016. Our assessment of the evidence base is 'weak', although as we state below, there is an opportunity to build in an evaluation to a roll-out of Head, Hearts, Hands in Wales.

Policy and practice implications for Wales

Funding the extension of this programme to Wales would extend its reach beyond England and Scotland and allow Wales to become part of the programme

This is a holistic programme that aims to create systematic change rather than just intervene in one part of a looked after young person's life. It therefore meets the Big Lottery Fund's desire to have an ambitious programme.

Despite these positives, the programme is currently not supported by an evidence base, therefore its implementation might be seen to be more risky than some of the other interventions on the shortlist.

Any implementation would need to be accompanied by a rigorous evaluation.

Costs:

Fostering Network states: 'We have a four year programme – 6 months set up, 3 years operation, 6 months finishing – total costs for the six sites is £3m. This covers central programme management costs, one social pedagogue in each site, one day familiarisation workshop for a wide range of staff, two day introduction to social pedagogy for staff more closely involved, 8 day intensive training for 40 foster carers in each site and their supervising social workers, input at site level to advise and assist with systemic change, ongoing supervision and networking for the social pedagogues, an ongoing learning programme for the sites who meet together and learn from each other. An evaluation of the whole programme (£300K)'

Key sources of information.

1. Cameron, C. (2011) Social Pedagogy: what questions can we ask about its value and effectiveness? *Children Australia*, 36, (4) December 2011.
2. Cameron, C., Petrie, P., Wigfall, V., Kleipoedszus, S. and Jasper, A. (2011) *Final*

report of the social pedagogy pilot programme: development and implementation, available at <http://eprints.ioe.ac.uk/6767/1/Cameron2011Final%28Report%29.pdf>

3. Cameron, C. and Petrie, P. (2011) *Social Pedagogy And Foster Care: A Scoping study*, Thomas Corum Research Unit, Institute of Education, University of London.
http://www.fostering.net/all-about-fostering/resources/reports/head-heart-and-hands-scoping-report#.Um_kBPmzKul

The Fostering Network web-site: https://www.fostering.net/head-heart-hands#.Um_oIPmzKul. Personal communication from Robert Tapsfield, Fostering Network and Loughborough University evaluators of the scheme.

5. Paired Reading Literacy Scheme

Description of intervention

The Paired Reading Literacy Scheme seeks to directly involve foster carers in the child's education based upon the premise that reading is the foundation of learning and so offers a good starting point in enhancing the education of looked after children. The Scheme adopts an interactive process whereby the carer and child read together at first but gradually move towards the child reading alone. The child selects what to read and receives support from the carer through discussion, questions and correction. This model enables the child to gain extra reading practice, receive feedback, and model their behaviour. The Scheme was offered to looked after primary aged children in Hampshire and involved foster carers reading with children at least three times a week for a minimum of 20 minutes for 16 weeks. The Scheme also brought together school staff with social workers at the outset of the project and fostered weekly links between school staff and foster carers.

Paired reading is incorporated into BAAF's broader **Fostering Education** training programme for foster carers (Linked to the Fostering Changes group). The training pack has been offered for free to all LAs in the UK and a pilot programme is said to have had similar results to that reported by Osborne et al. This programme covers the following areas: Supporting literacy, Understanding the education system, Skills that underlie learning: social and emotional skills, Creating a space to learn, Understanding learning. The program is for 10 sessions with carers being given tasks to take home each week. There is a simple scaled questionnaire at the end of each session for carers to feedback their thoughts. Paired reading is introduced in session 4.

Assessment of evidence base

A small scale evaluation has been carried out in Hampshire with looked after children. Results showed that on average, children's reading ability progressed by 1 year for every month's participation. This finding supports the Department of Education and Skills' (2003) criteria for effective intervention. The authors note that whilst progress might not have continued at this rate, the findings presented suggest that paired reading offers an effective short literacy intervention for improving the literacy of looked after children. In addition, additional benefits were noted by foster carers who reported improvements in the child's confidence, enthusiasm for reading and in their relationship with the child. Our research team assessed the evidence as weak to moderate.

Policy and practice implications for Wales

Paired reading is a low cost intervention that may fit well as a *boost* to the Letterbox Intervention already implemented in Wales.

The Fostering Changes team state that Fostering Education would be a useful boost for carers who have received the Fostering Changes programme.

The intervention has been developed and evaluated in the UK.

It has been incorporated into a broader Fostering Education programme and also BAAF's Supporting children's Learning training programme.

The evidence base is weak and any implementation would need to be accompanied by a rigorous evaluation.

Costs:

A training pack is available free of charge from BAAF for one paired reading programme: *Supporting Children's Learning*. Costs will depend on whether the training can be delivered in-house or with outside trainers (BAAF supply training at £750 per day).

Key sources of information.

1. Osborne, C., Alfano, J., & Winn, T. (2010). Paired Reading as a Literacy Intervention for Foster Children. *Adoption & Fostering*, 34(4), 17–26. doi:10.1177/030857591003400403

2. <http://www.communitycare.co.uk/2011/01/06/how-fostering-education-is-improving-the-reading-of-looked-after-children/#.Um6oyvmzKul>

3. Winter, K., Connolly, P., Bell, I and Ferguson, J. (2011) *Evaluation of the Effectiveness of the Letterbox Club in Improving Educational Outcomes among Children Aged 7- 11 Years in Foster Care in Northern Ireland*, Centre for effective Education, Queen's University, Belfast.

Personal communication from BAAF.

Fostering Healthy Futures Programme

Description of intervention

The Fostering Healthy Futures programme was developed in Colorado, USA and lasts for 9 months and involves a skills groups lasting 30 weeks for 1.5 hrs per week for 9-11 year olds (involving cognitive behavioural activities including emotion recognition, problem solving, anger management) and one-on-one mentoring by graduate students in social work lasting 30 weeks (involving creating empowering relationships with the children, teaching them to apply skills learned in skills training to the real world, responding to their varied needs e.g. emotional, educational, recreational). The ultimate aim is to reduce mental health and similar problems.

Assessment of evidence base

There are over 30 peer reviewed publications. The programme has been evaluated for children in foster care using rigorous methods – randomised control trial with longitudinal follow up with a large sample.

Mental health outcomes: At Time 3 (6 month follow up) youths in an intervention group scored significantly lower on the multi-informant mental health factor and reported significantly fewer symptoms of disassociation. Furthermore, at T2 (end of intervention) intervention group youths scored significantly higher on a self-report scale measuring quality of life.

Placement outcomes: At 1 year follow up children who were in non-relative care and received the intervention were significantly less likely to enter residential treatment care and were significantly more likely to have achieved permanency.

Our research team assessed the evidence as very strong. The intervention has been rated 2 out of 5 (where 1 is highest) by the California Evidence-based Clearing House for Child welfare. A '2' is defined as 'supported by research evidence'.

Policy and practice implications for Wales

This intervention has a strong evidence base

Unlike most of the interventions in the shortlist this one works directly with children

The skills and mentoring aspects suggest a comprehensive approach.

It has only been implemented and evaluated in the USA. There has been no

implementation in the UK. Implementation in Wales would therefore be pioneering.

