WHAT WORKS IN PREVENTING AND TREATING POOR MENTAL HEALTH IN LOOKED AFTER CHILDREN?

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Declaration of interest

Dr Woolgar is one of the authors of the Fostering Changes programme, which is discussed in chapters 4 and 5. He teamed up with the Rees Centre on the current report to provide advice about the mental health assessment and treatment of looked after children from a Child and Adolescent Mental Health Services perspective. He did not contribute to the evaluation and discussion of Fostering Changes in this report.

CONTENTS

EXECUTIVE SUMMARY

Background

Looked after children and young people have consistently been found to have much higher rates of mental health difficulties than the general population, with almost half of them (three quarters of those in residential homes) meeting the criteria for a psychiatric disorder.[1] There are many reasons for this, including the experiences they have had in their birth families before coming into the care system. Children's experiences, once they enter care, are also linked to their well-being and can further contribute to both the causes and the nature of any difficulties. Despite these possibilities, there is evidence that many of the children who are in care do better if they remain there and are not returned home. The task of this review is to determine how these benefits can be further enhanced: for example, by taking children's experiences into account in the selection of specific interventions, and in understanding their capacity to benefit from these interventions.

The emerging evidence provides some key messages that may challenge existing assumptions about the 'best' type of mental health interventions for this group. The first is that one should expect diversity in outcomes following maltreatment and neglect because of the range of individual factors (biology, personal characteristics) as well as environmental factors (experiences before and in care, situational context) that contribute to each child's response. The uniqueness of individual responses to early adversity is one reason for the importance of ensuring an adequate assessment is undertaken. A second message is that it may be helpful to avoid thinking of the consequences of maltreatment simply in terms of 'damage' done to the child, even while recognising that looked after children are at a significantly elevated risk of mental health and well-being problems. A response that is a strength in one context (eg detecting threat) can become 'problematic' in another. Understanding why 'problem' behaviours may have developed is key to finding effective interventions.

Aim of the review

This review was commissioned by the NSPCC in order to provide an overview of the evidence available to address the question:

What works in preventing and treating poor mental health in looked after children?

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1   For example, see Ford et al (2007); Meltzer et al (2003).

In order to do this we focused on identifying and bringing together original evidence and relevant reviews, including 106 individual studies of interventions identified from searching the literature and suggestions made by an international panel of experts in the field. The report focuses mainly on care in England, although in reviewing interventions we also discuss evidence from international studies. This evidence informs our conclusions on possible next steps and we have made clear the relationship between the evidence we cite and the recommendations we make.

The review distinguishes between the effects of 'add–on' interventions (eg therapeutic services or mentoring), and the effects of variations in the quality of 'ordinary care' provided (eg whether the foster placement is a good one). Differences within ordinary care can be a powerful influence on well-being for children in residential and foster care, as well as providing the context for any additional interventions. The discussion of ordinary care, therefore, forms the foundation of our review; we build on this by considering the key tools used in the assessment of mental health and well-being in looked after children, and the specific interventions that have been used.

Methodology

The review of 'ordinary care' was informed by two recent reports that drew on research produced by the Care Inquiry (2013a) and NICE/ SCIE (2010). Both reviews base their recommendations on broad principles that combine beliefs about what well-being is and how it is to be brought about. Our review moves beyond these two reports to identify a body of interrelated evidence in order to synthesise the key issues in the care system that are relevant for looked after children's well-being. We review a range of evidence that enables us to draw some general conclusions for policy and practice.

Our discussion of tools used to assess mental health and well–being focuses on the instruments that are commonly used in practice with looked after children and that have been tested in research studies with this population, to allow us to say something about their usefulness in both contexts. Our literature search for evidence on how these tools have been used in research with looked after children was guided by experience of their use in the clinical context.

Finally, our literature search on specific interventions covered any programmes that were listed as targeting behavioural, emotional or hyperkinetic outcomes for looked after children and young people. The search of relevant databases and websites (see list in appendix C) uncovered 12,476 original research articles and literature reviews on interventions specifically tested with looked after children. We restricted our discussion to interventions for which we found two or

more articles evaluating the approach. From the screening of the titles and abstracts identified, we selected (on the basis of the criteria in appendix C) 106 studies to be included in the synthesis.

Key findings

Overall, the review of the general literature on care suggests that the importance of positive aspects of ordinary care in predisposing looked after children to benefit from interventions targeted at improving mental health and well-being should not be underestimated.

Characteristics of ordinary care associated with mental health and well-being

Before and after care

This report focuses on what happens to children *in* the care system, for it is there that the specific interventions take place. However, chapter 2 includes some discussion of before and after care as well as a specific section on those 'graduating out of care'. Appendix A gives our conclusions on these 'care leavers'. The following summarises some of the main findings from studies on the time before or after care.

In general, decisions over admitting or discharging children from care need to be taken as early as possible, but also take account of the wishes and rights of the child and family, to make the 'right' choice. Relevant findings are:

- The earlier children are placed in any kind of permanent placement, the more likely that placement is to succeed.

- Measures of well-being tend to be better among children who remain in care compared with apparently similar children who return home.

- The 'success rate' of children who do return home is not high: around half return to care.

- Those who return to care do not fare as well as those who have not experienced failed attempts at reunification.

There is a 'consensus model' on how to balance the conflicting considerations involved in decisions over entry or discharge from care. This model involves:

- agreement by families and older children on what needs to change; the speed at which it needs to change, and the consequences if it does not do so

- the ability to keep children safe while decisions are being taken

- the availability of alternatives (eg adequate numbers of potential adopters)

- resources (eg effective local programmes for treating addictions) that will tackle the problems identified

- purposeful work that is not rushed, but equally does not delay and put off hard decisions.

The evidence suggests that the application of this consensus model may have different consequences for older and younger children. With younger children, placement delays are reduced while the children themselves remain equally or more likely to be adopted. Therefore, the risks of further maltreatment may be reduced. On the other hand, older children involved with drug and alcohol projects are more likely to be returned home or allowed to remain there than they might otherwise have been. Although follow-ups of these older children are typically short-term and not focused on their well-being, there is some evidence to suggest that they may be at greater risk of failed attempts at rehabilitation. American studies suggest that application of the model to children in the care system can increase the probability and the appropriateness of allowing children to return home, but also indicates that the model is difficult to apply consistently on a state-wide basis. The main risk of the consensus model is that it may encourage the return of older children to their homes without ensuring that the necessary supports for this are available on a long-term basis.

In care

Comparisons between adoption, special guardianship, permanent fostering and residence orders are rare and hard to make. However, in general:

- Differences in outcome between permanent care options reflect the differences in the ages at which these orders tend to be made, with very young children being far more likely to be adopted and to 'succeed'.

- If allowance is made for age, there remains a slight advantage to adoption and this might be expected to become more pronounced after 18, but the relevant research has not yet been done.

- Children can do well in all kinds of permanent options, but will not necessarily do so.

- Specific circumstances, such as the child's age and wishes, or the existence of a bond between the child and other family members or with their foster carer, may suggest preference for particular permanence options.

Increases in the availability of different forms of permanence reduce the strain on the care system and increase choice, without apparently resulting in the reduced use of other permanent options.

Other types of placement are not necessarily intended to be permanent. Ordinary foster care, for instance, is often unable to provide effective placements for the most challenging children; residential care has very varied results depending on the quality, while both residential care and Multidimensional Treatment Foster Care (MTFC) as yet have failed to consistently demonstrate lasting effects.

Effective foster placements and residential units depend on the quality of the carers, staff and heads of home. In residential care, the degree to which the head and staff agree on their approach, establish 'warm' relationships with residents and have clarity of expectation about behaviour and education are key to the impact of the home. In foster care, warm, sensitive carers, who are committed to the child and clear about what they expect of him or her are more likely to be successful. Other factors that influence the outcomes of these placements include:

- The behaviour of the child and their attitude to being in care; relationships with other foster children and adults in the foster home; the nature of contacts with their birth family; and how the child gets on at school – these may all affect the likelihood of disruption and other negative outcomes.

- Even given good carers or staff, 'cycles' of difficulty can arise with the stability of the placement and the well-being of the children or young people.

- The costs of residential care and MTFC are such that few children can remain in them long-term. This suggests that these options should probably only be used for those young people who are expected to return home (or to a long-term placement), with intensive support offered to their families when they do so.

- We lack proven models for selecting, training, supervising and quality-assuring carers and staff in such a way that the quality of care is enhanced.

The effectiveness of assessments of mental health and well-being for looked after children

The 'usefulness' of assessment instruments in research depends on their ability to detect change in individuals over time; their usefulness as clinical screening tools depends on whether they are capable of predicting mental health service need (when used by non-clinicians) or, for clinicians, whether they can help to select and direct the allocation of resources or further diagnostic assessments. Ease of use

is also an important consideration. Taking this range of uses into account, key findings that emerged from the review included:

- Use of the Strengths and Difficulties Questionnaire (SDQ) with looked after children has been shown to provide a good estimate of the prevalence of mental health conditions, allowing the identification of children with psychiatric diagnoses based on the Development and Well-Being Assessment (DAWBA).

- Caregivers' and teachers' responses on the SDQ have proven to be more useful than self-reports and its use as a screening tool during routine health assessments for looked after children has been shown to increase the detection rate of socio-emotional difficulties.

- The SDQ, Child Behaviour Checklist (CBCL), Children's Global Assessment Scale (CGAS) and DAWBA can be scored and assessed to determine children's clinical needs. The SDQ, CBCL and CGAS may be more useful as broad measures of well-being than for assessing specific conditions.

- The DAWBA's use of different types of questions and added focus on patterns, duration and impact of symptoms may explain why it is most effectively used by clinicians, especially with complex cases where clinical judgements are needed.

- The reliability of assessments depends on who is completing the instrument; in what context; and the skills of the person interpreting them.

The effectiveness of specific interventions

Limitations of the research make it difficult to say a particular intervention or factor has been shown to 'work', leaving us with a set of common principles that require more rigorous testing. These include:

- Structured programmes focusing directly on the child are more effective when they have core components with some flexibility to meet individual needs, and a 'joined-up' approach from services with follow-up support.

- Approaches to behavioural issues that focus on the carer (and thereby indirectly on the child) are more effective when they are underpinned by a combination of attachment theory and social learning theory that informs relationship-building, focusing on caregiver sensitivity and attunement, positive reinforcement, behavioural consequences and limit-setting.

- Approaches to behavioural and emotional issues are more likely to be effective when they include some focus on developing relationships and understanding; targeting both the caregiver's understanding of the causes of children's behaviour and the young person's understanding of their own emotions and identity.

- Consistent approaches that reflect fidelity to the programme are associated with better outcomes.

- High levels of commitment from both carers and young people enhance the efficacy of the interventions.

Looked after children have complex histories and needs, and it is unlikely that a single intervention or one that focuses only on the child will address all of these needs. However, few interventions take the mixed approach needed to target both the child and the system around them, for example their carer, school and social worker, even though there are indications that for some children this might be the most effective. Of the interventions reviewed, perhaps the most promising is Fostering Changes, which shows improvements in carer-rated behaviours – including in one randomised controlled trial (RCT) – but lacks a longer-term follow-up. Fostering Changes might be used to address broader or lower-level issues of well-being, as a way of preventing further escalation and the involvement of more intensive mental health services.

Recommendations for policy and practice

Recommendations for ordinary care

The ethical principles that are the foundation of the Care Inquiry (2013a) and NICE/SCIE (2010) reports require that practitioners:

- place the children's relationships at the heart of all they do

- listen to and empower children and young people and their families

- tailor specific interventions to their particular circumstances.

These principles offer a basis for a wide variety of practical recommendations for policy and practice – for example, that children should have a say in what kind of placement they have and that, if possible, particular placements should be tested out before committing to them. Where rotating, shared or respite care has been chosen, the same carers rather than a succession of different ones should be involved. Finally, the harm done by failed reunifications should be reduced by enabling children to remain in touch with and return to former carers with whom they have a good relationship.

The ethical principles outlined above should also inform the use of the evidence given in chapter 2. In relation to the findings on 'before and after care', these suggest that:

- Local authorities should attempt to identify children at risk of entering care as early as possible, since this will enable early decision taking.

- All authorities should adopt the consensus model as a basis for their work with children of whatever age, whether in or out of care, and resource it appropriately, ensuring for example that there is adequate provision for those with drug addiction problems.

- Local authorities should be particularly careful to ensure that the return of children at high risk to their parents is adequately resourced.

- They should monitor their performance in these respects with particular reference to the numbers of moves that children experience before a permanent placement and the age at which the relevant decisions are taken.

- Evaluation of the effects of schemes using the consensus model should include long-term follow-ups and an examination of the effects on the well-being of the child.

A range of permanent and other placements need to be in place in order to support this model – to enable young children to move out of the care system if they cannot go home, and to enable others to remain within it on a long-term basis. The evidence suggests that more permanent placements are needed, and will need to include:

- adoption by strangers and foster carers

- special guardianship orders (SGOs) largely to kin, but also to foster carers

- residence orders

- properly supported fostering by kin

- permanent fostering by stranger foster carers (ie as in the Department for Education policy informed by Schofield et al, 2012), a more clearly delineated option with greater delegation of responsibility to the foster carer and more possibility of staying on for the child.

