What did they think? An evaluation of the satisfaction and perceived helpfulness of a training programme developed as an indirect intervention for foster carers

Children who are looked after are at greater risk of developmental, mental or physical health problems. Research suggests that this population experiences greater difficulties accessing appropriate services. Sharon Robson and Natalie Briant evaluate a training programme that was developed as a multi-agency intervention for foster carers. It aimed to cover a wide range of topics and increase carers’ knowledge and skills in order to improve the quality of care provided for young people who are looked after and adopted. A content analysis of participants’ responses was undertaken and themes arising from this explored. It was found that their views were generally positive but that the experience of evaluating the training raised a number of issues for the organisers about this type of intervention.

Introduction

Background
At any one time, some 60,000 children are looked after in England and about 90,000 pass through the care system each year (Department of Health, 2004). Looked after children display a high number of risk factors that predispose them to developmental, health and mental health problems (Lindsey, 2000; Hill and Thompson, 2003). Some of these are adverse life events that occurred prior to becoming looked after, others were the reason for entering care. Unfortunately, these risk factors are sometimes compounded by the care system (Richardson and Joughin, 2000).

In recent years, the difficulties seen in children placed for adoption and foster care have increased (Hill-Tout et al, 2003; Kelly et al, 2003), due in part to the fact that children are being placed at an older age and so present a greater number of difficulties (Howe and Fearnley, 2003). Sargent and O’Brien comment that:

. . . given the level of difficulties experienced by looked after children, it is not surprising that providing foster placements is a complex task which foster carers are unlikely to carry out successfully without support. (2004, p 32)

There are particular problems in defining mental health needs, however. Studies which use a broad definition that includes emotional and behavioural difficulties have shown high levels of need within this population. For example, Minnis and colleagues (2006) found that approximately half the children entering the care system were assessed by their foster carer as having considerable emotional and behavioural problems that needed attention from professionals. McCann et al (1996) investigated the adolescent looked after population in Oxfordshire and found high numbers of significant and untreated mental health difficulties, with an especially higher proportion among young people placed in residential care. Mount et al (2004) found that carers perceived 70 per cent of the young people in their care to have mental health issues. There are similar elevated levels of difficulties in children who are adopted (see Rushton et al (2006) for a fuller discussion). Recently, the Department for Children, Schools and Families (DCSF) has requested that the Strengths & Difficulties Questionnaire (SDQ) (Goodman, 1997) be used as a measure of emotional well-being and as a mental health/screening instrument for all looked after young people aged four to 16 years who have been in care for one year. Since this is a performance indicator, the data will be collected nationally and so will provide more detailed information on these matters.

Emotional and behavioural difficulties

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have a pervasive impact on young people in all areas of their life, including school, family, communication and peer relationships. Such difficulties also affect carers and the ease with which they feel able to parent looked after children. Ironside (2004) describes how the challenging emotional experience of parenting a looked after child can cause foster carers to feel insecure and inadequate. Hill-Tout et al (2003) comment on how carers struggle to manage challenging behaviour and feel increasingly isolated until, finally, the placement breaks down. Herbert and Wookey (2007) report the helplessness that foster carers feel when faced with the high levels of challenging behaviour presented by some looked after children. While there is some suggestion that children with a greater number of difficulties prior to entry into care experience greater placement instability (McCarthy, 2004), it is also true that the experience of placement breakdown itself affects mental well-being and increases the young person’s vulnerability to developing problems. In recognition of this, the Quality Protects initiative (Department of Health, 1999) has focused services upon increasing placement stability and providing support for foster carers.