The Colorado team have indicated a willingness to be involved in an implementation in Wales, as long as the implementation was evaluated.

It is only designed for 9-11 year olds, although this anticipates significant transitions. The mentoring programme is currently being developed for adolescents.

Sourcing mentors may be a challenge, although the US connection with trainee social workers in HE could be an original and promising partnership.

Any implementation would need to be accompanied by a rigorous evaluation to assess programme implementation in a different national context.

Costs

In the current implementation in Colorado, child welfare agencies are paying \$5,600/child for the 9-month program. A sizeable portion of that cost is reimbursing mentors for mileage, and those costs are quite variable across sites. If you would like to see the staffing specifications and other cost breakdowns, we would be happy to share them with you.'

Key sources of information.

Taussig, H.N., Culhane, S.E., Garrido, E., & Knudtson, M.D. (2012). RCT of a mentoring and skills group program: Placement and permanency outcomes for foster youth. *Pediatrics*, 130:e33-e39.

Taussig, H. N., & Culhane, S. E. (2010). Impact of a mentoring and skills group program on mental health outcomes for maltreated children in foster care. *Archives of Pediatrics and Adolescent Medicine*, 164, 739-746 .

Programme

web-site:

<http://www.ucdenver.edu/academics/colleges/medicalschoo/departments/pediatrics/subs/can/FHF/Pages/default.aspx>

Other web-sites: <http://www.cebc4cw.org/program/fostering-healthy-futures-fhf/>

2.2 Young People's Engagement

A further key component of the project was for engagement to take place with young people with recent experience of being involved with the care system in Wales. With the 6 shortlisted models having been identified, the project team was keen to ascertain the views and opinions of young people in respect of each of the models prior to the planned discussions with the Expert Advisory Group. This process of engaging children and young people first was deemed most appropriate and the information gleaned would act as a backdrop to deliberations amongst advisory group members.

Children in Wales and Expert Advisory Group member organisation Voices from Care Cymru have in place a National Reference Group of Children and Young People who are routinely engaged by external bodies including Welsh Government on matters concerning looked after children and were ideally placed to contribute to this phase of the project. With the support of Voices from Care Cymru staff, Children in Wales facilitated a half-day workshop style discussion with a group of young people on the 6th November 2013. 7 participants were involved in the discussions in total.

Process

The workshop provided an opportunity for young people to have a fuller understanding of the purpose and parameters of the scoping study and of their role in the process. Young people were provided with an overview of the Evidence Gathering Review Stage and the knowledge and analysis which had led to the emergence of the 6 shortlisted models.

The workshop provided an opportunity to share with the young people some overarching and acknowledged specifics drawn from the research. These included

- Looked after Children population is dynamic – move in and out of care
- Looked after Children are not all the same – diverse needs and experiences
- Looked after Children have the same needs as other children, but needs are likely to be greater
- Looked after Children needs often developed prior to entering care, but may also be connected to care experience
- Sizeable amount of Looked after Children are doing WELL – education, emotionally and health

The workshop also provided an opportunity to share the wide variety of needs associated with Looked after Children recognised within the literature.

- Physical health Needs
- Mental health, emotional and behavioural needs
- Neurobiological needs
- Educational needs
- Relational Needs
- Placement Needs
- Individual / Personal Needs

In order to assist the young people to make an informed decision in their later discussions around the 6 shortlisted models, the workshop provided an opportunity for a facilitated discussion around Looked after Children priorities, values and preferences. Dickson et al (2009) in their study examined the experiences, views and preferences of looked-after children and young people and the headline priorities were shared as a basis for discussion. The broad themes in their work were

- Being Supported
- Having someone to talk to
- Positive relationships
- Education and encouragement to do well
- Good professional support
- A sense of belonging
- Love, acceptance and respect
- Desire to maintain contact
- Unwelcome stigma and prejudice
- Involvement in decisions

The young people through the workshop discussion were asked to consider each of these in term and through discussions as a group, asked to identify their particular priorities. They were also encouraged to identify any additional priorities not listed.

The top priorities for this group of young people were

- Positive Relationships – with professionals, carers and peers
- Acceptance and respect

- Being supported
- Having someone to talk to
- Good advice and information
- Stable environment
- Opportunities for socialising

These preferences now enabled for a more detailed discussion around each of the 6 shortlisted models. The young people were provided with the central features and components of each of the models (as outlined in pages 29-43) and were given an opportunity to discuss the strengths, differences and any weaknesses of each of the models in turn. Main points and comments were collated on flip charts and formed the basis for wider discussions amongst the group.

The following points were raised in discussions

- What happens if a young person moves placement? How would this impact on interventions?
- If it is up to 18, what happens if you leave care at 16?
- Many of the models focus on support for foster care. Need to look at options for residential carers.
- The direct training seems mostly for foster carers not young people.
- What happens after the programmes finish, will there be continued support, otherwise it could be 'another services that does good and then leaves'.
- Need to consider interventions that have an element of direct work with children and young people.
- One of the key priorities is 'attachment'.
- Need to consider younger children in care in addition to older children.
- Interventions which seek to improve the educational outcomes of young people should be prioritised.

Recommendations

Overall, the young people considered there to be identifiable strengths in each of the models and for this reason none were discarded. All of the models were considered to be worthy of more detailed consideration, with the young people content for their thoughts to be shared with the Expert Advisory Group as part of their forthcoming meeting.

When pressed in terms of any preferences, the young people reiterated that given the similarity between the first 4 models (Model 1, 2, 3 & 4) in that they work directly with carers that it may be preferable for only one of these to be put forward to the final two. Models 5 and 6 could be considered as a secondary option, although it was felt that Model 5, whilst appearing to be the most economical, it alone was too narrow and specific an intervention.

Finally, in terms of strengthening the Models, the young people considered that there should be an element of direct work with children and young people operating, either as part of the chosen model or operating alongside of. Young people also felt that the preferred intervention should also consider the applicability to residential care settings, the need for long term sustainability and on-going evaluation. The cost of the models and transferability should also be deciding factors given the need to maximise effectiveness and improve lasting outcomes.

2.3 Stakeholder engagement

Second Meeting

The second meeting of the Expert Advisory Group took place on 8th November at Children in Wales. To ensure continuity of engagement, all of the organisations who attended the first meeting together with those organisations who had sent apologies were invited. 13 organisations were in attendance and apologies were received from 5 representatives in advance. An additional representative from the Voices from Care Cymru National Reference Group was also present.

This meeting provided for members of the Expert Advisory Group with an opportunity for a detailed discussion around each of the 6 shortlisted models and to hear the overarching views and thoughts from the young people who took part in the workshop event earlier the same week. A report from Phase 1 and 2 of the evidence gathering and analysis stages was produced and circulated in advance of the meeting to provide members with an opportunity to consider the findings with colleagues within their organisations. This report included links for further reading and to recognised websites. This was brought to the attention of participants prior to the meeting with the expectation that they would have had an opportunity to access and consider each of the models in more detail in advance. This report has been shared with the Big Lottery Fund.

The meeting opened with a summary of the aims and parameters of the scoping study and an information exchange from the Project team in respect of the research and analysis phases and the journey to date.