Other placements that are needed include:

- permanent care by foster carers and kin with greater delegation of responsibility to the foster carer and more possibility of staying on beyond 18 years (something promoted by national policy but requiring reallocation of resources both nationally and at local authority level)

- 'ordinary' foster carers who are trained in the techniques derived from the principles underlying intensive fostering systems so that their capacity to care for challenging children without costly interventions is enhanced

- long-stay residential care options that are less costly and less intensive than current models and can accommodate those who would choose residential care but do not require intensive adult support

- MTFC and treatment residential care, for those who are expected to return home or move to a long-stay placement and whose families will be offered intensive support when they do so.

Above all, there is a need to improve the quality of placements, not because they are poor, but because this is the key to how the children do in care. So there is a need to select good carers, residential staff and heads of home; to train them appropriately; to supervise them so that short-run cycles of trouble do not occur or are addressed promptly; to make their performance the focus of quality assurance and to ensure that poor quality provision is not used. In practice, there are a variety of ways of approaching these issues and proven methods of doing them are not available. As discussed below, some models of training are more promising than others and there is an urgent need to build on these. In the meantime, the highest priority should be given to developing and testing models for selecting, training, supervising and quality-assuring foster carers and residential staff.

Recommendations for assessments

The review of assessments suggests that local authorities should note the following in promoting the mental health and well-being of looked after children:

- The assessment instruments considered in this review are helpful as part of the regular system of checks that local authorities use to monitor looked after children's progress in care, enabling services to pick up on any issues at an early stage.

- The SDQ, for example, comes in a short and user-friendly format that enables it to be completed on a regular basis by caregivers or primary healthcare staff.

- The SDQ provides an easy way of monitoring children's well-being over time; it could give a broad indication of those who are having significant difficulties and may need further assessment, though the data collected could be much more extensively used.

- There is further room for the development of tools that assess the child *in their context*, to enable practitioners to identify where the interaction between child and context might be especially problematic and, therefore, require early intervention.

Recommendations for interventions

This review of the interventions targeted at preventing problems and enhancing the mental health and well-being of looked after children suggests that policy makers and care providers need to consider the conditions under which interventions are effective and the longer-term sustainability of the reported effects. The key messages to emerge from the review suggest that:

- Interventions should be selected that offer evidence of flexibility to meet individual needs; a 'joined-up' approach from services, and follow-up support.

- Attachment theory should not be regarded as the sole framework for understanding children's behaviour: many effective programmes also incorporate social learning theory and some emotional issues may require alternative approaches.

- Those designing interventions should explore the opportunity to include components where adult and child work together for part of the time, as these offer a promising avenue for future work for some children.

- Efforts should be made to ensure that support for children and carers is consistent; for some interventions, this support should extend beyond the end of the intervention.

- Foster carer training should also be complemented by ongoing 'consultation' in order to ensure that carers can generalise what they have learned in the context of a specific carer-child relationship and apply this to their work with other children.

Recommendations for future research

Overall, research should focus more on the positive outcomes that looked after children want and how these can be achieved, and less on the problems. Conversely, more is needed on what maintains problems or allows gains (eg greater ability to control one's behaviour) to transfer across settings. There is insufficient robust research that addresses the key problem of how to ensure that care is of high quality – whether this is through selection, training, supervision, intervention at key points, or quality assurance. Future research needs to:

- Incorporate more robust research designs to investigate what makes a 'successful' intervention, and the mechanisms by which it might work.

- Include RCTs (while maintaining other research designs) that address previous methodological shortcomings, such as lack of attention to context, or which children (eg of a particular age, gender or with specified problems) did not benefit from the intervention.

- Include follow-ups that measure whether improvements are sustained at least one, or preferably two, years after the intervention. A key challenge here is identifying the unit of change. In MTFC, for example, it is the child, but in other programmes it is often the carer, who may have more than one child, which leads to radical changes in the context over a longer-term follow-up. The clarification of the ways in which long-term results can be assured is a continuing and urgent task for research.

- Evaluate interventions that target both the child and those around them – this includes identifying the children and carers who would most benefit from them.

Concluding comments

This review of mental health and well-being interventions for looked after children highlights issues that are relevant for practitioners and policy makers because of the importance of improving prevention and earlier decision making about care placements, as well as the consequent resource allocation for assessments – given that interventions targeting behavioural or emotional difficulties are sometimes costly. The evidence reviewed supports the position that high-quality caregiving, with added interventions targeted either directly at the child or indirectly (through the carer or those around the child), providing support where necessary, might effect positive change in children's well-being.

However, looked after young people share more commonalities than differences with their peers who are not in care, and it is important to recognise that in spite of some distinctive experiences, many of the mental health and well-being interventions that 'work' with the general population are also likely to be successful with this group.

Ultimately, there is evidence that some children in care do well despite challenging circumstances. This is often assumed to reflect their 'resilience', though this term is hard to define consistently. More attention could be given to what promotes positive outcomes, rather than the current overemphasis on challenging behaviour. Finally, children and young people in care would not want research on outcomes to be restricted to mental health, but also want studies about them doing well on their own terms. Listening to their views will be paramount.

Chapter 1: Background and overview of the report

Section 1: The mental health of looked after children

Looked after children and young people have consistently been found to have high rates of mental health difficulties, with almost half meeting criteria for a psychiatric disorder: a rate that is many times higher than for children raised in birth families and even those in birth families at elevated social risk (Ford et al, 2007; Meltzer et al, 2003). These extensive surveys suggest that in England (Meltzer et al, 2003) and Great Britain (Ford et al, 2007), up to 38 per cent of looked after children have symptoms that are indicative of conduct disorders; up to 12 per cent could be diagnosed with emotional disorders and up to 8 per cent have hyperkinetic symptoms. Within the care system, children raised in residential homes have the highest rates of mental health problems, with approximately three quarters meeting a psychiatric diagnosis (ibid). There are many reasons for this, some of which – but certainly not all – are to do with the experiences they have had in their birth families before coming into the care system. The risk of mental health disorders in looked after children derives from a wide range of potentially diverse bio–psychosocial factors, and the issues that looked after children present with are wide-ranging. So too are the causes, some of which may date from before birth, although these intrinsic factors can interact with maltreatment experiences as well (Kim–Cohen et al, 2006).

It is important to remember that the increased risk of mental health and well-being problems for looked after children cannot be solely attributed to their experiences of maltreatment and neglect within their birth families. The factors contributing to any individual looked after child's presentation of strengths and difficulties are likely to be complex and specific to that child. In chapter 2 we examine some of the links between differing experiences in the care system and children's well-being. It is evidently important to keep an open mind about the origins of looked after children's difficulties; the reasons why they are currently the way they are; the factors that may be maintaining them; as well as the interventions that are likely to help them. Chapter 4 of this report is concerned with the latter, focusing on the types of interventions that have published evidence on their effectiveness in supporting the mental health and well-being of looked after children.

Although issues surrounding maltreatment and neglect will not be common to all looked after children, it is helpful to briefly review their impact on the looked after child's development. There has been a huge growth in scientific evidence of the neurobiological impact of maltreatment and neglect on the developing child (see McCrory et al, 2010, for an excellent review). However, experts have also noted that this impact is often overstated in the public dissemination of the science due to it being "misinterpreted or misrepresented" (Shonkoff and Bales, 2011, p18). Nonetheless, it is useful to consider some of the key messages from the emerging science when thinking about the challenges facing looked after children in achieving their potential (eg Woolgar, 2013). The first is that one should expect diversity in outcomes following maltreatment and neglect because there are so many interacting biological, psychological and social factors that can be affected to a greater or lesser degree in different children (Rutter et al, 2006). The uniqueness of each child's response to early adversity is one reason for the importance of ensuring an adequate assessment is undertaken, and we include a brief discussion of some assessment tools in chapter 3 of the report to aid this process.

A second message is that it may be helpful to avoid thinking of the consequences of maltreatment simply in terms of 'damage' done to the child, even while recognising that looked after children are at significantly elevated risk of mental health and well-being problems. Several studies have shown that exposure to maltreatment leads to the development of responses that are adapted to the young person's non-optimal environment. For example, brain scans of children who have experienced physical abuse have shown them to have more rapid brain responses to threatening faces, and so to be faster at detecting the presence of possible threats in their environment: an advantage that could be adaptive in a hostile or unpredictable environment (Pollak, 2008). However, if a child is moved out of a toxic and threatening environment, then the tendency to have a bias for detecting threats could lead them to predict danger where there is none, and what was an adaptation could become a barrier to them being able to respond to consistent, sensitive and reliable caregiving. Even so, there remains the possibility of recovery, even with biological responses to maltreatment. For example, several studies have demonstrated that children exposed to maltreatment and neglect can show differences in their management of physiological arousal, which are associated with poorer developmental outcomes but can be understood as adaptations to non-optimal caregiving environments (Dozier et al, 2008; Fisher et al, 2007). Crucially, in chapter 4, we will show how some interventions have been linked to improvements in biological differences caused by maltreatment.

Section 1 messages

- Looked after children have a higher than average risk of developing mental health difficulties.

- This is likely to be due to a range of individual factors (biology, personal characteristics) as well as environmental factors (experiences before and in care, situational context).

- Assessment tools can help practitioners identify looked after children's unique responses to adversity.

- A biological or behavioural response that is a strength in one context (eg bias to detecting threats) can become 'problematic' in a different context.

Section 2: Reviewing the evidence on mental health and well-being in looked after children

The purpose of the current report is to provide an overview of the evidence available to answer the question:

'What works in preventing and treating poor mental health in looked after children?'

In order to answer this question we have focused on identifying and bringing together relevant reviews that have already been completed, individual studies on interventions from a search of the literature, and material suggested as relevant by an international panel of experts in the field. The report focuses largely on the context of care in the UK, although in reviewing interventions we also discuss evidence from international studies. We have brought together a large body of literature on the work that has already been done, together with the conclusions reached. This body of work informs our own conclusions on what next steps would be sensible, and we have made clear the relationship between the evidence we cite and the recommendations we make. The report is not a systematic review, and our coverage of the relevant literature is not exhaustive. However, it has been subject to review by an international panel; any full account of how to improve the mental health of children in care throughout the world would need to accommodate the evidence on which we have relied.

In reviewing the evidence on 'what works' for looked after children and young people, we wanted to distinguish between the effects of 'add–on' interventions (eg therapeutic services or mentoring), and the effects of variations in the quality of 'ordinary care' provided (eg whether the children's home is a good one). The effects of differences

within ordinary care can be extremely powerful in the case of both residential and foster care, and so we begin in chapter 2 with an examination of the evidence on variations in ordinary care. We identify the key issues in the care system that are relevant for looked after children's well-being, drawing largely on the situation in England in order to outline some general messages about ordinary care. We review evidence that enables us to draw some general conclusions for policy and practice. Chapter 2 also sets the context of care within which specific interventions that target looked after children's mental health are delivered.

In chapter 3 we shift the focus from the broader issue of 'well-being' to begin examining specific mental health issues. The chapter examines what the evidence tells us about how we can assess looked after children's mental health. We focus on instruments that are commonly used by clinicians working with looked after children, with a particular consideration of the evidence on the use of assessment tools with this population.

In chapter 4 we move on to review specific interventions that target looked after children's mental health, with an overview of original research articles and messages drawn from previous literature reviews. Our review of the literature is not exhaustive, but neither does it exclude studies on the basis of methodology or perceived 'quality' of the research. We have attempted to include all of the published literature on a particular intervention where it has been tested with looked after children, but have also commented on the strength of the evidence base in each case, to allow readers a clearer appreciation of the likelihood that a particular approach will 'work' in practice.

Chapters 2 and 4 form the bulk of this review, and we would urge readers who are seeking approaches to improve the mental health of looked after children to consider the ways in which these two chapters provide complementary information that can inform a more holistic understanding of the contributing factors. The evidence in chapter 2, which discusses some important general features of the care environment and their impact on 'general well-being'[2], provides the context within which the individual interventions presented in chapter 4 operate. These general features have a major impact on well-

2   This outcome is measured in different ways, and through the use of varying markers (measures of behaviour, mental health, and so on). In general, factors like parental harmony that seem to promote one measure (eg law-abiding behaviour) also tend to promote others (eg low scores on measures of psychological distress). This review assumes that something that promotes one aspect of well-being is likely to promote, or at least not work against, others unless there is good reason to think the contrary.

being[3], provide a context for and constraint on other more specific interventions, and are an essential background to the review of the evidence provided in chapter 4.

There are a number of reasons why general features of the care environment should be considered before investigating specific interventions:

- As will be seen, these background variables (for example, the quality of the placements or the age at first entry to care) can have a major impact on children's behaviour and happiness.

- It is unlikely that specific interventions will work if this background is unfavourable (for example, if the child is being poorly cared for in their placement).

- Conversely, by influencing such variables (eg by improving the quality of their placements), local authorities and other fostering providers should be able to maximise the potential efficacy of their interventions.