Despite the high prevalence of mental health difficulties suggested in the literature, there is evidence that few looked after young people access mental health services. For example, Mount et al (2004) found that fewer than half the young people identified as having such problems were seeing a professional. This is supported by anecdotal evidence from professionals, both locally and nationally. Various authors have discussed why this discrepancy occurs and the reasons for it, such as failure to identify difficulties, placement moves or uncertainty, young people’s reluctance to engage and paucity of provision (see Mount et al (2004) and Sargent and O’Brien (2004) for a fuller discussion). There is also general agreement that traditional Child and Adolescent Mental Health Services (CAMHS) models are not effective in meeting the mental health needs of looked after children. Rushton et al (2006) note the importance of adapting interventions to meet the specific needs of enhancing parenting and illuminating the ‘meaning’ of behaviour for adoptive carers, a situation that similarly applies in foster and kinship care contexts. Taylor et al (2008) develop this idea further and show how the beliefs held by the adult about the reasons for a child’s behaviour influence how that carer responds to him or her.

The local model
Various models have been proposed to provide effective mental health services for looked after young people. For example, Odell (2008) argues the benefits of a strengths-based model. Arceclus et al (1999) describe a structural approach that provides flexible, direct access for looked after young people. Street and Davies (2002) propose an intervention that views the child’s behaviour in the context of their attachment patterns, care relationships, history and the care system itself. They stress the importance of considering these different levels when intervening.

Hill and Thompson (2003) point out that ‘mental and physical health services have traditionally been separate. There are obvious pitfalls in professional separatism’ (p 318). We are in an unusual situation in Northamptonshire because the local authority funds a specialist health service (Centre for Health). This is positioned within social services but primarily staffed by health professionals. For many years, the aim of this service has been to consider the needs of young people within a holistic context and engage the carers and the young person in a partnership agreement. The Centre for Health team works alongside a small group of professionals from the local CAMHS who have a particular remit for working with looked after children. This has led to the development of a range of services to address mental health needs, promote emotional well-being and provide
physical health care. Hill and Thompson (2003, p 319) comment that:

... fundamentally, it is important that health practitioners are trained and aware of the mental health problems experienced by looked after children and develop integrated links with child and adolescent mental health services.

We would claim that our local service does this and facilitates the integration of physical, social and mental health dimensions in a unique way.

Since both teams have limited resources, we carefully developed an appropriate service model. We aimed to incorporate attachment models and ensure that young people were not expected to make and break more relationships than absolutely necessary. This led to a staged model (Figure 1) and a slow development of the service to ensure sustainability. The approach has been designed to provide a flexible, responsive service that carers can access directly and that will meet physical, emotional and mental health needs. As can be seen in Figure 1, the local model prioritises training and consultation as interventions of choice. While some young people may require direct interventions, this service aims primarily to work with the people around the child.

**Figure 1**

Diagram of model for C4H and mini LAC

Stage 3: Direct work with a young person

Stage 2: Indirect work with carers or joint work with carers with a young person

Stage 1: Training, consultation, screening and audit (Stage 1 work is expected to make up the majority of involvement by the service)

**Why develop training?**

Foster care is often perceived as a ‘holding’ environment rather than an activity that promotes change within a young person. However, Street and Davies (2002) suggest that ‘therapeutic parenting’ can contain behavioural problems and lead to improvements in the young person’s psychosocial health. They argue that foster care should be seen as offering these possibilities.

Wilson (2006) has investigated the characteristics of successful foster care and found that one component is the foster carer’s experience, understanding and child-centredness. In addition, we know that carers require the skills and knowledge to manage behavioural difficulties and ‘cope with a wide variety of mental health issues, ranging from the more mild and moderate to the extreme’ (Sargent and O’Brien, 2004, p 32). Our question then became how best to enhance this knowledge and skill in carers within the possibilities of our limited local resources. Mount et al (2004) propose that ‘a pragmatic inter-agency training programme to enhance early identification of mental health concerns, seems a useful beginning’ (p 379) and Together We Stand (Health Advisory Service, 1995) suggests that indirect interventions can be more effective than direct ones.