The issues identified by the young people in respect of their 'needs' and 'priorities' were shared by the representative from the young person's group together with an overview of the workshop event and the groups thoughts in respect of each of the 6 shortlisted models (as outlined in the preceding section above).

The remainder of the meeting was focused on the 6 models. Replicating the format of the young people's interactive workshop event, members of the Expert Advisory Group were asked to consider each of the models in turn through small group discussions (4-5 individuals per table). 2 models were allocated to each of the 3 tables. Further information on the models was also provided and participants were asked to reference the information previously circulated and contained in the report. Utilising the Paper Carousel engagement technique, each model was circulated to each table in turn to ensure that all participants had an opportunity to discuss and share their thoughts on each of the shortlisted interventions. Main points and comments were collated on flip chart to aid discussions.

Recommendations

Replicating the overall assessment by the young people, the Expert Advisory Group considered there to be strengths in all of the 6 models presented. None of the models were immediately discarded and all were felt to be appropriate to have reached the final shortlist phase.

To aid further discussion amongst the whole group, the project research team shared their thinking, informed through the analysis process and more detailed background reading and conversations with key individuals and/organisations involved in the development and/or delivery of the models.

A number of the key strengths and suggestions for improvements identified by the Expert Group in the roundtable discussions were verbally shared amongst the whole group to help enable further deliberation between participants. The Group recognised and appreciated the similarities between a number of models in terms of their reach, the process and the outcomes. Participants also brought the project teams' attention to the challenges in selecting preferences given the strengths of the

models but understood the key role they had to play in informing the next steps in the process and for the Big Lottery Fund to have a ‘clear steer’ around preferences.

The Group further considered Models 1 – 4 which work predominantly with carers. It was recognised and agreed that whilst there were differences between Models 1, 2 & 3, there were notable similarities. Through the discussions, it emerged that there was greater support for Models 2 & 3 and both it was conveyed were worthy of further consideration.

Whilst the Group accepted the value and potential of positive literacy and educational outcomes from the evaluations of Model 5, echoing the views of the young people, they considered this intervention to be too narrow in focus and they didn’t consider it alone would ‘transform the life chances of Looked after Children in Wales’ and meet the aims of the scoping study.

There was agreement in the meeting that whichever of the remaining four models were put forward to the Big Lottery Fund for consideration for future funding, that they could support that decision. Each model had their own unique strengths and differences, and each model would be worthy of selection for future funding.

Finally, the Group raised the need to explore the potential for the involvement of Looked after Children and/or Care Leavers, potentially through direct work alongside one of the models or as part of a model (if this was possible where licensing allowed). They also supported the young people’s views that the preferred intervention should also consider the applicability to residential care settings, the need for long term sustainability and on-going evaluation. The cost of the models, its transferability (particularly pertinent to Model 6) should also be deciding factors.

The Group therefore agreed to pursue the following

NO	MODEL
2	KEEP: Keeping foster and kinship parents trained and supported
3	Fostering Changes: Revised programme
4	Head, Heart, Hands: social pedagogy
6	Fostering Healthy Futures Programme

It was suggested and agreed that the Group would have a further short period of time in which to give further consideration to the four remaining models with reference to the information outlined in the report and the website links as discussed above. Flipchart notes were to be circulated.

Further consideration took place during the week of the 11th November and the additional points and reflections raised by the Expert Advisory Group from their deliberations with colleagues in their organisations would help inform the final decisions.

Phase 3

Two potential models for the Pilot

Through the evidence gathered from the rapid review process, detailed analysis, and the expertise from young people, the Expert Advisory Panel and other key stakeholders, the project team have selected the following evidenced based models to inform the Big Lottery Fund's pilot project

Model 1

The first proposed Model encompasses the following elements

- Fostering Changes Programme +
- Follow-up Support Group for Carers +
- Children/Young People's Group (skills base group component) +
- Feasibility Study (mentoring component)

Summary

Model 1 proposes that the Fostering Changes Programme is rolled out on a phased basis across Wales for foster, residential and kinship carers. A second element is a follow up support and reinforcement group for carers trained through the Fostering Changes programme. A complementary group for looked after children could also be developed and piloted in a small number of local authorities in addition to a short feasibility study which would explore the potential for developing a mentoring programme for looked after children comparable to that provided by the Fostering Healthy Futures programme in Colorado (see Model 2). A rigorous evaluation of all aspects of the programme would be included. The Pilot would take place over 5 years from 2014 within a total budget of £5m.

Description and aims of the intervention

Fostering Changes Programme - Fostering Changes is a flagship course developed for foster carers that provides them with the practical skills to manage placements. The programme was developed by the Adoption and Fostering National Team at the Maudsley Hospital, South London, in conjunction with King's College London. The revised Fostering Changes intervention is an adaptation of the positively evaluated Fostering Changes programme (Pallett et al 2005). The revised

scheme has been updated to take into account the advanced understanding of what the impacts of neglect and abuse are on children, with a greater emphasis on how to help carers implement techniques to enable children to identify, acknowledge, express and manage their feelings more effectively. The revised model includes more about the importance of developing secure and positive attachments and ways in which carers can help improve the educational outcomes of children and get involved in their foster children's school life. The programme has an emphasis on effective communication and problem solving skills and aims to provide carers with both knowledge and practical skills to positively impact upon behaviour and security

The Programme is behaviourally based and derives from research into parenting skills, attachment, educational attainment and the academic progression of looked after children who are in foster care. The evidence based programme is underpinned by social learning theory, attachment theory and cognitive-behavioural therapy.

The learning is delivered via weekly, three hour group sessions over twelve weeks. Two fully trained facilitators deliver the course with between 7-10 carers in each group. There is a dedicated facilitator manual which outlines the programme and each of the 12 sessions in detail.

Although the programme was initially developed for carers of 2-12 year olds it has been adapted for 12+ with the 'train the trainer' 4 day programme having an additional day for 12+ issues. It has been implemented with foster carers and in groups which include kinship carers. It has been adapted for residential carers in England and rolled out on a national level in residential care settings in Austria.

In Feb. 2009, the Department for Children, Schools & Families (UK Government) awarded a grant to Kings College London to develop and roll out a training programme for facilitators in 152 local authorities in England which trained 2-3 group facilitators in each area. Though this funding has since ceased, there continues to be demand for the training including by TACT Cymru, a charity providing adoption and fostering services in parts of Wales, who have begun running courses for their own foster carers.

The programme would add value to existing statutory duties in aiming to improve the skills and competencies of carers with children in their care. It would provide them with the practical skills to manage placements which in turn will enable statutory

partners to have increased confidence in their carers' skills and ability to make a significant difference to a looked after child's life.

Group work with children – The Fostering Changes Programme has only undertaken limited direct work with children and young people in care. This would be a new innovation and could be specifically tailored for the needs of looked after children in Wales and developed to add value and complement the programme delivered to carers. To date, Kings College London have been piloting and evaluating two types of groups for children in foster care settings. A 'social skills group' has been run with primary and secondary school children and a 'mindfulness/acceptance group' with older children. In our dialogue with Kings College London, they would be very interested in developing a manual for this with the engagement of stakeholders in Wales.