Chapter 2 does not employ a systematic search of the literature, and so the research discussed is typically from England and is often written up in books. For its conclusions, the chapter relies on the accumulation of different kinds of evidence rather than on well-controlled comparative studies. By contrast, chapter 4 uses systematic search principles. The interventions discussed most commonly originate in the US, and they are ideally (if seldom in practice) evaluated through a randomised controlled trial (RCT). This difference in approach between the chapters offers a complementary view of the literature that is potentially stronger than either approach taken alone:

- The approach taken in chapter 2 identifies evidence that goes beyond that unearthed by systematic search protocols (such as that employed in chapter 4),[4] handles its inter-relationships in ways

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3 For evidence of variations in quality and outcomes of care see, for example, numerous enquiries into scandals (eg Corby, 2005), the evidence on the consequences of care in Romanian orphanages (Rutter et al, 1998), and on the variations in the quality and outcomes of 'ordinary' residential and foster homes (Sinclair, 2006; Sinclair et al, 2005a).

4 An illustration of this point can be taken from the systematic correlates review used to support the recent NICE report on looked after children (NICE/ SCIE Review E4, 2010). This identified around 3,500 papers, but there was very little overlap between the research evidence used to support this inquiry and the less systematically collected evidence used to support the recent Care Inquiry (Boddy, 2013). A random sample of 10 references from the latter report produced none that were either included or specifically rejected in the correlates review, a stark illustration of both the size of the literature and the difficulty of bringing it together.

often ruled out by systematic review processes,[5] and analyses the role of context and motivation in a way that is difficult in the standard RCT.[6]

- The approaches of the two chapters can correct and, to some extent, test each other, ensuring that evidence is not noted simply because it reinforces the developing picture or the world view of the reviewers.

- A particular strength of chapter 4 is that it deals with interventions that may be needed to correct the weaknesses in placements. For example, the questions of what to do when placements start to go wrong; how to help children who continue to have serious problems despite excellent parenting; and what kind of training is needed to ensure that foster carers can use their natural good qualities to the best effect.

The possibility of using the two chapters in this complementary way depends in large part on the degree to which they are dealing with underlying processes that are the same and can be understood in the same way. For example, it seems likely from chapter 2 that foster carers (and, for that matter, residential homes) are more effective with teenagers if they practise 'positive discipline', being clear about what they want; praising more than they blame, but also ensuring that unacceptable behaviour has consequences on which they follow through. Evidence that training based on these principles is also effective would add strength to these conclusions. As will be argued in chapter 4, these principles constitute some of the key features of 'successful' interventions.

In such ways, this review may help towards defining the principles that underlie good practice in this area. Obviously, the degree to which it can do so is limited by the existing research. Over and above its methodological limitations, research has been largely concerned with avoiding negative outcomes rather than achieving positive ones. Interventions that might be designed to enable children to enjoy school or find hobbies that they really enjoy have been much less common than attempts to lower their 'problem' scores on various

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5   Though this approach was not taken in chapter 4, many systematic reviews use a methodological criterion to exclude articles (eg not based on an RCT). The descriptions, qualitative material and loosely controlled comparisons that are included in this review would be unlikely to be included or considered together.

6   RCTs typically assume a standard context (eg that operations take place with well-trained staff and in a clean hospital) and don't easily allow for children's placement preferences. As will be seen, variations in context and in what children want are very important in this field. Multi-site trials and preference trials diminish these problems but do not completely address them.

psychological tests.[7] A full account of the theories needed for this area of work would include this more positive perspective, while also taking full account of the problems that looked after children face.

Given this limitation, much of the research reported in both chapters 2 and 4 can be understood within the framework of attachment theory and social learning theory when these are broadly interpreted. Potentially, the review could, therefore, be seen as helping to refine the contributions of these theories to this area of work.

Our review concludes with chapter 5, which provides our recommendations for policy, practice and research, based on our reading of the literature in chapters 2 to 4. Where possible, we have provided evidence-based messages on effective practice, but in some areas our recommendations are for the need for further or more robust research and evaluation of interventions.

This review should be useful to policy-makers and practitioners who wish to ensure that decisions that can affect looked after children's mental health are based on the best available evidence. By combining information on factors relating to the care system, targeted interventions, and methods of assessment, we aim to provide a more holistic view of the factors that can impact on behavioural and emotional well-being than is traditionally presented in literature reviews on this topic.

Section 2 messages

- Chapter 2 considers the evidence on general features of the care environment and children's well-being.

- Chapter 3 examines some of the assessment instruments used with looked after children.

- Chapter 4 reviews a number of specific interventions for looked after children's mental health issues.

- Chapter 5 offers some recommendations for policy, practice and research.

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7   The well-known Strengths and Difficulties Questionnaire (SDQ) (Goodman, 2001) is an example (see chapter 3 of this report). Although the title includes 'strengths', there is only one scale that measures an area of strength, and this is hardly ever analysed. By contrast, much attention is focused on the four negative scales and their cumulative total.

Chapter 2: General features of the care environment and looked after children's well-being

Section 1: Introduction

In chapter 4 of this review we will examine the direct or indirect interventions that have been used to address specific mental health problems in looked after children. Before doing so, however, we provide important information on the context and constraints within which such interventions might operate, in the form of evidence on general features of the care environment and the broader outcome of 'general well-being'.[8]

In terms of content, chapter 2 will cover:

- general principles relevant to all practice in this area
- the choice between being at home and being in care
- the choice between different forms of permanence for those not returned to their families
- the choice between residential care, foster care, and multi-dimensional foster care for those who have not achieved this family-based permanence
- influencing the quality of care in these placements
- leaving care.

These headings cover the broad issues that arise in the care system. Should the child be in care at all? If so, what kind of permanent placement would suit her or him best? If such permanence is impossible, what is the best kind of placement for this particular child, and how can one ensure that it is as good as possible? And how can one ensure that any gains that are made while the child is looked after are not eroded when he or she goes home or moves out into independence?

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8   There are wide variations in the literature on definitions of 'mental health' or 'well-being'. In the course of the chapter we will refer to a wide variety of measures that are assumed to be indicators of one or other or both. These measures include such things as delinquent behaviour, 'happiness', general ratings of how well the child is doing and so on. The justification of this eclectic approach is that in practice these measures tend to be correlated with each other and that different 'good' or 'bad' outcomes tend to have the same antecedents.

We treat these issues in a general way, overlooking many key differences between groups of children other than those that arise through differences in age.[9] In general, we have aimed to produce a set of conclusions that are 'sensible' rather than 'proven', in keeping with the evidence on how 'care works' and, in the rare occasions where this is possible, on 'what works'.[10] This part of the review is not comprehensive but we have tried to highlight any evidence that contradicts the points we make. Details of particular studies are provided in footnotes, to allow readers to follow up on points of interest.

Section 2: The Care Inquiry and NICE/SCIE reports – practice principles and recommendations

The issue of quality of care has been the subject of two recent and research-informed reports, one under the aegis of NICE/SCIE (NICE/SCIE Review E2, 2010) and the other a Care Inquiry sponsored by an umbrella group of eight charities (Care Inquiry, 2013a). Both reviews base their recommendations on broad principles that combine beliefs about what well-being is and how it is to be brought about.

The Care Inquiry argues that all children should achieve 'permanence', something that is embodied in relationships and defined in terms of "security, stability, love and a strong sense of identity and belonging" (Care Inquiry, 2013a, p2). Its first core principle is to bring relationships to the heart of all that is done in the care system. Its second principle is to promote choice by children and carers. A third principle – the need to tailor services to children – is implicit in the above, since the relationships children have will have implications for

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9   Sinclair et al (2007) distinguished six groups of children: young entrants (ie children who entered the care system under the age of 11 almost invariably for reasons connected with maltreatment); adolescent graduates who had entered under the age of 10 but were still being looked after; abused adolescents who entered for reasons of maltreatment; adolescent entrants who entered primarily because family relationships had broken down; unaccompanied asylum seekers, and children with very severe disabilities. These groups differed in their problems and behaviour, their care careers (particularly the degree to which these were stable) and the options available to them (eg their chances of being adopted or of entering residential care). Recommendations for the care system must take account of such distinctions and of equally crucial distinctions relating to ethnicity and gender. For the purposes of this review we have decided that these are too many groups to discuss. Age is, however, the basic distinction between many of the groups (asylum seekers and severely disabled children in care also tend to be older) and we have implicitly structured the discussion around this.

10 An illustration of this distinction can be provided by the example of training. It is possible to devise a training programme based on an understanding of how care works. This should enhance the probability that training will work but does not guarantee that it will.

their placements (eg where they are placed and whether with kin) and they are likely to want different things. From these three principles the Inquiry draws implications for both practice (eg the handling of transitions) and management (eg workforce planning).[11]

These principles can be compared with those spelt out at the beginning of the NICE/SCIE report relating to:

- core processes – relationships (once again seen as the key to good care), listening to children and tailoring services to them in a way that is culturally appropriate and sensitive

- general desired outcomes (well-being) with children developing 'resilience', a strong sense of identity (including cultural and religious identity), secure attachments and a sense of belonging

- some more concrete outcomes so that children are safe, in a stable placement, achieve educationally and are ready to take their place in an adult world

- more specific means of achieving desired outcomes[12] – good education, the encouragement of social participation, support for care leavers, a general commitment to 'services that work' and a very strong endorsement of a multi–disciplinary approach.

These principles derive in great measure from sources other than research: government guidance, the UN Convention on the Rights of the Child, general ethical principles, the passionate views of young people[13] and professionals. It is, however, clear that:

- They inform a very wide variety of concrete recommendations – for example, the commitment to valuing a child's relationships can underpin recommendations for keeping siblings together or in contact, enabling children to return to the same carers following failed attempts at reunification, or treating important 'foster siblings' on the same footing as birth ones.

- Only extraordinary research evidence could overturn them – what evidence could overturn the ideas that services should be individually tailored and effective, that children need good relationships and that one should listen to them?

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11 These principles can be related to the research review undertaken for the inquiry. The basic argument of their review is that the concept of permanence should underlie all forms of care. Even those that are brief should be undertaken with a view to what would be the best permanent option for the child.

12 In both reports there is an inevitable blurring between the desired outcome and the means of getting there. Love, for example, is described as an outcome but can also be seen as a core part of 'relationships'. That a child is loved is both good in itself and also seen as likely to lead to him or her becoming a successful human being.

13 See, for example, the admirably pithy summaries of the views of young people in the evidence they submitted to the Care Inquiry (2013b).

- Insofar as research evidence is needed, it can be of a weak kind – for example, the principle that there should be a variety of different forms of permanence is supported by the evidence that all forms of permanence can have manifest successes; that some children want some forms and some want others, and that with the exception (see below) of returning home, up to age 16 there is no strong evidence that any one form of permanence is much better or worse than another.

The principles underlying the recommendations on management are less morally self-evident and not immediately relevant to this report, which is about practice. However, we will discuss training and quality assurance, seeing them as do the reports: as key to implementing good practice on a wide scale.

Section 2 Messages

Practice and policy in looking after children are governed by ethics as well as considerations of effectiveness. Key principles include the need to:

- treat children as individuals

- listen to them

- value and seek to preserve their relationships.

Simple descriptive research that includes children's voices can give more substance to these principles, for example by emphasising the need to:

- privilege children's views, which vary significantly on what sort of family contact they want and with whom

- listen carefully to the views of young children about their placement, since they are sometimes unhappy and wish to move but feel that no one listens to them

- unless there are clear reasons relating to the child's needs, keep siblings in care together as this preserves relationships, enhances long-term stability and reflects what they want.

Section 3: Choosing between home and care

National statistics show that some authorities have very high rates of children in care and others very low ones. Much of this variation has to do with social factors. Authorities with high rates of income deprivation, social security claimants, lone parents and minority ethnic populations along with high housing density all tend to have high rates of children in care.[14]

In practice, such 'social need' probably accounts for no more than half to two-thirds of the variation in the rate of children in care. Other factors like the political composition of the local council and the views of present or past heads of children's services also play a part. Variations in practice are reflected in differences in the rate of adoption or Special Guardianship Orders (SGO)[15] and in the 'thresholds' for admitting children to care. Some authorities may set this threshold high and emphasise support at home, while others may be readier to admit to care.

The Care Inquiry (2013a) argued that placement at home is one of a number of permanent options that are needed for different children. How can councils balance the risks between being in care and at home? And how can they take these decisions fairly, without undue delay, and enable safe returns home when these are possible.

3.1 Choosing between home and care: the balance of risks

Most children are better off at home. Some, however, are harmed by remaining there. The longer a baby is kept in grossly unsatisfactory surroundings, and the more unsatisfactory these surroundings are, the greater the chance that he or she will develop serious psychological problems. Improvement can occur when the child is placed elsewhere but the rate of 'catch-up' varies with the age of the child at first placement, and is more marked with cognitive than emotional difficulties. Problems associated with 'disinhibited attachment' seem particularly hard to shift (see Rutter et al, 1998; Rutter, 2000; Smyke et al, 2012).

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14 Research on these issues goes back to the work of Davies and his colleagues (1972) and Packman and Parker (1968). Appendix 2 in Sinclair et al (2007) and Carr-Hill et al (1999) provide evidence for most of the statements in the first two paragraphs of this section.