Training is obviously a common intervention used by other professionals working with this client group. This has mostly comprised parent-training groups based upon social learning theory. For example, Street and Davies (2002) discuss group training as a useful intervention and Hill-Tout et al (2003) provided foster carers with a behavioural management programme over three days. Warman et al (2006) and Golding and Picken (2004) developed a broader curriculum than is typical of behaviour management programmes but delivered this over a longer period. Gilkes and Klimes (2003) ran a similar course for newly accepted adopters, and Herbert and Wookey (2007) adapted a course for foster carers. These were well received and felt to be useful by foster carers.
But despite these auspicious contexts, as Sinclair (2005) points out, there is little evidence that these interventions lead to change. Certainly Hill-Tout and colleagues found that a three-day course did not produce significant differences as measured on the criteria they employed, although Warman et al did find that some change occurred in the foster carers’ stress and distress as well as there being some benefits for the children. Golding and Picken (2004) also found evidence of positive effects but acknowledge that their evaluation tools were not tested for reliability or validity.

Locally, we see the value in adapting parent-training group approaches for our client group and would place these within Stage 2 of our model and view them as indirect interventions. Training within Stage 1 of the model is perceived more akin to academic advancement and relies more upon an adult learning model. In this way, it is more similar to the training developed by Minnis and Devine (2001). We see our training as primarily an opportunity to increase carers’ knowledge and not necessarily focused around current difficulties with a child. It seeks to increase the overall quality of care within the service and thus promote placement stability. In this way, it complements our whole model and can be seen as both primary prevention and early intervention.

We decided to intervene at a systemic level with foster carers, although within our local service all training must also be open to adoptive parents and kinship carers. A few from these other groups attended the training but their number was so small that we have not distinguished between their responses in this article and will use the term ‘foster carers’ to refer to all participants.

The aim of training
The aim of this training programme was to provide information and a basic theoretical context to increase foster carers’ knowledge and understanding of children’s difficulties. This would enable them to formulate difficulties better. We also sought to develop foster carers’ skills in managing behaviour and provide them with useful practical ideas and techniques. In addition, we aimed to provide a basis upon which the professionals involved could build more specialised or complex interventions. Given the knowledge that foster carers are often unsupported as they struggle with difficult behaviour, we also felt it was essential to address issues of self-care. All of these aims complemented the Centre for Health’s service aim of promoting placement stability.

Course content
We developed a comprehensive course that introduced a range of theories, techniques and models. This started off as a simple programme and grew as components that we felt important were added. At the end of the development process we had compiled a course that was planned to run one day a week over four weeks. The curriculum was varied and included:

- introduction to local services for foster carers, e.g. how to access help, what type of help could be expected;
- self-care techniques, e.g. the importance of looking after oneself, stress management strategies;
- anxiety and anger management strategies, e.g. ways of explaining this to young people;
- improving emotional literacy, e.g. modelling emotional expression, reflective listening;
- attachment and attachment interventions, e.g. child-directed play, family attachment narrative approaches;
- formulation, e.g. common core beliefs;
- dealing with disclosures of abuse/supporting survivors of abuse, e.g. avoiding burnout, managing flashbacks;
- common mental health disorders, e.g. what the disorder looks like, differential diagnoses, tips to manage;
• communication and transactional analysis (TA), e.g. Ego State model, tips to improve communication;

• behaviour management techniques, e.g. consequences, how to praise.

Topics were delivered in discrete blocks, roughly in the order above. While we provided a great deal of information orally and via handouts, we also used interactive learning techniques such as group work. We also encouraged discussion about the topics, with reference to the personal situations of participants. As facilitators, we aimed to highlight links and overlaps between the different parts.

Method
Having developed the course content and made adjustments to the programme, we decided to pilot and assess participants’ reactions in order to obtain a more formal evaluation of the topics in the curriculum. This took the form of quantitative data on usefulness and satisfaction. In addition, participants were asked to provide qualitative feedback, for instance, by finishing a statement such as, ‘One thing that was particularly useful for me personally was . . .’

The evaluation questions were adapted from the existing Northamptonshire County Council training evaluation forms. The results are drawn from two groups that were facilitated by the two authors in the autumn of 2006. As planned, the courses were run once a week on the same day for four weeks and were timed to fit into the restrictions imposed by school obligations.