Follow up Support Groups for Carers- The Fostering Changes Programme does not currently include facilitated support groups for carers post-training. This again would be a new innovation for Wales and add value to the existing programme by reinforcing the learning and enabling trained carers to share experiences and obtain mutual support in a facilitated environment.

Feasibility Study (Mentoring element) – Full discussion in Model 2

Outcomes and measures of success

Training has become central to improving the outcomes for looked after children. Carers can bring about significant improvements in the life experiences and outcome of looked after children and be real agents of change if well trained and well supported. We would suggest that implementation in Wales should be accompanied by a rigorous evaluation of the programmes effectiveness in meeting its aims and achieving positive outcomes both for carers and looked after children. This would include follow up measures to evaluate the longer term impact of the intervention.

We are proposing a 'step wedge' design for implementation which would be mirrored by the approach taken for the evaluation.

Evaluations of the Fostering Changes programme to date have measured the following outcomes

- Positive changes in carers behaviour
- Positive changes in the behaviours of their children

- Improvement in the interaction between child and carer
- Improved confidence levels in carers handling difficult behaviour with reduced levels of stress
- Improved attachment levels

Additional reported outcomes we would propose are measured would include

- Engagement of carers with their children's education and learning which has a positive impact on educational outcomes
- Improved relationships between carers and children which aid placement stability and avoids breakdowns and frequent placement changes
- Improved engagement with education (carers and children)

The facilitator manual includes a dedicated section on the use of evaluation measures which are recommended by the programme. These are

- The Alabama Parenting Questionnaire (Shelton et al 1996)
- Strengths and Difficulties Questionnaire (Goodman 1997)
- Eyberg Child Behaviour Inventory (Eyberg and Pincus 1999)
- Care confidence questionnaire – 'How it feels to be a foster carer'
- A visual analogue scale – 'concerns about my child' (Scott et al 2001)

As an added value for Wales, we would suggest incorporating

- Engagement directly with looked after children including self evaluation methods which reflect the age and abilities of children
- Follow up measures post training to evaluate the long term impact of the intervention

Group work with children - We would suggest that implementation in Wales should be accompanied by a rigorous evaluation of the effectiveness of the intervention directly with children and young people. The overarching outcomes we would suggest are measured mirror those listed above but captured through direct engagement with children and young people. Evaluation techniques would be appropriate for children and young people which build on the methods currently in use by Kings College London to evaluate the two pilots described above.

Any priorities (e.g. equality strands, specific issues etc)

The programme has been developed for foster carers with children in care with a range of needs and has been selected following a clear steer from our Advisory Group to identify programmes which had the potential to make a positive difference to the greatest number of looked after children in Wales. The Fostering Changes Programme works with all age groups and in all settings. The Group work with children would be all inclusive and include children from foster, kinship and residential settings.

Proposed duration of the pilot and considerations around location

Given the learning to date from other countries where the Programme has been implemented and our engagement in Wales, we do not envisage there being any reason why this programme could not in time be rolled out to every local authority in Wales. Interest to date in this programme and the other shortlisted interventions has been positive. We would however suggest that the programme is piloted through a phased approach and that the duration for the pilot is over 5 years. This would allow for an evaluation of the pilot to be done in stages. The precise detail of roll out process will need further discussion and negotiation should this model and approach be accepted. We would suggest that a maximum of 3 local authorities deliver the programme in the first year with a maximum of 3 in subsequent years within the existing budget (this will be determined and influenced by whether or not the complimentary elements to the Programme are also accepted as part of the Model as well as the outcome of the feasibility study on the potential for a mentoring element to be included). A local authority location in South, West and North Wales would be preferable

We would suggest that further engagement with the Association of Directors for Social Services (ADSS Cymru) takes place following the Committee's decision and those negotiations take place as soon as possible thereafter.

Group work with children – We would propose that a development funding phase is required for this element of the model. The first phase would be the development of the manual during Year 1. We would suggest that this part of the model is then piloted in one or two local authority areas only. This would be accompanied by a rigorous evaluation which would measure the impacts and outcomes. The two local authority areas would also need to have the Fostering Changes programme for carers in operation.

How each model will interact with stakeholders in the field

Trained facilitators in England have been drawn from both the third sector and from local authorities. A professional qualification is required, such as social worker or teacher, or a professional with experience of working in the field with looked after children. A partnership approach between local authorities, third sector organisations, Kings College London and a University could be explored. The programme has been designed for use with carers in local authority, voluntary and independent sectors.

We would suggest that an advisory group is set up which informs the delivery of the pilots and the evaluation process throughout the duration of the project. Members of the group could be drawn from the existing Expert Advisory Group for this study with additional local partners, independent academic expertise and with the involvement of young people.

Training requirements

To ensure fidelity, the programme has been designed to be delivered by trained facilitators who have undergone training and accreditation in facilitating the programme. Facilitators would be recruited and attend a 4-5 day training programme delivered in London. In May 2009 the fostering changes training centre was established as a centre of excellence to ensure quality and accreditation of fostering changes facilitators. www.fosteringchanges.com. Accreditation is also offered and this is voluntary.

Relative strengths, weaknesses, opportunities and threats of each model

As outlined, the evidence base for the Fostering Changes Programme is strong and the intervention has successfully been implemented in parts of England since 2009. It was exclusively developed in the UK, has been adapted for other groups of carers, is age inclusive and focuses on the key priorities for enhancing the well being of looked after children, notably attachment, communication and education.

We consider that the existing programme could be enhanced and tailored specifically for the needs and our priorities in Wales. This would include formulating follow up support sessions post training for carers to better measure success and embed practice, alongside the development of a specific programme which works directly with the children in care.

Estimated cost of delivering each of the models

We have suggested that the programme is piloted through a phased approach and that the duration for the pilot is over 5 years. The cost of delivering the Fostering Changes Programme is around £1,200 per carer. This figure has been arrived at by considering the cost of delivering in England in 2011 and factoring in additional costs such as inflation and other costs.

There are approximately 3000 fostering households in Wales and 4,440 children in foster care. Estimate costs of rolling out the training to all fostering families would be approximately £3,600,000. The precise cost for a structured roll out may be slightly different and the additional follow up sessions with foster carers would need to be factored in. We are currently in on-going discussions with Kings College London to ascertain as much information around ballpark costs as we can within the given timescales for this scoping study. This is to further aid the Committee in their decision.

The most expensive type of evaluation would also be the best one to do - a Randomised Control Trial of both the carers' training and the children's group. This would be two studies. A ball-park figure would be 10% i.e. £500,000. The results would be very important in terms of improving the evidence base in this area.

Group work with children – We have made further enquiries with Kings College London to explore the costs of developing a manual and training for the programme for young people.

Feasibility Study – this would be undertaken over a 9 months period in Year 1 with a cost of between £30k and £60k dependent on the scope

Overall, we would not want to spread the available resources too thinly and compromise the outcomes. There are a number of options to consider and more detailed discussions around costs of delivering the model can more appropriately take place should the Committee decide to recommend this Model.