15 These orders are almost always made for children who are young and who would otherwise have had extended careers in care.

In keeping with these findings, age at first placement is a strong predictor of success within the placement, whether that placement is adoption (eg Selwyn et al, 2006), special guardianship (Wade et al, 2014) or general care (eg Sinclair et al, 2007). In all these different forms of placement, the younger the child is at placement, the more likely it is that placement will succeed, and that the child's mental health will probably improve (Biehal et al, 2010). In contrast, the highly disturbed behaviour often found among children who are placed late can persist despite devoted and skilled parenting, and does so in all forms of placement including adoption (Biehal et al, 2010; Selwyn et al, 2006; Selwyn et al, 2014; Wade et al, 2014).[16]

Where children return to their families, outcomes obviously depend in part on the situations they find there (Sinclair et al, 2005b). They are more likely to do well if they go back to a home from which the abusive adult has moved out, or go to a different parent altogether (Farmer and Lutman, 2012; Wade et al, 2011). Young people who return to disharmonious or unsatisfactory homes tend to do worse than those returning to more satisfactory conditions; and also worse in comparison to when they were in care (Quinton and Rutter, 1988; Sinclair, 1975).

Typically, children seem to return to families who have severe difficulties. Most of them are seen by their social workers as living in situations that are far less safe, materially adequate or satisfactory than children who are adopted or remain in foster care (Sinclair et al, 2005b). Despite returns home being predicated on the understanding that previous problems have been addressed, re-abuse seems common (for example, 59 per cent of a sample of neglected children had been re-abused within two years of returning home)[17] and is associated with a decline in mental health (Sinclair et al, 2005b). Those who return to the community and then again to care are much more likely than others to have unstable care careers (Sinclair et al, 2007).

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16 There is also some evidence in keeping with the preceding paragraph that changes in 'compulsive self-reliance' or stoicism may respond to high quality foster care, whereas more disinhibited forms of attachment behaviour may not (Sinclair et al, 2005b).

17 Farmer and Lutman (2012). Compare: Ellaway et al (2004), Farmer and Parker (1991).

In keeping with these findings, children who have been admitted to care at any time or seen to be at risk seem on average to do better if they are in care and remain there. Children failing to thrive who go into care from the 'at risk' (child protection) register do better in terms of gains in height and weight than those who remain at home or return there (King and Taitz, 1985) and there are analogous differences among those with symptoms of poor mental health (Hensey et al, 1983). Difficult behaviours are very much more common among older foster children[18] who go home than those who remain (Sinclair et al, 2005b).[19] Two sizeable follow-up studies involving both younger and older children found that composite outcomes or ratings of general well-being seem to favour those who remain in care as against those who return home, even after allowing for prior adverse factors (Farmer and Lutman, 2012; Wade et al, 2011).

These findings can be criticised in detail[20] but they are surprisingly consistent in suggesting that over a range of outcomes and ages, and in studies of varying methodology, children 'do better' if they do not go home or only do so to a radically changed situation. This is particularly striking because these returns home are most commonly explained on the grounds that problems at home have much improved, that this has always been part of the plan, or that the child or parent has had the motivation to insist on it (Farmer et al, 2011), all of which would lead one to expect that those who go home are the 'better risks'.[21]

18 Aged eight or over.

19 This is in keeping with some American evidence (notably Taussig et al, 2001). Bellamy (2008) found evidence that return home from foster care increased the prevalence of 'internalising problems' (as measured on the Child Behaviour Checklist – see chapter 4 of this report) but not externalising ones, but his sample seems much younger, with an average age of under eight. Lau et al (2003, cited by Bellamy, 2008) also found that reunification affected internalising problems, a result probably mediated by exposure to stressful homes rather than by reunification per se. Lau et al (2003) did not look for externalising problems.

20 For example, children are more likely to go home if they have not been abused. However, these children are more likely to have been admitted for reasons to do with their behaviour and it may be this rather than the effect of return that accounts for the apparent effect on behaviour. This explanation is made less likely by the fact that the study reporting it (Sinclair et al, 2005b) controlled for earlier predictors of 'bad behaviour' (a high score on the Strengths and Difficulties Questionnaire, the SDQ – see chapter 3 of this report – and unhappiness at school) and still found a very strong relationship with return home. However, this kind of alternative explanation is very difficult to rule out.

21 There is some evidence that success at home is more likely where a) both parent/s and child want return and b) the parent/s can provide reasonable parenting (Sinclair et al, 2005b). Even so, case studies in the same research suggested that success was almost always associated with a radical change in the situation (eg child went to a different parent).

At the same time it is worth noting that these are 'average results'. Evidence from the US suggests that some very young maltreated children can do reasonably well if returned to their homes.[22] In England – regardless of the evidence – there is no possibility that the return of children to their homes will stop: to do this would infringe their rights and wishes and those of their families as well as grossly overloading the care system. It is, therefore, important to see whether some children do well at home here, and whether the chances of this can be improved. We look below at some relevant strands of research.

3.2 Choosing between home and care: can local authorities improve early decision making?

Children are much more likely to be adopted if the decision to put them up for adoption is made very early in their lives. Furthermore, the earlier this decision is made the more stable their careers are likely to be (Selwyn et al, 2006). Similar findings hold for SGOs (Wade et al, 2014) and fostering (eg Biehal et al, 2010), suggesting that the earlier these decisions can be made, the better. Two points, however, must be borne in mind. First, we do not know in advance and for sure which children will not be able to survive at home. Second, in making these decisions we have to bear in mind the rights of the families concerned. The following sections are concerned with ways of 'squaring this circle': reducing delay in decision making, while simultaneously acknowledging the rights of the family to show they can, with help, look after their own children.

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22 The main evidence for this comes from Lloyd and Barth (2011) who compared the outcomes of children investigated for maltreatment when aged 12 months or less, according to whether at 66 months they were at home (63), in foster care (99), or adopted (191). "Results support the longstanding tenet of children's welfare services that remaining in foster care is less developmentally advantageous than having a more permanent arrangement of return home or adoption" (Lloyd and Barth, 2011, p1,383). This result is dubiously relevant to England where, in contrast to the US, most adoptions are to strangers, not as in the US to foster carers and kin (McNeish and Scott, 2013). It is also overstated. Foster children scored better than 'home children' on a measure of adaptive behaviour; the differences favouring home as against foster care seem to be intellectual skills in language and maths, and there is no discussion of the possibility that outcomes reflected a selection effect (ie that children placed in foster care were those whose difficulties made them unattractive to adopt, or who had returned home and failed there, whereas by contrast those at home had remained there if and only if they were seen as doing well). More importantly, the conclusion seems to be contradicted by a much larger study in the US (Harden and Whittaker, 2011) which drew on the same database of removed or maltreated babies and cited 'overwhelming evidence' that the early home environment of maltreated children was harmful, concluding that children who remained in the same home during infancy (typically the birth family home) had more compromised developmental outcomes in every domain except behavioural problems. It is, therefore, unsafe to use the Lloyd and Barth (2011) study to inform policy or practice beyond the limited message that good outcomes are possible when maltreated children are returned home.

Changes over time and variations between authorities suggest that practitioners and policy makers can respond to these pressures. English figures show that between 1999 and 2011 the average length of the adoption process fell by 9 per cent (Thomas, 2012). The power of the authorities to influence this outcome is also illustrated by the wide variations between authorities in the likelihood that children will be adopted, and the speed with which they are adopted. Similarly, trial at home and being from a black or minority ethnic background seem to be more serious barriers to adoption in some authorities than they are in others (Biehal et al, 2010; Sinclair et al, 2007).

What measures local authorities actually take to increase the number of adoptions is less clear. They may, however, include: attention to caseloads – teams under pressure from caseloads may make fewer adoptive placements (Sinclair et al, 2007); reduction in the number but improvements in the quality of parenting reports (Thomas, 2012; Ward et al, 2006); a willingness to widen the search for potential adopters at an early date; readiness to undertake parallel planning while checking out the suitability of kin; and creating specialist 'family finding' teams to focus on this part of the work (Thomas, 2012).

Much may also depend on the attitude of local managers. These differ in their views on the threshold for care and on who is 'adoptable', and these differences probably influence the number of adoptions (Thomas, 2012; further evidence is cited in Biehal et al, 2010). In one study (Sinclair et al, 2007) an assistant director in a medium-sized authority appeared to have markedly increased the number of adoptions through a change in procedure, insisting that he signed off all care plans for children under five, and refusing to sign off those that did not explicitly consider the possibility of adoption. This strategy for promoting a policy establishes a procedure (for example, a placement panel) for taking decisions but also ensures that those involved with the procedure (eg the chair of the placement panel) are signed up to the required policy. In principle, this approach can be used with all kinds of placement and it seems to be effective.

3.3 Choosing between home and care: concurrent planning and related approaches

In recent years, the aim of policy has been to both speed up and improve decisions over long-term care and particularly so for young children. Schemes or approaches intended to achieve this include parallel planning (defined here as attempting reunification while making alternative plans in case this does not work out),[23] concurrent

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23 The term 'contingency planning' is also used and appears to be similar to parallel planning, although it only requires the formulation of a plan B rather than immediate efforts to implement it. It is not clear whether there are 'official definitions' of these terms, which are used here as described.

planning (attempting reunification but placing the child with a foster carer who will adopt if reunification fails) and the New Orleans model, which seems to be a blend of the two.[24]

Evidence from the US (Information Gateway, 2012) suggests that concurrent planning may speed up the process of adoption, but that its success depends on organisational factors that are rarely found together. These include the availability of suitable carers; the ability of social workers to manage the potentially conflicted role of working with would-be adopters and existing carers (one study suggests the roles should be split), and the cooperation of the courts. As a result, whereas most states appear to have adopted concurrent planning in theory, few of them appear to be applying it fully in practice.

The most thorough attempt to evaluate concurrent planning in England also suggested that its role may be relatively limited (Monck et al, 2004; Wigfall et al, 2006). The children subject to concurrent planning were indeed adopted much more quickly and with fewer changes of placement than those in the comparison group. There was, however, a dramatic difference in age between the comparison group and the 'concurrency group'. In the comparison group only three out of 44 were under 26 weeks, whereas the comparable figure for the concurrency group was 23 out of 24. It seems likely that this disparity reflected the highly selective nature of the project, which received 219 referrals but only accepted 27 of them, the most common reason for refusal being lack of a carer available for the child, and the next most common that the decision for rehabilitation or adoption had effectively been taken.[25]

This experience suggests that concurrent planning will only ever be one element in a more general strategy to improve the speed and appropriateness of care planning for young children. What may be important is not that concurrent planning or the New Orleans model or any other branded model is used, but that the principles that underlie these approaches are applied in a skilled way. In the case of concurrent planning, these principles seem to include:

- a determination to ensure that the child is safe while the decisions are being taken

- a measured process for taking decisions that has a reasonable timetable and is not marked by either drift or undue rush

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24 A limitation of this part of the review is that it proved possible to track down proposals for researching this model in the UK, but not the evidence on it that apparently exists in the US.
25 Other difficulties included a failure by the social workers to understand or use the relevant concepts, and the strain on carers who, however, generally approved of the approach. Approval, however, was broadly to be expected. In the end only two of the 27 children were not adopted by their carers.

- that there are options (a plan A and a plan B) of which at least one is reunification

- that families are given a genuine chance to regain their child, and understand what has to be achieved if this is to happen; the timetable within which this must happen; and the resources available to overcome their difficulties

- that the child will be adopted by their current carer or cared for long-term if it is decided that the child cannot return home

- that the courts are 'signed up' to the general approach and do not undermine it.

3.4 Choosing between home and care: courts, families and social workers

Principles very similar to those involved in concurrent planning seem to be employed by the Family Treatment Drug Courts (or Drug Dependency Courts) in the USA and the Family Drug and Alcohol project in the UK. In these projects families agree to participate in a plan for their treatment and rehabilitation, which is sanctioned, monitored and encouraged by the court, and all parties know the consequences of a failure to comply. The projects are staffed by specialised teams of social workers but also make use of a wide range of community resources. So far, the evidence found for this review (Boles et al, 2007; Harwin et al, 2014; Worcel et al, 2007) suggests that:

- There are important differences between sites in the clientele served, the models of intervention employed and the results apparently achieved.

- Children who return home from the projects typically do so after a slightly longer time than children who do so from the comparison groups. By contrast, placements from the project into other forms of permanency normally occur slightly more quickly.

- On average, those participating in the projects are more likely to enter treatment, complete it successfully and have their children stay with them or be returned to them than are their comparison groups. The sizes of these apparent effects vary across sites and are typically said to be small.

- The effect on costs of the greater rate of reunifications almost certainly means that money is saved.

The tone of these research reports and summaries is positive and the results are encouraging. There are, however, three reasons for caution:

- Parents volunteer to take part in the projects but not, as far as can be seen, for the comparison groups; the groups may, therefore, not be well-matched on motivation.

- The follow-up time is very short – the longest period is two years.[26]

- The use of reunification as the primary measure of outcome is not balanced with measures of how well the children are doing and how happy they are.