Demographics of the two groups
Group A contained 11 participants and Group B 17. In Group A, all the carers were female, whereas in Group B there were two men. Participants in both groups were predominantly foster carers. There was a slight difference in the age range, with Group B having a wider agespan. However, the majority of participants were aged between 36 and 65 years. All had asked to attend the training and places had been allocated on a ‘first-come’ basis.

The groups differed in the mean length of time people had been fostering. In Group A, the average time was ten years, with a range of 18 months to 24 years. In Group B, the average was lower at 6.3 years, with a range between three months and 18 years. Despite these differences, both groups contained a mix of participants in terms of experience.

Eleven participants fostered primary-aged children, seven fostered secondary-aged children and four fostered children in both age ranges. The actual age spreads of children varied between participants and few foster carers accepted exactly the same-aged children. Carers generally fostered two children, although some were fostering as many as four while others had none currently in placement.

Results
Satisfaction with the individual topics
Participants were asked to rate the helpfulness of each topic on a 10-point Likert scale, where 0 was not at all helpful and 10 was extremely helpful.

Group A rated the environmental strategies component as the least helpful (mean = 8.91) and the attachment play interventions as the most (mean = 9.9). Group B rated the reflection component as least helpful (mean = 7.84) and the communication and transactional analysis components as most (mean = 9.33). Overall, participants rated the programme as very useful, with the mean rating being 7 or above, although there was wide variation among individual respondents in their ratings of specific components.

Qualitative feedback
Participants also provided qualitative feedback for each day of the programme. In addition to completing unfinished statements, they were invited to add any further comments. This information was amalgamated and a
content analysis undertaken. Comments were grouped into particular themes, as reported here. To highlight these, we have included some illustrative quotations. Since participants were asked to provide written information, this was often brief and has less depth than would emanate from interviews or informal conversations. But while this information is limited, it is congruent with the evidence gathered from other sources.

The first question asked what they had enjoyed about the course. Participants responded generally, for example, ‘the content was brilliant’, ‘all of it’. Noticeably, both groups commented more on specific components on the day that attachment theory and interventions were discussed. This topic appears to have been particularly useful to the carers. A number of comments were also made about presentation and delivery. This was a superordinate theme that included components of presentational style, such as ‘clear examples’, ‘mixture of input and stories’, ‘the interaction between the tutors is good, how they all input their ideas as subjects are delivered’; it also related to the written information given, e.g. ‘lots of handouts to revisit subjects as necessary’. On the first day there were a number of comments related to talking to other carers and sharing experiences, for instance, ‘meeting new foster carers’, ‘all the talks we had as a group’.

The next question asked what participants disliked (see Figure 2). The majority of participants said that there was nothing they disliked. Group B made several comments about the time pressure and the number of participants, criticisms that were not mentioned by Group A, although it had its own gripe about the geographical distance of the training venue from people’s homes. Some of the things that people disliked were related to personal issues. This varied from ‘it brought out deep feelings as I was an abandoned baby’ to ‘a bit apprehensive about playing with toys’ or ‘not good at writing things down’.

Responses to the question ‘one thing that was helpful to me personally’ were often incorporated into a superordinate theme about personal reflection and growth. Within this, there were three patterns. The first was recognition and validation of the weight of their own importance within the care relationship and the skills that they already had: ‘reinforcing that I have to look after me’, ‘confirming how I dealt with a
disclosure was good’. Another sub-theme related to the acquisition of new skills, for example, ‘help me to see . . . how I can develop [my responses]’, ‘how I can approach different ways to communicate’. A third perspective related to a growing awareness of their own contribution to behaviour and environment, as in ‘I learned how to manage my own feelings as well as the child’, ‘I need to stop and listen to what I am saying’, ‘making me take a step back and think before I speak’ and ‘I have also learned to look at myself differently and hopefully understand the children better’.