Potential savings to society

It is envisaged that there will be incremental cost savings over time and long term savings to society. Greater stability and avoiding placement breakdown will address many of the shared concerns by professionals and young people and lead to resource savings. Enhancing the education outcomes for children will have immediate and long term benefits for individuals and society in increasing attainment

levels and thus being more attractive to potential employers. Better wellbeing outcomes for children could reduce the current overrepresentation of children leaving care who access health and mental health services, are not in education, training or employment, who are in prison, who are homeless and who are in poverty. The cost savings to society are potentially significant.

Model 2

The second proposed Model encompasses the following elements

- Fostering Changes Programme +
- Follow-up Support Group for Carers +
- Fostering Healthy Futures (Feasibility Study) +
- Piloting of the Fostering Healthy Futures or an adaption of this programme (determined by the recommendations of the feasibility study)

Summary

Model 2 also proposes that the Fostering Changes Programme is rolled out on a phased basis across Wales for foster, residential and kinship carers, and also includes a follow up support and reinforcement group for carers trained through the programme. We also propose that a feasibility study is carried out in Year 1 to explore in greater detail the process for implementing or adapting the mentoring element of the Fostering Healthy Futures Programme in the Wales context. The Fostering Healthy Futures programme could then be piloted in a small number of local authority areas. A rigorous evaluation of all aspects of the programme would be included. The Pilot would take place over 5 years from 2014 within a total budget of £5m.

Description and aims of the intervention

Fostering Changes Programme - Full discussion in Model 1

Follow up Support Groups for carers – Full discussion in Model 1

Fostering Healthy Futures

The Fostering Healthy Futures Programme was developed in Colorado, USA and targets risk and protective factors that have been identified as strong predictors of

risk behaviors and associated outcomes. The Programme has been developed to work directly with looked after children age 9-11 through the following two components

i. Skills Group

Looked after Children attend a skills group which meets for 1.5 hours per week over a 30 weeks period. The group follow a detailed manualised programme that combines cognitive-behavioural strategies with activities designed to help children process experiences related to placement in out-of-home care. The interventions focus on emotion recognition, problem solving, anger management, cultural identity, change and loss, and peer pressure. Multicultural stories and activities are integrated throughout.

ii. Mentoring

Looked after children are paired with graduate student mentors and receive 30 weeks of one-to-one mentoring of between 2-4 hours per week. The role of the mentor is to work to create relationships with children that serve as positive examples for future relationships; help children put into practice the skills learned in the skills group; engage children in educational, social, cultural, and recreational activities, and to promote positive future outlooks and resilience

Feasibility Study - The Fostering Healthy Futures has enormous potential, has been well evaluated and has a strong evidence base. However, the programme has only been implemented and evaluated in the USA. Though we consider there is potential for implementing the programme in Wales which would be pioneering, we propose that a feasibility study is undertaken to allow for more detailed consideration of how this could happen. More specifically, we do not consider that the mentoring element of the programme is immediately transferable for the Wales context.

The 1:1 mentoring is provided by graduate students in social work and related disciplines as part of their internship over the 9 month period. In Wales, the placement period for graduate students is 6 months. For the mentoring element to be successful, the feasibility study would examine the potential for the placement timetable to be reorganised and extended as well as securing the commitment from universities in Wales. The feasibility would also look at the potential of involving undergraduates and other individuals who could serve as effective mentors, as well as the efficacy of the programme for looked after children of other age ranges. The mentoring programme is currently being piloted and evaluated for older looked after children in Colorado and is more academically focused. The feasibility study could

start in April 2014 and be completed by December 2014. Dependent on the recommendations from this study, the programme could be piloted in September 2015 (academic year) in one or two local authority areas.

Outcomes and measures of success

Fostering Changes Programme - Full discussion in Model 1

Fostering Healthy Futures

We would suggest that implementation in Wales should be accompanied by a rigorous evaluation of the programme's effectiveness in meeting its aims and achieving positive outcomes both for carers and looked after children. This would include follow up measures to evaluate the longer term impact of the intervention.

The programme aims and the outcomes we would wish to evaluate are outlined in the detailed manual and include the following.

- Improved relationships with peers and adults (including their carers)
- Positive attitudes about self and for the future
- Skills for regulating behaviour and coping with adaptations and change
- Improved mental health functioning
- Improved confidence levels and problem solving skills
- Improved engagement with school and learning

The additional long term outcomes we would suggest are measured would be

- Reduced likelihood of involvement in risky behaviours
- Improved placement stability and likelihood of achieving permanency
- Prevent adverse life outcomes, such as delinquent behaviours, risky sexual behaviours, substance use and disengagement from lifelong learning

A range of age appropriate quantitative and qualitative evaluation techniques would be utilised for children and young people building on the existing methods currently in use to evaluate the two elements of the programme. Evaluations are also undertaken with graduate mentors given the additional benefits to students in terms of their development and learning, and these are provided as part of the programme manual.

Any priorities (e.g. equality strands, specific issues etc)

The programme has been developed for children in care with a range of needs and has been selected following a clear steer from our Advisory Group to identify programmes which had the potential to make a positive difference to the greatest number of looked after children in Wales. The Fostering Healthy Futures works directly with children in all settings. The feasibility study would also examine the potential for working with other age groups.

Proposed duration of the pilot and considerations around location

Fostering Changes Programme - Full discussion in Model 1

Fostering Healthy Futures

We would propose that a development funding phase is required for this element of the model. The first phase would be the undertaking of a feasibility study as previously described during Year 1 (April – December 2014) for the mentoring element alongside the recruitment and training of the skills group facilitators, and an adaption of the manual. Further preparatory work would be undertaken in early 2015 (informed by the recommendations of the study) prior to the programme being piloted in September 2015 (academic year) in one or two local authority areas. There is currently no set protocol for implementation which provides a degree of flexibility for us in Wales although the programme will need to follow the academic calendar for reasons explained.

This would be accompanied by a rigorous evaluation which would measure the impacts and outcomes. The two local authority areas would also need to have the Fostering Changes Programme for carers in operation and with a university within the authority or within reasonable distance.

How each model will interact with stakeholders in the field

Fostering Changes Programme - Full discussion in Model 1

Fostering Healthy Futures

A partnership approach between local authorities, third sector organisations and at least 1 university setting (to attract the mentors and for the evaluation) could be explored. Facilitators would be required to have a professional qualification and mentors would be graduate students in social work and related disciplines, such as psychology.

As outline for Model 1, we would suggest that an advisory group is set up to inform the delivery of the pilot.

Training requirements

Fostering Changes Programme - Full discussion in Model 1

Fostering Healthy Futures

The skills group leaders possesses a postgraduate/doctoral degree in social work, psychology, or a related field and are responsible for all aspects of the implementation of the skills group programme as well as the supervision and training of skills group assistants. A mentoring supervisor is also in place to oversee the recruitment and management of the graduate student mentors. Following recruitment, skills group leaders will undertake training on the dedicated manual (Year 1) and the mentoring supervisors will undertake the training with the graduate mentors prior to their direct engagement with children. A degree of experience of working with children who have experienced trauma, neglect and abuse would also be expected for skills group leaders. As there is currently no set protocol for implementation, detailed negotiations will need to take place with the programmes creators in Colorado to ascertain how the training would be delivered.