The importance of the last two points is brought out by the study with a two-year follow-up by Boles et al (2007). At this point, 27 per cent of the children in the comparison group had reunified as against 42 per cent of the project children. Comparison group children were also much less likely to be receiving 'ongoing rehabilitation services' (3 vs 14 per cent). As a corollary, comparison children were much more likely to be in adoption (32 vs 22 per cent), guardianship (13 vs 5 per cent) and long-term placement (19 vs 5 per cent) (ibid.).

The intervention group could be seen as achieving a more ethical set of outcomes – or more risky, depending on one's point of view. As an illustration of the potential risks, 19 per cent of the project cases re-entered care following reunification as against only 10 per cent of the comparison ones. The question is whether the enthusiasm for these projects will result in a number of children being placed in families where their parent(s) have made great efforts to have them back but which are, in the long run, risky and bad for them. How real this danger is cannot be assessed without further research.

3.5 Choosing between home and care: minimising planned moves for young children

The desire to speed up decisions is accompanied by a wish to minimise the amount of movement that occurs during the process of taking them. Here it is important to distinguish between planned and unplanned moves, and also between the effects of movement on very young children as against others.

Unplanned moves are mainly disruptions, and usually occur because the foster carer or home can no longer cope with the child's behaviour: they are generally a feature of older children's placements and in this group strongly related to measures of disturbance (eg the Strengths and Difficulties Questionnaire or SDQ); they are predicted

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26 Note, however, that the interventions discussed in chapter 4 were generally followed up for a maximum of two years – and most for a much shorter period, if at all.

by measures of carer or home quality (Munro and Hardy, 2006; Sinclair et al, 2005a; Sinclair et al, 2005b; Sinclair et al, 2007).

A measure of the degree to which authorities influence unplanned moves is provided by the proportion of children who have been looked after for four years and been in the same foster placement for two. After a child has been in the care system for two years, the authority would normally be hoping that he or she was settled in a long-term placement. Interestingly, however, this measure does not seem to vary by authority, once allowance has been made for the children's characteristics (Sinclair et al, 2007). The lack of variation between authorities suggests that these moves are not affected by the obvious differences in resources, systems, procedures and policies that are found between authorities. By contrast, the variables we discuss in our section on quality of care (section 6 in this chapter), which have to do with differences between carers, do seem to have a strong impact on unplanned moves.

Planned moves are found both among older and younger children. They occur mainly because a child needs to move to a more suitable placement (eg from an emergency or short-term one to something more permanent), and are more commonly found at the beginning of a child's time in care (Munro and Hardy, 2006). Most moves are to placements that are planned to end in the near future (Sinclair et al, 2007) and even long-staying children are more likely to have a planned move than any other type (Ward and Skuse, 2001).

Care needs to be taken over the implication of these moves. In general, there is a presumption against too much movement: children do not like it; moves take up social work time and thus cost money; and moves for babies are bad for them (Ward and Skuse, 2001). However, it is also true that some young children want to move from placements where they are unhappy, and there is a strong case for listening to them (Sinclair et al, 2007).

The strongest case for minimising movement among young children comes from a study by Rubin and his colleagues (2007) in the USA. They found, after adjusting for various risks, that very young children who achieved a permanent placement within 45 days did much better on a measure of behaviour than children who achieved one *after* 45 days – who in turn did better than those who had not achieved one at follow-up. This study does not show precisely that it was movement in itself that caused the difficulty,[27] and in fact another study, using a different sample from the same dataset, found that movement was not

27 The differences could reflect movement, but also the positive effects of achieving a permanent placement early, or factors like parental resistance to adoption, or difficult behaviour that only became apparent after the baseline measurement and made it difficult to achieve a permanent placement.

linked to outcome – though the authors explained this on the grounds that many were stable in noxious environments.

Despite these uncertainties, the safest interpretation of these findings is that delay, frequent movement, and remaining in noxious environments are all harmful to children. A poignant description of these interlinked problems is provided by a UK follow-up of very young children at risk of maltreatment (Ward et al, 2006). This describes a harrowing mixture of frequent moves; returns to environments that were never going to improve; delays while family members were sought to provide alternative care and vacillation over moving children from grossly unsatisfactory homes.

Given the presumption against moves, it is fortunate that authorities do seem able to influence the proportion of children who have had three moves or more in a year. This measure includes a high proportion of planned moves, since most moves are planned anyway, and it varies sharply by authority in ways that do not seem to be explained by variations in the children's characteristics (Sinclair et al, 2007).

How authorities exert this influence is not clear. Ward and her colleagues (2006) in their study of very young children focus on the attitudes of social workers and the behaviour of the courts. The former are seen as overoptimistic, keeping children with families when this is never going to work, or alternatively as overcommitted to placement with kin so that time is wasted looking for relatives to look after the child. The courts are also seen as too willing to give families the benefit of the doubt and to return children to homes in the belief that the parents deserve a try. In these ways their study revisits the dilemmas raised in the last sub-section: how to balance the child's need for a rapid decision and a safe environment with recognition of the rights of families and their claims on their child.

A further dilemma arises from the difficulty of finding the right placement for a child needing an urgent placement. In general, social workers seem to accept that at the start of their care career children will be in placements that are not perfect for them but good enough. At this point it is logistically impossible to have a pool of placements so large that an exact match would always be available on all the criteria social workers use. Indeed, there may be more movement if the local authority disrupts this system by moving children on when the placement has outlasted the time for which the carer is approved, or by insisting that decisions on a final placement are made quickly. Consequently, social workers take much more care and time about finding what they consider a really good match for a long-term placement (Sinclair et al, 2005a).

3.6 Choosing between home and care: enabling safe returns

If children are to return home, it is important that these returns work out well. A very approximate measure of the percentage doing this is provided by the proportion of children who return to care.[28] The probability of return after reunification varies quite widely between studies, but a recent follow-up of a consecutive series of discharged children who had spent at least six weeks in care found that around half (47 per cent) of reunifications had broken down (Farmer et al, 2011).

Whatever the average figure, the proportion of children returning to care varies widely between authorities. Sinclair and colleagues found that across 13 authorities the proportion of children looked after at any point in a year that had experienced 'failed' returns ranged from 27 per cent in one authority to 59 per cent in another. These differences were not fully explained by the characteristics of the children concerned, but higher proportions were found among those councils who were more likely to return children to their homes.[29] More recently, Farmer and her colleagues (2011) similarly found highly significant differences between authorities in the likelihood that children who had been discharged would return to care.[30]

Reviewing the literature on returns to birth families, Biehal (2006) concluded that purposeful social work activity was probably an important ingredient in successful reunion. She based this conclusion largely on American evidence and a related summary is available online (Child Welfare Information Gateway, 2011). The latter suggests that success in family reunification depends on engaging families; agreeing clear goals appropriate to the individual family; and using a "cognitive-behavioural, multi-systemic, skills-focused" approach (Child Welfare Information Gateway, 2011).

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28 Adolescents are more likely to return to care than young children (Farmer and Parker, 1991; Farmer et al, 2011; Sinclair et al, 2005b). It is not known whether older children are in a better position to make their pain felt or whether young children are genuinely more likely to have successful placements.

29 This is likely on purely mathematical grounds. The more children there are who go home, the more there are to fail there and so the greater the likelihood of 'failed' returns in care. However, it would also be true if authorities returning higher proportions of children to their homes were taking greater risks.

30 In one model (see Farmer et al, 2011, table 10.2, p173) all local authorities differed significantly, and in two cases very highly significantly from the reference authority. In a second model (see table 10.3) no individual authority was significantly different. This does not exclude the possibility that if the local authorities were included as a set they added significantly to the variance explained. This is not discussed, but if it is not so, it seems likely that variables included in table 10.3 (involvement of other agencies and provision of adequate support) are strongly associated with individual authorities, which would thus remain a significant source of variation, albeit possibly because of their provision of support or use of other agencies.

Unfortunately, the American review does not present the detailed evidence for this plausible statement and its definition of 'success' seems to be that the child returns to her or his home as quickly as possible and then stays there. This definition underpins the official measures of success, which are concerned with the percentage of those entering foster care who subsequently return home; the percentage of these doing so within 12 months; the median length of their stay; and the proportion of returns who then go back to foster care. Examination of two of the most quoted relevant studies (Fraser et al, 1996; Stein and Gambrill, 1977; 1979) support the view that while it was certainly possible to increase the speed at which returns took place in parts of the US at that time, this may have little relevance to whether or not it is safe to return abused children to their homes in England in 2014.[31]

The most thorough and relevant research on the latter issue was completed by Farmer and her colleagues (Farmer et al, 2011).[32] This examined 180 returns from six local authorities.[33] The main outcomes were whether or not the return lasted, and a researcher rating of quality of return. As already reported, 47 per cent of the sample returned to care. There was a strong but not perfect relationship between the quality ratings and return, with the great majority of those with poor quality returns going back into care. Overall, 49

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31 Both studies provided specialised interventions characterised by the use of contracts, determined efforts to motivate the families, and the use of a broadly behavioural approach. Both used the occurrence of reunification (or that and its prospect in the case of Stein and Gambrill) as their primary outcome. The Stein and Gambrill sample is not fully randomised, did not have balanced samples and includes children referred to the control condition, quite possibly because their return was not thought likely. The Walton study is properly randomised but excludes children who were thought to be in danger through return (a high proportion), and found that the completion of treatment goals was negatively related to speed of return in the treatment group. There was, however, interesting evidence that completion of treatment goals before return was strongly related to the likelihood of remaining in the community.

32 Qualitative evidence on 'successful returns' was provided by Sinclair et al (2007) who suggested that they depended on clarity over what was planned and conditions for its success; commitment by all parties including the carer to the success of the plan, and a consequent need for good communication and work that proceeded at a measured but urgent pace. These things were probably made more likely by continuity (eg child remaining with same siblings and in same school), a high quality carer, and adequate social work staffing.

33 The sample was a consecutive series collected over the course of a year but excluded children who spent less than six weeks in care, were over the age of 15, or were receiving 'respite care'. The data came from the case records and interviews with sub-samples of parents, children, social workers, and 'policy makers', and were analysed using a mixture of researcher ratings and bivariate and multivariate statistical techniques.

per cent were thought to have had poor quality returns; 14 per cent borderline ones; and 28 per cent adequate or good ones.[34]

The result of this work is an in-depth description of what is done for children returning home from care (often, it seems, not very much); confirmation of factors found to predict a poor outcome (notably substance abuse, domestic violence, 'anti-social behaviour') and hence of what probably needs to change if a return is to be successful; identification of the correlates of what seems to be thorough work (for example, a multi-disciplinary assessment); and some convincing examples of what seems to be good and successful practice.

Inevitably, the multi-variate analysis does not prove beyond all doubt that the practice that seems to be desirable would actually produce the desired result.[35] There is, however, enough evidence in this book to suggest that it may well do so. In their conclusion, Farmer and her colleagues (2011, p217) write as follows:

> "Since we found that the concerns that led to entry had often not been addressed, assessment and decision-making need to focus more explicitly on what needs to change before return is possible with targets clearly set and monitored by means of conditions accompanied by appropriate services prior to and during the return. If parents are unable to meet the conditions set and agreed within reasonable timescales and appropriate assistance, this may mean that they are unable to care for their children and other plans may need to be made."

All of this seems very close to the model that inspires the theories behind contingency, parallel and concurrent planning at different parts of the care process and in both the UK and the USA.[36]

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34 In 9 per cent of cases the outcome was 'unknown' or 'inapplicable' since the child either returned immediately to care (1 per cent) or the case was closed almost immediately (8 per cent).

35 The main difficulties are: the lack of blind ratings (the researchers were aware of the outcome when they made them); the existence of logical relationships between some of the outcomes and some of the ratings (eg whether the return was adequate and whether the support was adequate); the ambiguous nature of some of the associations (for example, the apparently greater stability of those supported by independent agencies could reflect the more thorough work done by these agencies, their focus on keeping the child in the community rather than safeguarding, or simply the fact that authorities that used the agencies a lot had different thresholds for taking children into care); the fact that the analyses generally had no measure of initial risk.

36 This is not to say that there are not also important differences between the various sites in the models employed. Typically, for example, the American practitioners seem more inclined to use behavioural models so that, for example, one Drug Dependency Court was willing to impose days in prison as a consequence for failure to adhere to a treatment plan, but also to reduce these in return for an agreement by the parent(s) to take part in a more intensive regime.

3.7 Choosing between home and care: interim conclusions

There is strong evidence that authorities can influence the likelihood that children in difficulty will enter care and, if they do, stay there for an extended period of time or leave it for various kinds of permanent placements or return home. The choice between these various options is strongly influenced by the relative weight given to the risks of returning children home on the one hand and the moral, legal and financial case for doing so on the other.

It is apparent that returning children to their homes is a high-risk strategy, yet a decision to return none would be unjust and place unmanageable burdens on the care system. There is no research that provides an adequate picture of this balance of risks (ie that shows the likely average impact of a low or high threshold for care admission and retention on the well-being of children who end up in care, at home, or in some other form of permanence).

Despite this lack of fundamental research, some of the findings reviewed above can suggest the way ahead.