When participants were asked to comment on ‘something that made me think’, the responses could be divided into three themes, as shown in Figure 3. There were general comments such as ‘all of it’, but the majority of replies were related to specific components, such as ‘child-directed play’, ‘behavioural strategies’ and ‘communication’. Perhaps the most interesting superordinate theme concerns personal awareness and growth. Here the three main sub-themes were: first, increased awareness of the child’s perspective, e.g. ‘think more about how they are feeling’, ‘about where the child is coming from’; second, increased awareness of the impact of foster carers’ own beliefs and behaviour, e.g. ‘my reactions’, ‘how I always want to ask questions and be in control’ and ‘expectations which we have of children that can be unrealistic’; and third, was ‘doing it differently’, for instance, ‘realising how to speak differently’ and ‘to re-word what you do and say’. A smaller sub-theme was the need for carers to look after themselves.

When asked for other comments, many participants made general points. These included many positive statements about the style of presentation and the practical usefulness of the programme. In addition, people made constructive comments about its structure and practicality, such as how it should be made available to more people and to specific groups, such as new recruits, social workers and kinship and adoptive carers. Some recommended that the most appropriate day to run a course was mid-week since school activities, teacher training days and school assemblies often take place on Mondays and Fridays. Others criticised the geographical location, preferring somewhere close to home. In Group B, there were comments about the difficulty with keeping to time and holding discussions in a large group.

**Discussion**

There were many individual differences in how positively various components of the course were rated, which support our decision to retain a broad curriculum.

In general, the feedback from participants echoed our views as facilitators. Practically, it had been difficult to fit all the participants in the second group into the room, so that some had trouble seeing the overheads or hearing all that was said. As facilitators, we also noticed that we were less able to support participants who were struggling to understand a particular concept and had less time to help them during the small-group exercises. Discussions often had to be curtailed owing to lack of time and
we felt that this was detrimental to the aims of the training. We also noticed that Group B was less cohesive, although this could be due to differences in members’ characteristics as well as to the greater variance. The combination of the feedback and the experience of facilitating such a large group meant that we have since decided to restrict membership to 15 participants.

We found it interesting that, overall, participants rated ‘reflection’ as being less helpful than other specific components of the course, despite the fact that the qualitative feedback contained a large number of reflective comments. We wondered whether these would have occurred without first introducing the topic on ‘reflection’. It is quite possible that providing this component at the start of the training influenced the growth and reflective process of the participants. Indeed, Walker (2008) views the acquisition of reflective function as one of three important capacities found in good substitute carers.

One theme that emerged in several responses highlighted the influence of the training on the relationship between the carer and the young person. It was heartening to see that participants were becoming more aware of the way in which early experiences had influenced the young people in their care, and their own part in maintaining unhelpful beliefs, especially as it contrasts with Taylor and colleagues’ (2008) finding that foster carers did not comment upon their own role in children’s behaviour when considering possible causes. We hope that the increased awareness displayed by our participants was reflected in practical improvements in the care they offered.

As professionals, we felt it was important to include some emphasis on self-care for carers. Before running and evaluating the training, we had been unaware of the effects on participants of helping them to recognise their importance in the care relationship. We were unclear whether carers simply did not have a concept of self-care or accepted that it was unlikely to be acknowledged by professionals. This seemed to be an extremely important component of the course and we would query the degree to which it is sufficiently recognised by those responsible for training.

**Implications for the process of training foster carers**

During the evaluation, we encountered six issues that we think deserve further consideration. First, we had no prior knowledge of who would be attending the course and no information about their personal histories. During the training, and through the qualitative feedback, participants explained some of the ways in which the training had influenced them personally. This included greater understanding of their own childhood, particularly as a ‘child in care’ or ‘abandoned baby’, as well as increased insight about difficulties their own family members might be experiencing, for instance, ADHD or problems overcoming experiences of abuse. Our experience highlighted the need to manage these issues through the contracts we made with the group, through interactions during break and lunch times, the support we are prepared to offer outside the programme and the language used when delivering its content. This will always be an issue in facilitating such training because we can never know whether the participants have learnt the self-care skills that can be taken for granted when training professionals.