Relative strengths, weaknesses, opportunities and threats of each model

Fostering Changes Programme - Full discussion in Model 1

Fostering Healthy Futures

The evidence base is strong and the intervention has been successfully evaluated. The programme works directly with looked after children with high rates of engagement recorded which was considered a priority for both the Expert Advisory Group and the looked after young people we consulted during the course of this study. As previously outlined, the programme has only been delivered in Colorado and to deliver the mentoring element of the project as prescribed would require a short feasibility study to be undertaken. Adaptions may have to be made to the mentoring element following the feasibility study yet this could be seen as an opportunity to strengthen the model by engaging other individuals with the necessary skills, capacity and interest over the 9 month period.

Estimated cost of delivering each of the models

Fostering Changes Programme - Full discussion in Model 1

Fostering Healthy Futures

The estimated cost of currently disseminating the programme in Colorado is £3,500/child which includes staffing and materials and is based on delivering the programme for 16 children per year. A sizeable portion of the cost is for reimbursing mentors for mileage. Given that Wales is of course a much different context to Colorado and significantly smaller in size, these costs are likely to be less. We expect an economy of scale such that there will be reduced costs per child as the number of children/groups increase.

Aside from the cost of the feasibility study (between £30k-£60), adaptations would need to be made to the existing manual in Year 1 (approximately £9,500) and training for group facilitators (approximately £18,500). Following further engagement, these figures have been provided by the service provider in Colorado who have indicated a willingness to have more detailed discussions around the precise costs of delivering the model should the Committee decide to pursue this option further. The cost of the evaluation, as discussed in Model 1, would be around £500,000 which would include both Fostering Changes and Fostering Healthy Future programmes.

Potential savings to society

We consider that the potential savings to society of adopting this Model would reflect that outlined for Model 1.

FINAL NOTE

- Why other models have been discounted.

KEEP: Keeping foster and kinship parents trained and supported

There were recognised similarities between this programme and that of the Fostering Changes Programme which are more fully described between pages 32-36. The latter intervention was however considered to meet more of the broader aims and the priorities of the young people and members of the expert group by focusing on communication, attachment and educational attainment and also met the priorities of the Big Lottery Fund. We have suggested adopting elements of the KEEP

programme, notably the facilitated monthly support group for carers and building this in to the Fostering Changes programme.

Head, Heart, Hands: social pedagogy

Social pedagogy is an approach rather than an intervention and therefore the research evidence is mostly descriptive and it is difficult to evaluate its effectiveness using conventional methods. Nevertheless, this programme could have potential to create systematic change and raised much interest during the course of this study. The programme as yet is not supported by an evidence base. The current independent evaluation of the pilots underway in parts of England and Scotland is not expected to be available until 2016. We therefore suggest that the Big Lottery Fund awaits the outcome of this evaluation prior to making any firm decision in relation to any additional future funds.

APPENDIX 1

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Appendix 2

List of academic databases searched:

1. ASSIA (Applied Social Science Index and Abstracts)
2. Campbell Collaboration
3. CINAHL (Cumulative Index to Nursing & Allied Health Literature)
4. Cochrane Library
5. EMBASE (Excerpta Medica)
6. HMIC (Health Management Information Consortium)
7. IBSS (**International Bibliography of the Social Sciences**)
8. JSTOR (Journal Storage)
9. Medline (Medical Literature Analysis and Retrieval System Online)
10. PsycInfo
11. Social Services Abstracts
12. SSCI (Social Science Citation Index)
13. Web of Science

List of websites searched:

1. Google Scholar
2. NSPCC
3. National Research Register for Social Care
4. National Institute for Health and Care Excellence
5. Social Services Improvement Agency
6. Social Care Online
7. The Adolescent and Children's Trust

APPENDIX 3

Key word search results

<i>DOMAIN</i>	<i>Databases (13)</i>		<i>Websites (7)</i>		<i>Total number of hits</i>	<i>Total number retained</i>
	No. of hits	No. retained	No. of hits	No. retained		
Education	1427	22	5580	1	7007	23
Health	6517	10	1139	4	7656	15*
Mental health	5096					22
TOTAL	13040					60

*Includes additional interventions identified by key contacts.

Quantitative appraisal search results

<i>DOMAIN</i>	<i>Review abstract</i>		<i>Quantitative appraisal</i>		<i>Inter-rater reliability</i>	
	Total reviewed	Total retained	Total reviewed	Total retained	No. of excluded papers	No. of included papers
Education	23	16	16	5	1	4*
Health	15	4	4	4	2	2
Mental health	22	12	12	9	7	2*
TOTAL	60	32	32	18	10	8

*The Incredible Years (IY) Programme appeared as 3 separate interventions in the search results (One as IY's only, one with a behavioural component and one which offered IY to mixed biological-foster parent dyads). The final recommendation was

based on IY using evidence from all three sources of evidence. Hence, the results presented here have the two additional sources as separate interventions.

APPENDIX 4

Quantitative appraisal checklists

Please use these checklists to classify studies as strong, moderate or weak. Rather than include an exhaustive list of critical appraisal tools for each individual study design, this checklist^[12] is designed to be used for randomised controlled trials, case-control studies, cohort studies, controlled before-and-after studies and interrupted time series. It is based on the 'Graphical appraisal tool for epidemiological studies (GATE)', developed by Jackson et al. (2006), revised and tailored to be more suitable for public health interventions. It is anticipated that the majority of study designs used to determine the effect of an intervention on a (quantitative) outcome will be amenable to critical appraisal with this revised tool.

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 1 of 5 responses is possible:

++	Indicates that for that particular aspect of study design, the study has been designed or 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 (or might have) been considered.
Not applicable (NA)	Should be reserved for those study design aspects that are not applicable given the study design under review (for example, allocation concealment would not be applicable for case control studies).

Checklist for intervention studies

Study identification: (Include full citation details)	
--	--

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 or 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 or clusters agreed to participate? Were there any sources of bias? Were the inclusion or 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 interventions and comparisons described in sufficient detail (i.e. enough for study to be replicated)? Was comparisons appropriate (e.g. usual practice rather than no	++ + -- NR NA	Comments:

intervention)?		
<p>2.3 Was the allocation concealed?</p> <p>Could the person(s) determining allocation of participants or clusters to intervention or comparison groups have influenced the allocation?</p> <p>Adequate allocation concealment (++) would include centralised allocation or computerised allocation systems.</p>	<p>++</p> <p>+</p> <p>-</p> <p>NR</p> <p>NA</p>	Comments:
<p>2.4 Were participants or investigators blind to exposure and comparison?</p> <p>Were participants and investigators – those delivering or assessing the intervention kept blind to intervention allocation? (Triple or double blinding score ++)</p> <p>If lack of blinding is likely to cause important bias, score -.</p>	<p>++</p> <p>+</p> <p>-</p> <p>NR</p> <p>NA</p>	Comments:
<p>2.5 Was the exposure to the intervention and comparison adequate?</p> <p>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)?</p> <p>Was lack of exposure sufficient to cause important bias?</p>	<p>++</p> <p>+</p> <p>-</p> <p>NR</p> <p>NA</p>	Comments:
<p>2.6 Was contamination acceptably low?</p> <p>Did any in the comparison group receive the intervention or vice versa?</p> <p>If so, was it sufficient to cause important bias?</p> <p>If a cross-over trial, was there a sufficient wash-out period between interventions?</p>	<p>++</p> <p>+</p> <p>-</p> <p>NR</p> <p>NA</p>	Comments:
<p>2.7 Were other interventions similar in both groups?</p> <p>Did either group receive additional interventions or have services provided in a different manner?</p> <p>Were the groups treated equally by researchers or other professionals?</p> <p>Was this sufficient to cause important bias?</p>	<p>++</p> <p>+</p> <p>-</p> <p>NR</p> <p>NA</p>	Comments:
<p>2.8 Were all participants accounted for at study conclusion?</p> <p>Were those lost-to-follow-up (i.e. dropped or lost pre-, during or post-intervention) acceptably low (i.e. typically <20%)?</p> <p>Did the proportion dropped differ by group? For example, were drop-outs related to the adverse effects of the intervention?</p>	<p>++</p> <p>+</p> <p>-</p> <p>NR</p> <p>NA</p>	Comments:
<p>2.9 Did the setting reflect usual UK practice?</p>	<p>++</p>	Comments:

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	
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 or 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?	++ +	Comments:

<p>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.</p> <p>Analyses can be adjusted to allow for differences in length of follow-up (e.g. using person-years).</p>	NR NA	
<p>3.6 Was follow-up time meaningful?</p> <p>Was follow-up long enough to assess long-term benefits or harms?</p> <p>Was it too long, e.g. participants lost to follow-up?</p>	++ + - NR NA	Comments:
<p>Section 4: Analyses</p>		
<p>4.1 Were exposure and comparison groups similar at baseline? If not, were these adjusted?</p> <p>Were there any differences between groups in important confounders at baseline?</p> <p>If so, were these adjusted for in the analyses (e.g. multivariate analyses or stratification).</p> <p>Were there likely to be any residual differences of relevance?</p>	++ + - NR NA	Comments:
<p>4.2 Was intention to treat (ITT) analysis conducted?</p> <p>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?</p>	++ + - NR NA	Comments:
<p>4.3 Was the study sufficiently powered to detect an intervention effect (if one exists)?</p> <p>A power of 0.8 (that is, it is likely to see an effect of a given size if one exists, 80% of the time) is the conventionally accepted standard.</p> <p>Is a power calculation presented? If not, what is the expected effect size? Is the sample size adequate?</p>	++ + - NR NA	Comments:
<p>4.4 Were the estimates of effect size given or calculable?</p> <p>Were effect estimates (e.g. relative risks, absolute risks) given or possible to calculate?</p>	++ + - NR NA	Comments:
<p>4.5 Were the analytical methods appropriate?</p>	++	Comments:

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	
4.6 Was the precision of intervention effects given or calculable? Were they meaningful?	++	Comments:
Were confidence intervals or p values for effect estimates given or possible to calculate?	+	
Were CI's wide or were they sufficiently precise to aid decision-making? If precision is lacking, is this because the study is under-powered?	-	
	NR	
	NA	
Section 5: Summary		
5.1 Are the study results internally valid (i.e. unbiased)?	++	Comments:
How well did the study minimise sources of bias (i.e. adjusting for potential confounders)?	+	
Were there significant flaws in the study design?	-	
5.2 Are the findings generalisable to the source population (i.e. externally valid)?	++	Comments:
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.	+	
	-	

APPENDIX 5

Intervention name	Publications appraised by the research team	Brief description	Final shortlist ? (recommended to the advisory group for consideration)	Reason for decision
Incredible Years	<p>1. Nilsen, W. (2007). Fostering futures: a preventive intervention program for school-age children in foster care. <i>Clinical Child Psychology & Psychiatry</i>, 12(1), 45–63.</p> <p>2. Linares LO, Montalto D, Li M, & Oza VS. (2006). A promising parenting intervention in foster care. <i>Journal of Consulting & Clinical Psychology</i>, 74(1), 32–41.</p> <p>3. Bywater T, Hutchings J, Linck P, Whitaker C, Daley D, Yeo ST, Edwards RT. (2011) Incredible Years parent training support for foster carers in Wales: a multi-centre feasibility study. <i>Child Care Health Dev.</i> 2011 Mar;37(2):233-43</p>	These papers detail research on transferring the evidence based parenting programme Incredible Years to foster care.	Yes	Strong evidence base. Already trialled in wales.

KEEP <i>(Keeping foster and kinship parents trained and supported)</i>	<p>1 Price, J. M., Chamberlain, P., Landsverk, J., Reid, J. B., Leve, L. D., & Laurent, H. (2008). Effects of a foster parent training intervention on placement changes of children in foster care. <i>Child Maltreatment</i>, 13(1), 64–75.</p> <p>2. Price, J. M., Chamberlain, P., Landsverk, J., & Reid, J. (2009). KEEP foster-parent training intervention: model description and effectiveness. <i>Child & Family Social Work</i>, 14(2), 233–242.</p> <p>3. Leathers, S. J., Spielfogel, J. E., McMeel, L. S., & Atkins, M. S. (2011). Use of a parent management training intervention with urban foster parents: A pilot study. <i>Children and Youth Services Review</i>, 33(7), 1270–1279.</p>	<p>Developed from the more intensive Multi-dimensional Treatment Foster Care programme. Designed for carers of elementary school age children (primary school). Training and demonstration of parent management training skills in a group format, with a focus on developing skills and providing support to foster parents (16 weeks).</p> <p>Strong evidence base from the United States.</p> <p>Currently being rolled out in England (London and the North-East) by BAAF, funded by the Department for Education.</p>	<p>Yes</p>	<p>Strong evidence base.</p> <p>Although developed in the USA, has already been piloted in the UK (England)</p>
Fostering Changes (revised	Dept of Education, Research Report DFE-RR237 Briskman, J., Castle, J., Blackeby, K., Bengo, C., Slack, K., Stebbens, C., 2010.	Foster carer training programme – 12 weeks@3 hours. Developed in the UK by the Maudsely	<p>Yes</p>	Recent randomised control trial in

programme)	<p>Leaver W. and Scott, S. <i>Randomised Controlled Trial of the Fostering Changes Programme</i> https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/183398/DFE-RR237.pdf</p>	<p>Hospital and Institute of Psychiatry. Carers of 2-12 year olds.</p> <p>Widely used training programme with new evidence of effectiveness. Revised programme includes more emphasis on attachment and education. A programme for 12+ age group is now available.</p>		England showed positive results.
<p>Head, Heart, Hands (social pedagogy)</p>	<p>1. Cameron, C. (2011) Social Pedagogy: what questions can we ask about its value and effectiveness? <i>Children Australia</i>, 36, (4) December 2011. 2. Cameron, C., Petrie, P., Wigfall, V., Kleipoedszus, S. and Jasper, A. (2011) <i>Final report of the social pedagogy pilot programme: development and implementation</i>, available at http://eprints.ioe.ac.uk/6767/1/Cameron2011Final%28Report%29.pdf</p>	<p>Foster carer and residential carer training programme currently being trialled in England and Scotland. Based on social pedagogy. Fostering network delivering the programme and being evaluated by Loughborough University.</p>	Yes	<p>Advisory group and Big lottery Fund asked research team to consider this programme as promising, despite lack of established evidence base.</p>
ABC:	1. Bick J., & Dozier M. (2013). The effectiveness of an	Home based relational	No	Intervention