- Children are harmed by remaining in an abusive environment and these effects can be very difficult to reverse. Those defined as being at risk or admitted to care tend to do better while they are away from home on a wide variety of criteria.

- The younger children are when decisions over permanent placement are made, the better things are likely to go.

- Children who return from care to homes where little has changed are likely to do badly.

Improving early decision making requires early identification. In the short run, this will not save money since authorities will be faced with the costs of the new preventive work while maintaining children for whom all possibility of prevention is long since gone. Saving money in the long run will depend on the ability to distinguish sharply between those at high and low risk of care, leading to precisely targeted and timely interventions that obviate the need for care in a high proportion of cases. The immediate effect is likely to be the identification of more children in trouble and a slight increase in the numbers admitted to care and thus a rise in costs (for evidence for this argument, see Beecham and Sinclair, 2007). It follows that more money has to be spent or steps taken to minimise costs elsewhere.

There is a plausible practice theory that applies to decision taking regarding high risk children and work towards keeping them in their families whether this is done during, before or after the period in care. This requires:

- agreement or at least a clear understanding by families of what needs to change; the speed at which it needs to change; and the consequences if it does not

- the ability to keep children safe while decisions are being taken

- the availability of alternatives (eg adequate numbers of potential adopters)

- resources (eg effective local programmes for treating addictions) that will tackle the problems identified

- purposeful work that is not rushed but equally does not delay and put off hard decisions.

Conclusive evidence for or against this practice theory is lacking.[37] It does, however, take seriously the claims of children's family relationships, the right of families to be involved, and the harm that can be done to children by being at home. A major risk is that this kind of practice can increase the likelihood of children remaining at home or returning from care without ensuring that adequate resources are available to the families in the long term. Selwyn and her colleagues (2006) provide case examples of children who were kept safely at home by an intensive package of services, which were withdrawn when problems seem to have been alleviated with the result that the children suffered and were taken into care.

In this respect there is a major difference between the application of this approach to young children, where the alternative is adoption, and its application with older ones, as in the Drug and Alcohol projects. In the former case, there is some evidence (Zeanah et al, 2001) that the approach results in: an increase in the proportions adopted and thus not returned home; no added delays; reductions in the proportions subsequently maltreated; and a reduction in the tendency

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37 This will be hard to provide. The theory depends on the agreement of the participants to the plans and this is hard to combine with an RCT. In addition, the theory can be correct but fail to work through the lack of resources or their ineffectiveness or inappropriate use.

of the mothers involved to maltreat subsequent children.[38] For older children, the result seems to be that more are returned home, as indeed is the explicit intention. The argument of this review is not that older children should not be returned home, but rather that this should not be treated as an outcome in itself in research or policy, and that the risks of returning home should be recognised in practice.

Section 3 Messages

- Children in need of permanent placements should be identified as early as possible and the early decision making improved.

- The need to take these decisions early needs to be balanced against the need to pay due attention to the needs and rights of the family, and to enable them to look after their own child well.

- There is some consensus on how to go about balancing this potential conflict and hence on what is good practice around the decisions on removing young children from home or returning them there.

- This should inform all practice, rather than being seen as lodged in a particular approach or scheme.

- The main risks lie in the possible underestimation of the dangers of returning the child home and overestimation of the efficacy of preventive work along with its ability to save money.

- Authorities are able to improve their performance in these respects and also to reduce the extent of planned moves before the decisions.

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38 This important study involves a 'before and after' comparison of an intensive intervention, carried out in a specific geographic area and focused on infants of less than four years where there was an adjudication of maltreatment. The intervention involved a very intense period of assessment designed to identify the strengths and weaknesses of the family and their ability to care for the child, followed by interventions tailored to the individual family and structured around the family's willingness to acknowledge their need for help. From a research point of view the study has a number of limitations, almost all of which are identified by the authors. It is not a standardised intervention so it is not certain if its results would be replicated; the numbers are small so that the differences are not always significant; any differences could be due to other changes that had occurred over time; it is not an 'intention to treat' comparison so that individuals who did not receive the intervention when they should have been offered it are treated as a separate 'no intervention group'; and there are no comparisons of the outcomes for the children. All that said, this study does suggest that better results may well be possible and it is important to build upon it.

Section 4: Comparisons of different kinds of permanent placement

If young children do not go home from care, it is generally assumed that they need an alternative permanent placement. In England they can achieve this through adoption; an SGO; residence order; fostering with friends and relatives (almost always kin); or fostering with strangers. Authorities, and in some cases social work teams, make differing use of these various provisions (Sinclair et al, 2007; Wade et al, 2014).

4.1 Differences in the effects of different kinds of permanent placement

Random allocation to one or another of these permanent options is probably unethical and has not been tried.[39] As a result, researchers have to rely on controlled comparisons; long-term follow up of large community cohorts; special cohort studies of children in care or on the verge of it; and 'informal comparisons'. The latter provide descriptions of the outcomes and processes in at least one of the options, which can then be compared with similar descriptions, not necessarily from the same study, of others.

The results of these comparisons are interesting but also easy to misinterpret. This is particularly so if use is made of results from different countries, where social security systems, average quality of placement, and type of child selected for different provisions may all differ radically. England, for example, makes many adoptions from care, and discourages inter-country adoptions, whereas in some other countries, such as Spain, the reverse is the case. Even within England it is difficult to allow for process – for example, not all of those who are put forward for adoption are adopted, so that 'poor risks' while initially considered for adoption may not go on to be so. Moreover, the information available on the backgrounds of those adopted or fostered is usually insufficient to be sure that like is being compared with like.

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39 The Bucharest Early Intervention Project did randomly allocate between foster and residential care. However, it was not able to ensure (and probably should not have tried to ensure) that the treatments stayed pure or that subject attrition was equal between the two arms. In theory it is possible to use this research approach with techniques intended to make some outcomes more likely.

In general it is possible to find clearly good and clearly bad outcomes in all forms of permanence. Most group comparisons of whatever kind have used adoption as a benchmark, usually comparing it to foster care. Two recent and as yet unpublished studies have considered SGOs (Selwyn et al, 2014; Wade et al, 2014) and residence orders along with adoption (Selwyn et al, 2014).

The care system does look after some children who were put forward for adoption but were not actually adopted and who have highly unstable careers. If these are omitted, the careers of children put forward for adoption seem similar to those of children actually adopted (Selwyn et al, 2006). Other studies of relatively young children in foster care (Biehal et al, 2010) and SGOs (Selwyn et al, 2014; Wade et al, 2014) suggest that these options are less stable than adoptions,[40] but the populations differ in age and this may explain at least some of the difference. One study compared children adopted very late with late permanent fostering and found no difference in stability (Fratter et al, 1991). Comparisons on outcomes other than stability find hardly any differences, though there is some suggestion that adopted children may have rather better attachments (Selwyn et al, 2006) and be slightly more confident about their futures (Biehal et al, 2010).

Exceptionally, one study compared children adopted after being on an 'at risk register' and found worse outcomes in this group than in comparison groups fostered or returned to or remaining at home (Gibbons et al, 1995). The reasons for this could be various, including the possibility that those adopted may have suffered more severe abuse; the lack of support then available for adopters, and the greater expectations – and hence possible disappointment among adopters.

Overall, the findings suggest that:

- Most placements made when the child is a baby or very young are highly stable.

- This stability drops off quite rapidly with age and does so in all types of placement.

- After allowing for age differences, adoption may have a slight advantage in terms of stability, attachment, and lack of anxiety about the future, up to age 16.

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40 It seems unlikely that the outcomes for children adopted when under six months can be bettered. International studies have found that this group outperform other comparison groups, such as lone parents and foster children.

- Permanent fostering may fare less well in this respect but comparisons are difficult because it is not a clear-cut category and the children typically enter their placement at an older age.

- There are obvious differences in what happens to children after 16.[41]

4.2 Kin care and long-term foster care

Family and friends care is almost entirely care by kin: mainly grandparents, uncles and aunts (Farmer and Moyers, 2008). It is the tip of an informal iceberg and the 2001 UK census shows many more children living with relatives, with the proportion higher in more deprived areas and correlating quite highly with the rate of children in care (Selwyn, personal communication, 2014). The existence of this informal care creates a dilemma for local authorities, who may wish to provide more support for these carers but also fear that it may be difficult to draw the line between supporting formal and informal care.[42]

Other countries make much more use of care by kin. It is, for example, by far the most common way of providing foster care in Spain, Ireland and Australia and also in some US cities (Wilson et al, 2004). Its use in England varies sharply between different authorities and also within authorities by social work team (Sinclair et al, 2007). These variations are not explained by known differences between the children looked after and there is no evidence that authorities that make relatively high use of formal kin care have less success with it (Sinclair et al, 2007). Unpublished analysis by one of the authors (Sinclair and colleagues, 2014) shows that the preference an authority has for kin as against ordinary foster care as a placement option is unrelated to the frequency of informal foster care within its boundaries as measured at the time of the last census.

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41 For a recent, thorough and well-referenced discussion of these issues see McNeish and Scott (2013).

42 There are numerous reviews of kinship care, all of which seem to say roughly the same thing, albeit with degrees of conviction that vary with their methodological preferences. For example, a recent Australian review (Child Safety Services, 2011) cites 72 references, in the main British work by Farmer and Moyers (2008), Hunt (2009) and Sinclair et al (2005a), as well as unpublished analysis of data provided by Julie Selwyn, who used the 2001 census data to examine the proportion of children living with relatives in different authorities.

There have been many comparisons of foster care by kin and by strangers in the US and two major ones in the UK, along with a number of others that have included this comparison but not made it the focus of the research. The broad outlines of these comparisons are clear:

- Kin care is not for everyone. It may break down because kin carers may disbelieve allegations of abuse and thus fail to protect the child; be terrorised by birth parents because they protect the child; or have unrealistic, and hence disappointed, expectations of what they can achieve (Selwyn et al, 2006).

- Kin care is a distinctive route so that, for example, children whose first placement is with kin very rarely become adopted, while around 85 per cent of SGOs are made to kin carers (Sinclair et al, 2005b; Wade et al, 2014).

- It has particular advantages: building on existing family strengths; making it easier to keep children together and in the same neighbourhood; enabling contact; avoiding the 'scary' experience of moving to a new family and trying to form new bonds; and being more likely to be approved by the children themselves. It has the advantages of 'normality' and continuity (Farmer and Moyers, 2008; Hunt, 2009; Sinclair et al, 2005a; Wilson et al, 2004).

- It also has particular disadvantages: carers tend to be poorer, more badly housed, and to be rated as having worse parenting skills than stranger carers, and they receive less support from children's services. Quarrels between carers and birth parents are very common, either antedating the placement or related to it (Farmer and Moyers, 2008; Hunt, 2009; Sinclair et al, 2005a; Sykes et al, 2002; Wilson et al, 2004).

- The advantages and disadvantages tend to cancel each other out. On average, the problems of children in stranger and kin care seem to be similar in kind and severity, and outcomes similarly so. Disruption rates are similar, so although kin placements last longer this is probably because they are meant to do so and some may go on when it would have been better if they had not (Farmer and Moyers, 2008). Other outcomes also seem similar, although individual studies have found differences favouring kin care in terms of a general measure of well-being (Sinclair et al, 2007) or homelessness in adult life (Benedict et al, 1996).

- A Campbell Systematic Review (Winokur et al, 2014)[43] reached similar but slightly more positive conclusions, finding that children in kinship foster care experienced fewer behavioural problems; fewer mental health disorders; better well-being; and fewer placement disruptions than children in non-kinship foster care.

As with other forms of permanence and up to age 16, there may be few detectable differences in the outcomes of kin and stranger care. However, there may still be good reasons for preferring one or the other in particular cases. For example, some children should not be cared for by kin since it is dangerous for them, whereas others may have a strong bond with a particular relative, which makes this a natural option. Where there are no strong reasons against doing so, and the child is unlikely to be adopted, kin care can continue to be a favoured option and authorities making little use of formal kin care should be able to use more of it. There is also a need to lessen its problems through additional support, and to think through the relationship between kinship care, which is part of the care system, and the much larger amount of informal kin care.

4.3 Choosing between permanent placements: interim conclusions

As seen previously, there are few dramatic differences between the main permanence placements up to the age of 16. From this it might be easy to assume that all is equal. This, however, is not the case. Clearly there are big differences in the futures available to children after 16, in the degree to which the state is willing to provide support after the leaving age for care, and in costs to the state.

At an individual level it may be the case that adoption is the safest option but the following considerations are often relevant:

- Motivation – some children are desperate to be adopted while others are determined not to be; some want to go to their grandparents and some do not (Sinclair et al, 2005b).

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43 Where these UK studies do find differences they tend to favour kin care (eg Sinclair et al, 2007). However, the UK results strongly suggest that although placements in kin care last longer, this is because they are meant to do so, rather than because they are less likely to suffer disruption (Farmer and Moyers, 2008; Sinclair et al, 2007). This suggests a reason for caution. There also needs to be clarity over the nature of the comparison. Much kinship care rests on a previous relationship and the mutual choice of child and family. It may be this that confers any advantage rather than the kinship tie itself. As with many options, the issue is not 'what is the best buy' but 'what is the best buy *for this child*'.