Second, we have become more aware of the challenges of delivering training to a group of people who are not necessarily prepared by educational attainment or professional standards. This posed particular difficulties for understanding theoretical concepts. While some participants found these components extremely useful, others struggled to understand even quite basic ideas. This difference was easier to overcome in the smaller group. It would be possible to solve this problem by setting different levels of acceptance criteria; however, this would have the disadvantages of being hard to imple-
ment and of excluding carers who are potentially the most needy. Given the resources to do so, it might be most useful to set up a mentoring system to provide extra support outside the training sessions to those who require additional help with these matters.

Third, we were aware that our training has a widely varied content and a busy programme. We made a purposeful decision to retain this broad range rather than reduce it or make greater use of experiential learning techniques. The variety has the advantage that all participants find something useful and do not have to ‘suffer’ for long through a component they find irrelevant or difficult. However, the disadvantage is that components are covered at a more theoretical level and often more quickly than is ideal. We have tried to compensate for this by incorporating several learning styles, opting for an informal presentation style, using ‘live’ practical examples and ensuring that participants have good written material to refer to in the future. This mix poses its own problems. For some participants, the small-group activities were personally challenging, especially if it involved role play. As we have seen, others found theoretical concepts hard to grasp. Such difficulties could be overcome by vetting participants and then developing a course content and learning style that best suits them. However, this was not possible within our resource limitations.

Fourth, there were practical issues. Some people were concerned about the geographical distance, timing or choice of days on which the course was held. In providing any such training in a large county such as Northamptonshire, it is difficult to accommodate everyone’s needs. Our decision was to place the training in a reasonably central location and ensure that the timing meant that participants who had to travel could do so around the timing of school runs. Decisions about days are often inevitably made around the timetables of the facilitators. However, we have become more aware of the need to provide some training courses outside normal working hours to ensure greater accessibility, even though this produces its own financial and organisational challenges.

Fifth, we faced the typical challenges presented by a varied group of participants. Some of our carers felt themselves to be very experienced and were reluctant to consider new techniques. Often these were the ones whom we felt were most in need of new ideas. It is significant that Minnis and Devine (2001) found that carers who had looked after the greatest number of children were more likely to experience placement breakdown. In our groups, there was little doubt that some of the participants were from an older generation and held views typical of their age group, making it hard for them to embrace components such as child-directed play or using praise.

Sixth, we faced problems in presenting a demanding programme to a varied group. Breaks and lunch times were used by participants to have further discussion with us, often about specific issues. This aspect was encouraged as it allowed us the opportunity to provide early intervention and sometimes preventive action. In other cases, we were able to ensure that the child and carer were directed to appropriate services. These challenges made us realise that the day’s training was personally and professionally very demanding.

Since running the training we have received a positive response from the wider system but this too has raised another set of challenges. Within the care system there are professionals who would like to make the course mandatory for all carers. At present we have a self-selecting group, making participants more receptive to ideas and changes in practice. If the course were mandatory, greater adjustments to the content and presentation would be needed in order to satisfy less-receptive carers. We currently run the training twice a year and are under pressure to accommodate larger groups but, as explained, we feel that extra demands would make it less effective and less helpful to participants.
We are aware that these results only provide information about the perceived helpfulness of the course. We plan to continue to evaluate the group in terms of the effect upon carers, child behaviour and placement stability. Some previous studies (eg Hill-Tout et al, 2003) have found that, although training for foster carers is often rated as helpful, it has little demonstrable impact upon child behaviour; however, others (e.g. Warman et al, 2006) report some benefits for carer stress and carer-reported child difficulties. Given that these studies have tended to evaluate parent-training type interventions, it is important for us to know if our different approach effects change, as this would inform the development and running of the course, indicate its cost-effectiveness and justify its replication.

Conclusion

Our experience of facilitating this new model of training and the results that have been presented suggest that the programme works well and that participants find it helpful. But it is only by proper evaluation of this and other similar adult-learning training models that we can be sure about their ability to produce change and offer a cost-effective intervention that helps looked after children.

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