Attachment and Biobehavioral Catch-up Intervention	<p>attachment-based intervention in promoting foster mothers' sensitivity toward foster infants. <i>Infant Mental Health Journal</i>, 95–103.</p> <p>2. Dozier, M., Peloso, E., Lewis, E., Laurenceau, J.-P., & Levine, S. (2008). Effects of an attachment-based intervention on the cortisol production of infants and toddlers in foster care. <i>Development and Psychopathology</i>, 20(03).</p> <p>3. Lewis-Morrarty, E., Dozier, M., Bernard, K., Terracciano, S., & Moore, S. (2012). <i>Cognitive flexibility and theory of mind outcomes among foster children: preschool follow-up results of a randomized clinical trial. Journal of Adolescent Health</i>, 51(2), 17–22.</p>	<p>intervention for foster carers. 10 weeks of one-to-one sessions. Also used with parents in other settings. Moderate evidence base for use in foster care settings.</p>		<p>designed for carers of infants only. Does not have wider applicability of programmes recommended.</p>
Our Place	<p>Comfort, R. L. (2007). For the love of learning: Promoting educational achievement for looked after and adopted children. <i>Adoption & Fostering</i>, 31(1), 28–34.</p>	<p>Our Place is a Centre situated in Bristol which has been operating for eight years. The centre (a charity) offers a comprehensive package of support for foster carers and adopters, after-school sessions for looked after children, men's groups, women's groups, groups for single foster carers/adopters as well as groups of gay or lesbian foster carers/adopters.</p>	<p>No</p>	<p>Evidence base is weak (description only), although the centre's work appears promising.</p>

Paired reading	Osborne, C., Alfano, J., & Winn, T. (2010). Paired Reading as a Literacy Intervention for Foster Children. <i>Adoption & Fostering</i> , 34(4), 17–26. doi:10.1177/030857591003400403	Four month intervention piloted in Hampshire. Foster carers receive training and support to read at least 3x weekly with primary school aged children. School and SW engaged in programme. Pre-post measures show significant gains in reading age, but evidence is weak to moderate (small sample).	Yes	Although published research evidence is weak to moderate, BAAF have incorporated paired reading into a Fostering education programme with wider roll-out and reported positive outcomes.
Middle School Success Intervention	Kim H.K., & Leve L.D. (2011). Substance use and delinquency among middle school girls in foster care: A three-year follow-up of a randomized controlled trial. <i>Journal of Consulting and Clinical Psychology</i> , 740–750.	Intervention for looked after children to help with transition in summer before entering middle school. Reports less substance use in 3 year follow up but no effect on delinquency.	No	Not tested in UK. Very specific age group.
Childwise	1. Herbert, M., & Wookey, J. (2007). The Child Wise	Foster care training (cognitive	No	Results from

	<p>Programme: a course to enhance the self-confidence and behaviour management skills of foster carers with challenging children. <i>Adoption & Fostering</i>, 31(4), 27–37.</p> <p>2. Macdonald, Geraldine, and William Turner. "An experiment in helping foster-carers manage challenging behaviour." <i>British Journal of Social Work</i> 35.8 (2005): 1265-1282.</p>	behavioural training) programme developed and trialled in the UK.		randomised control trial were disappointing.
<p>Life Books</p> <p>And Personal Life History Books</p>	<p>1. Holody, R. M., & Maher, S. (1996). Using lifebooks with children in family foster care: A here-and-now process model. <i>Child Welfare</i>, 75(4), 321 – 336.</p> <p>2. Kliman, G. (2006). Methods for maximizing good effects of foster care: evidence-based strategies to prevent discontinuities of foster care and raise IQ. <i>International Journal of Applied Psychoanalytic Studies</i>, 3(1), 4-16.</p>	Two research studies on effectiveness of adaptations of life history book interventions. The first is a 'here and now' life story book. The other is a 30 week intensive intervention delivered individually or in groups.	No	Evidence base weak in published papers.
<p>Mental Health and Foster Care training</p>	<p>Minnis, H., Pelosi, A. J., Knapp, M., & Dunn, J. (2001). Mental health and foster carer training. <i>Archives of Disease in Childhood</i>, 84(4), 302-306.</p>	A foster care training programme based on Communicating with children: helping children in distress. It provided extra training on communication and attachment. It is delivered by an experienced social worker and training sessions run for 6 hours	No	Results of strong research study were non-significant for intervention group.

		a day on two consecutive days and a follow up one week later.		
Fostering Healthy Futures Programme	Taussig, H. N., & Culhane, S. E. (2010). Impact of a mentoring and skills group program on mental health outcomes for maltreated children in foster care. Archives of Pediatrics and Adolescent Medicine, 164, 739-746 .	The Fostering Health Futures programme lasts for 9 months and involves manualized skills groups lasting 30 weeks for 1.5 hrs per week for 9-11 year olds(involving cognitive behavioural activities including emotion recognition, problem solving, anger management) and one-on-one mentoring by graduate students in social work lasting 30 weeks (involving creating empowering relationships with the children, teaching them to apply skills learned in skills training to the real world, responding to their varied needs e.g. emotional, educational, recreational). The ultimate aim is to reduce mental health and similar problems.	Yes	The evidence base is strong for this intervention (Colorado), although it is not tested in the UK.

<p>Cognitively based compassion training CBCT</p>	<p>Reddy, S. D., Negi, L. T., Dodson-Lavelle, B., Ozawa-de Silva, B., Pace, T. W. W., Cole, S. P., Craighead, L. W. (2013). All cognitive-based compassion training: a promising prevention strategy for at-risk adolescents. <i>Journal of child and family studies</i>, 22(2), 219–230.</p>	<p>CBCT is a contemplative practice that teaches active contemplation of loving kindness, empathy and compassion towards loved ones, strangers and enemies, Using mindfulness practice it employs cognitive restructuring and affect generating practices to foster acceptance and understanding of others. The intervention is delivered over 6 weeks (2 sessions per week).</p>	<p>No</p>	<p>Quantitative measures showed no significant gains from those who received intervention.</p>
<p>Foster carer training programme (unnamed)</p>	<p>Hill-Tout, J., Pithouse, A., & Lowe, K. (2003). Training foster carers in a preventive approach to children who challenge: mixed messages from research. <i>Adoption & Fostering</i>, 27(1), 47-56.</p>	<p>UK developed and tested training programme. Training to provide carers with skill development, clear plans for coping with emergencies, and strategies to smooth the fit between person and environment. It was delivered to groups of carers over a period of 3 days at weekly intervals (4hrs per session) with a follow up day 3-4 weeks later to discuss</p>	<p>No</p>	<p>Quantitative measures showed no significant gains from those who received intervention.</p>

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