- Strengths of particular options – for example, a strong bond between a potential carer and a child may be a reason for an SGO and is associated with good outcomes, whereas there is less of a case for this when the child does not have any particular bond with any carer (Wade et al, 2014).

- Weaknesses – for example, lack of financial and other support, and ease of access to abusive relatives may be reasons against making an SGO.

- Feasibility – there may be no relatives available for an SGO; the child's age or status as 'hard to adopt' may effectively rule out adoption, or the courts may be unwilling to countenance one.

In practice, long-term fostering is the option most likely to be available to children who are aged five and over. The average age at entry for those who are adopted from care is around 1.2 years (Selwyn et al, 2014) and hardly any adopted children first enter over the age of five (Sinclair et al, 2007). Similarly, three-quarters of those who leave care on receiving an SGO have entered it prior to the age of five (Wade et al, 2014). A central argument of this review is that early decision making needs to be improved so that if children are to go into care, delays are kept down, the rights of families acknowledged and the risks of wrong decisions reduced. There is evidence that this may well be possible in the case of young children. It is, however, unrealistic to think that a greater emphasis on early admissions will do more than reduce the number of later ones, and some of those admitted will continue to need an alternative home. For them, long-term fostering and kin care will continue to be the most likely option.

The need to find the right kind of permanent option for any child means that as far as possible these choices should not be biased by lack of provision, the nature of the options, or financial or other incentives to choose any one over another. It is, therefore, welcome that emphasis is being put on increasing the availability of all forms of permanence and on financial and other support for adoptions and to some extent SGOs. It is also welcome that more attention is being given to making 'permanent foster care' a better delineated and supported option. This means, for example, a greater use of Staying Put schemes,[44] greater autonomy for foster carers to decide such things as sleepovers, and greater deliberation about whether long-term foster care is the right decision.

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44 See: www.gov.uk/government/uploads/system/uploads/attachment_data/file/201015/Staying_Put_Guidance.pdf

Section 4 Messages

Comparisons between adoption, special guardianship, permanent fostering and residence orders are hard to make and, therefore, rare. However, in general:

- A strategy for improving early decision making that might lead to bringing some children into care earlier needs to be balanced by an increase in the number of permanent options available.

- Differences in outcome between permanent options reflect the differences in the ages at which these orders tend to be made, with very young children being far more likely to be adopted and to 'succeed'.

- If allowance is made for age there remains an advantage to adoption and this might be expected to become more pronounced after 18, but the relevant research has not yet been done.

- Specific circumstances, such as the child's age and wishes, or the existence of a bond between the child and other family members or with their foster carer may suggest preference for particular permanence options.

Increases in the availability of different forms of permanence reduce the strain on the care system, and increase choice without apparently resulting in the reduced use of other permanent options. A full range of these options should, therefore, be available and supported. These will include:

- adoption by strangers and foster carers
- SGOs, largely to kin, but also to foster carers
- residence orders
- properly supported fostering by kin
- permanent fostering by stranger foster carers.

The latter will continue to be needed and should become a more clearly delineated option with greater delegation of responsibility to the foster carer and more possibility of staying on for the child.

Section 5: Residential care, foster care, and Multidimensional Treatment Foster Care (MTFC)

The choices discussed in the last section mainly concern young children. We turn now to interventions primarily focused on older children, and thus to residential care and provisions that may act as an alternative to it.

5.1 Residential care, foster care and MTFC compared

There are many different kinds of residential care and residential units of the same kind can vary widely in quality. This diversity makes it difficult to establish that any comparison is fairly pitting (for example) 'average' residential care against 'average' foster care or 'average' specialised foster care. What follows examines what might be said about the relative advantages or disadvantages of current English residential care when compared with 'ordinary' or specialised foster care (eg MTFC: see chapter 4 for further details) for the same population.

Comparisons between residential care and foster care that allow for known adverse factors at entry tend slightly to favour foster care. Not much, however, can be made of this since selection for residential care is, in itself, a marker of difficulties, not all of which may be picked up in the analysis (Colton, 1988; Sinclair et al, 2007). Preferences vary: some young people prefer residential care because it is not family care, which they want to avoid as they see it as competition with their own family or generally threatening (see eg Sinclair and Gibbs, 1998); others prefer foster care (see eg Colton, 1988). It is commonly believed that some children are too difficult to be fostered. However, selected foster carers, given adequate support, can continue to foster even when they are looking after the most challenging young people (Walker et al, 2002). Despite this evidence, no authority manages to do without residential care at all, although there are wide variations in its use.

These comparisons are of 'averages'. However, there are very large differences between residential units in terms of the criminal behaviour, tendency to run away, morale, and feelings of well-being of their residents (see evidence cited in Sinclair, 2006). These differences may also occur over time (Sinclair, 1971) and within the same institution (Sinclair and Heal, 1976), and are far from fully explained by differences between the residents.

Only one English study has compared MTFC for children in care with 'care as usual' (mainly but not entirely residential care). It embedded an RCT within a larger observational study and found no difference in effect over 12 months on a global measure of children's functioning (for further details see chapter 4). However, the study

did report an interaction, with anti-social children (the group for whom MTFC was developed) doing significantly better with MTFC and the less anti-social children better with 'care as usual'. There is, thus, some evidence that MTFC 'works' for those for whom it was intended (Green et al, 2014) but that others may do better with another approach.

A further English comparison of the effects of MTFC on a sample of offenders in placement compared them with a sample discharged from prison and found a much lower reconviction rate than over the year in placement, but a rapid rise in the subsequent year. This finding strongly suggests that MTFC had a restraining rather than fully transformative effect (Biehal et al, 2011; for further details of this as well as Swedish and US studies of MTFC see chapter 4). This change in the apparent effect of an intervention on leaving a placement is commonly found. In the case of MTFC, it would seem to reflect the fact that the subsequent environment in which the young person finds themselves is unable to provide the specific support and supervision necessary to maintain the improvements made in the specialist setting.

5.2 Residential care, foster care and MTFC: interim conclusions

The basic premise of MTFC is one of firm, consistent, kindly discipline, which allows a place for reward but is also clear about consequences and which, in the initial stages, is highly restrictive. As described in the section on practice, this would seem to be consistent with the premises on which successful residential units run.

MTFC also resembles residential care in its costs, which are very high (see chapter 4 for discussion of a paper on the financial implications of both options in comparison to foster care). Around two-thirds of the costs of children's services has traditionally been devoted to children in care, and of this sum around a half has gone on the small minority in residential care (see Beecham and Sinclair, 2007). If long-term residential care is to continue for anyone but the handful of most 'difficult' children and others whom the public want kept 'secure', the provision must become cheaper or children kept in for a shorter length of time. This can be difficult if the young people need or want a long-term placement or if the good effects do not outlast the intervention.

Against this background it might be sensible to:

- Develop a new low-cost but long-stay form of residential care for those young people who do not have extreme needs but who do not want to be fostered.

- Continue to experiment with the use of MTFC-style approaches as in the 'Keeping Foster Parents Trained and Supported (KEEP)' experiments (see chapter 4), thus making the principles derived from social learning theory that underpin MTFC, such as placing greater emphasis on praising good behaviour while having clearly specified boundaries and consequences, available in ordinary foster care, and combining its benefits with long-term care.

- Use MTFC and/or specialised residential care for those young people who are 'beyond control' at home but where the plan is that they should return to it in the near future and where their parent(s) is/are willing to learn the positive approaches to discipline on which MTFC depends.

Section 5 Messages

The overall effectiveness of the care system is reduced by:

- the inability of many foster placements to contain challenging children

- major variations in the quality and effects of residential units

- the frequency with which the positive impact of a placement does not last when the child or young person moves on

- the very high costs of both residential care and specialist provision, which mean that few children can remain in them long-term.

Responses to these problems that should be considered include:

- training 'ordinary' foster carers in the techniques derived from the principles underlying intensive fostering systems, such as setting clear boundaries, so that their ability to contain challenging children is enhanced without a need for costly intervention

- developing a model of residential care that is less intensively staffed, less costly and thus able to be offered on a long-term basis to young people who want this option

- concentrating expensive 'treatment' options, such as MTFC and residential care, on young people who are expected to return home and whose families will be offered intensive support when they do so.

Section 6: The quality of care

In most studies of the quality of care the same 'good' or 'bad' factors seem to be involved in a wide variety of different outcomes. Sinclair (2005) summarised those factors that seemed to make foster placements 'go well', basing the model on 16 studies: 13 commissioned by the Department of Health and three by the then Scottish Office. In this section we describe this model and a related model of residential care (Sinclair, 2006) and then discuss its implications for influencing the quality of care.[45]

6.1 Models of foster and residential care

The foster care model suggests that the 'in–placement' outcomes of foster care depend on:

- the way the placement is made (placements made in a rush or without proper consultation with the foster carers are less likely to be successful)

- the characteristics of the children – those who show difficult or disturbed behaviour before entry to the placement or who do not want to be fostered are less likely to succeed

- the quality of the foster carers – those who are warm, caring, clear in their expectations, interested in doing things with the child that the child will enjoy, and agree with other adults on their approach are more likely to succeed not only with the placement being assessed but also with earlier ones

- the 'fit' between child and placement – a complex matter that relates to a) the way the child relates to the main carer ('some you bond with, some you don't'); b) relationships with other children and adult(s) in the household; and c) benign and vicious circles, whereby difficult behaviour on the part of the child leads to rejection, which in turn leads to worse behaviour

- contact between birth parent and child, which can be destructive or positive depending on the relative involved, and that in the case of abused children might sometimes lead to placement disruption

- how the child is getting on at school.

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45 As indicated in footnotes and elsewhere, this review does not attempt to discuss the evidence for and against these models. Those who wish to do this must go first to the summaries and then to the original material on which the summaries are based.

Sinclair (2006) also put forward a related model of residential care based on a review of a large volume of British research. This model is less elaborate but similar in that the 'success' of the child in the home is related to:

- the characteristics of the child (eg their previous history of offending)

- the quality of the head of home and in particular the degree to which the head and staff are agreed on their approach; clarity of expectation over behaviour and education; and relationships between staff and residents that are 'warm'

- interactive processes relating to the degree to which the child fits into the particular home, but also to short-run cycles of 'trouble' or peace

- external factors likely to impact on these variables (eg the 'authority' of the head as exemplified by whether they are 'acting up', and the occurrence of reorganisation).

The evidential base for these various processes varies, causation runs both ways and is difficult to sort out, and the crucial variables involved are not observed directly.[46] However, considerable efforts were made to ensure that the effects involved were genuine, that proper allowance had been made for differences in the children involved, and also that it was safer to assume that these differences were genuine than that they were not.[47]

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46 In both residential care and foster care it is easier to behave well towards those who are behaving well towards you. In addition, your personal qualities are judged on their success rather than observed directly (a prohibition may be seen as firm when it succeeds, weak when it does not; nagging when it is repeated and harsh when it is escalated and accompanied by dire threats). Thus, evidence for the processes inferred comes from a mixture of qualitative material and observation, complex statistics (eg multi-level models assessing effects of the foster carer on more than one foster child) and general inferences about the fit between the model and evidence on authoritative parenting in ordinary families, and the effects of interventions employing kindly consistent discipline.

47 For example, the assumption that a good placement process makes a good outcome more likely would naturally lead to more attention to the way children are placed. As this is almost certainly a good thing in its own right, the 'downside' of making a false causal attribution is probably nil while the upside, if the causal attribution is correct, should be positive.

6.2 Links between models of care and practice

Models of this kind can supplement ethical principles and be used to inform good practice. For example, it can be suggested that:

- Care should be taken over placing children in long-term placements, allowing both sides to meet and to commit to the placement; ensuring that full information is provided to the carers, and enabling other children and adults in the placement to feel that they have been properly consulted. This process can be married to simple methods of matching (eg ensuring that sibling groups go to carers who have room for them and feel they would fit into their family) to ensure that both sides have a chance to commit to each other.[48]

- It is important to develop ways of intervening early so that the bad relationships that mediate the strong association between disturbed behaviour and placement disruption can be prevented (possible ways of doing this are discussed in chapter 4).

- It seems sensible to keep a careful eye on the way children behave during and after visits; to talk to them about whom they want and do not want to see; to share information between foster carers and social workers on how contact is working and not to assume, as is often done, that closeness to home is always best.

6.3 Bringing about good practice through training and quality assurance

These are simply examples of the kind of suggestions that seem sensible and which can be made on the basis of this model. We cannot be sure that these suggestions will work. For example, there seems little doubt that the association between a high score on the SDQ and breakdown is mediated by relationships. Children who score high on this measure of mental health are much more likely to have carers who reject them and to be disliked by other children in the home. However, if they have a high score on this questionnaire but are not rejected in this way then they are no more likely to have a disruption than children with low scores (Sinclair and Wilson, 2003). And in the light of this, it would seem sensible to train carers to place a compassionate, understanding interpretation on disturbed behaviour rather than seeing it as an example of malevolence or 'bad blood'. However, it is possible for a training programme to use this approach and still fail to have a detectable effect (Pithouse et al, 2002).

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48 Ideally it would be possible to measure the 'style' of the foster carer and the needs of the child in such a way that the two could be exactly matched. We are not aware of evidence that this is possible. The suggestions above are based on the ideas that a) a placement is more likely to work if both sides have made an informed commitment to it and b) there has been some kind of a trial period to see if anything is obviously wrong.

The example of training and supervision is particularly important. Selection, training, supervision and quality assurance would seem to be the routes through which good practice can be brought about. In practice, however, there is no validated tool for selecting foster carers (Luke and Sebba, 2013), and research on supervision is completely lacking in the UK, though slightly more evidence is available on quality assurance and training.

The belief in the efficacy of quality assurance is widely held but seems to be unsupported by evidence. Internally, children's services may not use the evidence on quality of care that they have – many do not keep central records on their experience of spot-purchased highly expensive residential care, and so presumably may repurchase placements in highly unsatisfactory homes (Sinclair et al, 2007). External quality assurance in the form of the inspection of children's homes – and in earlier days, approved schools and probation hostels – has been established for a long time. This has not stopped abuse,[49] but it has meant that homes that were later found to be flagrantly unsatisfactory have been closed down, or ironed out the enormous variations in performance that exist.[50] Similar problems may exist in the inspection of foster care. The identification of unsatisfactory foster homes is in many ways more difficult than identification of poor quality residential ones and inspections of fostering services can only examine a very small proportion of the foster families.[51]

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49 It is perhaps not surprising that inspection failed to stop sexual abuse. Such abusers are skilled at covering their tracks. It is, however, odd that regimes like those in the Pindown and Beck scandals (Levy and Kahan, 1991; D'Arcy and Gosling, 1998) persisted, since much that was later seen as wrong was in the public domain. Similar puzzles exist elsewhere. For example, the flagrant lack of care in some of the wards in the Mid–Staffordshire hospital was not exactly a well–kept secret (Francis, 2010).

50 The reviewer's own experience can illustrate this point. He examined the 'failure rates' of 44 different wardens of probation hostels. Over ten years these wardens had admitted over 4,000 children and their failure rates (proportions of young children leaving as a result of absconding or offence) varied from 14 per cent to 78 per cent, with the warden with the highest rate remarking that 'each boy has his breaking point and I find it'. There was no difference in the risk profiles of those admitted by wardens with high, medium and low failure rates and these variations persisted despite the fact that the hostels received at least three inspections a year from the then Children's and Probation Inspectorates (Sinclair, 1971; Sinclair 1975). A much later study of children's homes (Sinclair and Gibbs, 1998) found similar stark variations, as indeed did other studies in the same Department of Health research initiative (Davies et al, 1998). In one of these homes, children were being routinely abused and sexually assaulted by older established residents, but these instances of grossly illegal behaviour did not prevent the home from receiving a clean bill of health in an inspection two weeks before the research team visited. For less personal and more balanced views of inspection see Munro (2011) and Nuffield Trust (2013).

51 The reviewer was given a figure of about six foster families per authority. This might be fine if there was a very strong authority effect so that all foster families in the same authority tended to share the same characteristics – in fact this is very far from the case.

Evidence on training is equally discouraging. Controlled observational studies of foster carers do not suggest that their success increases with training, although this may affect their retention and satisfaction (Sinclair et al, 2004; 2005a). Nor do observational studies suggest that children's homes with high proportions of trained staff or with trained heads do better than those who do not have these advantages. If anything, training is associated with lower morale among the trained but a greater ability to get other jobs (Sinclair and Gibbs, 1998; 1999). More recently, a systematic review by MacDonald and Millen (2012) failed to find any evidence that the training of residential staff had a beneficial effect on outcomes.

These studies of 'ordinary' (and, in practice, highly varied) training do not imply that more specialised training might not succeed. However, evidence submitted to the NICE/SCIE inquiry suggested that – in England at least – randomised controlled trials (RCTs) of enhanced training for foster carers suggested this did not work (NICE/SCIE Review E2, 2010). Three experiments in the US were identified that at first sight did work but of these, one was said to have a positive effect on one group of children, and a negative one on the other.[52] Moreover, all three tested their effects during or very shortly after training, thus raising the issue of whether what was being observed was in fact a sustaining effect or the result of long-term change. By contrast, the British research typically used a longer follow-up and in the opinion of the NICE/SCIE reviewer provided no solid evidence that the training had had any effect.

This discouraging evidence on the effects of training and quality assurance does not mean that they cannot have good effects. To give a further example, a study of kinship foster care showed that adolescents were concerned about difficulties in discussing their birth families with their foster carers and so there is very good reason to think that there is a need for training here (Fuentes-Peláez et al, 2013). As argued later, carers have to be part of the solution and chapter 4 identifies one English study of training that seemed to have highly encouraging results. However, the evidence presented above does strongly suggest that training and inspection cannot be assumed to have good effects.

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52 This suggests that the effect may be an artefact of the analysis and not real, or that the training is a powerful intervention but one that is little understood and may have as much potential for harm as for good.

Ideally, training programmes should be selected on the basis of the evidence about their efficacy. Chapter 4 reviews all the relevant evidence we could find and, as indicated above, does indeed find that some approaches are more promising than others. In general, however, no approach to selection, training, supervision or quality assurance has been conclusively shown to 'work'. The crucial gap in this area is, therefore, not so much understanding what is happening as being able to influence it.

6.4 Quality of care: interim conclusions

In an ideal world there would be a practice theory of care that would be ethically grounded; logically related to the way care works; rigorously tested in a wide range of special projects; and increasingly embodied in day-to-day work. This theory would encompass the time before the child was in care, while they were in it, and after they had left, and it would understand the links between these stages. It would be accepted by both courts and social services, and by the wide variety of professionals that are involved in care. Crucially, its implementation would be furthered by effective training and a system of quality assurance that was accurate, fair, comprehensive, and linked to appropriate action.

Viewed against this template, the picture is patchy. There is a body of ethical principles that is widely accepted, and in keeping with the views of both practitioners and children in care. These principles focus on relationships, the individualisation of treatment, and listening to children. There are also theories of how care works, incomplete but informed by research, albeit of varying quality, and based on observational studies and a mix of qualitative and quantitative data. The problem with these latter theories or models is not so much that they may be wrong – no doubt in detail they are, but that they have enough in common with what is known about how families operate for us to be reasonably confident that they are not far out – but rather that we have had limited success in putting them into practice.

Section 6 Messages

- Effective foster placements and residential units depend on the quality of the carers, staff and heads of home, and in residential care particularly on the degree to which the head and staff agree on their approach, establish 'warm' relationships with residents, and have clarity of expectation relating to behaviour and education.

- Positive relationships between carer/residential workers and children can reduce the effects of the strong association between current or previous difficult behaviour and placement disruption.

- Even given good carers or staff, 'cycles' of difficulty can arise with the stability of the placement and the well-being of the children or young people.

- We have relatively well-established understanding about what good practice is in this area, but lack proven models for selecting, training, supervising and quality-assuring carers and staff in such a way that the quality of care is enhanced. (Progress towards such models is reviewed in chapter 4).

- The development of these models should be given very high priority.

Section 7: Leaving care

This chapter is about care – not about what happens after it. That said, what happens next is a crucial criterion of the success of what went before. For this reason, we have included a brief review of British research on 'leaving care' in appendix A. A number of principles can, we believe, be derived from this review and we give them below, as many are relevant to the operation of the care system itself. Those who wish to understand our justification of these principles should examine the appendix. The principles (and associated messages) are given as messages below.

In essence these points, if followed, would mean that young people would move from the care system to independence in much the same way as other young people move out of their family home. The timing is flexible; there are false starts, and sometimes they may even return after divorce or when they lose their job. But ideally, they are neither held back nor forced to feel that they are alone in a world where no one is committed to them at all.

Section 7 Messages

- Begin planning early in a child's care career but do so at their pace, and in the light of what they want for their life and the skills and qualifications they need to achieve it.

- Ensure that young people can draw on the strengths available within their families, but have also come to a realistic assessment of their relationship with their family, and one with which they are comfortable.

- Ensure as far as possible that they have the secure base and education that can provide the skills and qualifications required.

- Enable them to move on at their own pace, without either being forced out of their placements or constrained to remain in them.

- Provide the practical resources (finance, access to housing, support to achieve training or employment) needed to enable this to happen.

- Appreciate that young people differ and that they all can make mistakes and will need to try things out that may fail, so that support must be both consistent (they need someone available to them) and flexible (ideally, for example, they would be able to return to their foster family if needed, in the same way as other young people who return home).

Section 8: Conclusion

It is useful when seeking to improve the situation of children in care to make a distinction between policy and practice. Policy can be decided and decisions that accord with it can be checked. For example, it is possible to have a policy that young children should, wherever possible, be placed in foster care. This can be made into a target and monitored, and systems can be put in place to ensure that the target is met. Practice, for example the degree to which foster carers treat children kindly, can hopefully be influenced, but

it is not possible simply to decide that carers will be good.[53] Our conclusions relate to policies, which authorities should be capable of implementing, and good practice, which they may find harder to bring about. Both are required if the young people are to have good mental health and flourish in other ways.

In brief, we conclude that:

1 Both practice and policy should be informed by the ethical principles that are the foundation of the Care Inquiry and NICE/SCIE reports. Although these may only be partially grounded in the evidence, they can form the basis for a wide variety of practical recommendations. Over time, the principles may slightly shift and modify (eg under the influence of social pedagogy), but for the moment they seem highly robust.

2 At a policy level, authorities should give priority to:

- lowering the age at which vulnerable children are identified and either effectively protected in their own homes or provided with long-term permanence

- reducing the number of failed attempts to reunite children with their families

- enabling greater choice between different permanent placements by increasing the numbers of children adopted, given SGOs, or residence orders; decreasing the disincentives to choose particular options within this set, and increasing the similarity between permanent foster care and adoption

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53 The potential importance of this distinction was illustrated by findings from Sinclair et al's (2007) study. This found very large differences between authorities, and often within authorities between social work teams, in all the things about which decisions could be taken. These differences were not fully explained by differences in the children served and the proportion of children returned to their homes; the likelihood that a child would be adopted, placed in foster care or placed in residential care; the kinds of legal orders used; and the proportion of children accommodated with family or friends. By contrast, a multi-level model found that a measure of 'child well-being' varied with the characteristics of the child, with an independent rating of the quality of the foster or residential home involved; perhaps very slightly with the child's social work team, but not at all with the identity of the local authority. This model does not rule out the possibility that the authority can influence child well-being through its influence on the foster carers or residential home, or on a child's age at entry or experience of failed attempts at rehabilitation (both treated as characteristics of the child). It does, however, highlight the issue of how local authorities can influence well-being if this is their aim.

- doing everything possible to reduce the proportion of expenditure on highly costly residential and specialised foster care, while recognising that the advantages enjoyed through these forms of care may need to be embodied in other ways.[54]

3 At the practice level, they should seek to ensure that:

- The models employed are informed (if not validated) by research and probably include the 'consensus model' for working with children on the verge of care or being considered for return home. The principles are: to move with appropriate speed and with the broad sanction of the courts; to ensure children are safe; to make clear to parents what needs to change, why, and what will happen if change is not evident.

- Very high priority is given to the quality of placements and to achieving this, initially by seeking to retain effective carers and not continuing to use manifestly poor placements, and increasingly through effective methods of selection, matching, training, supervision and quality assurance.

- Very high priority should be given to the development and testing of these methods of selection, matching, training, supervision and quality assurance for which at present we lack proven models.

- Very high priority should be given to work with those leaving care and to resourcing the practical initiatives that have been developed.

If successful, these suggestions should result in a change in the composition of the care population and in the care provided. This would involve an increase in the proportions of admitted children who are very young; more determined efforts to reach out to those on the verge of care or informally looked after by relatives, and a reduction in the number of failed reunifications. This change in the balance of care should be managed and contained by an increase in the use of adoption, special guardianship and residence orders for the very young. It would also involve an increase in the amount of kin care and the support provided to this, along with a change in the nature of long-term foster care as espoused by Schofield and colleagues (2012) and now embedded in the DfE permanence policy, which would

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54 At first sight this seems to have little to do with mental health. We include it for two reasons. First, authorities keep children in expensive placements for as little time as they reasonably can. The more expensive a placement is, the less permanent it is, therefore, likely to be and we believe that permanence can be important to mental health. Some of the measures we advocate (for example, the development of training, the early identification of children at risk, and the use of effective interventions) will cost money, which in the short run may not be recouped. They are, therefore, likely to depend on the authority making savings elsewhere.

approximate adoption more closely. For older children, new models of care are required that embody the lessons of research on residential care and MTFC but do not involve disproportionate costs.

Above all, there needs to be recognition that the key to the well-being of children in care lies in their relationships with those with whom they live. Training, supervision and quality assurance must, in the end, be the keys to producing – as opposed to simply profiting from – this high quality day-to-day care. At the moment we do not have validated models for training, supervision, or quality assurance – the assumption that we do may itself be part of the problem. Solving the problem will depend on a determined and iterative combination of development and research. There have been, however, promising starts in this direction and this is an issue discussed in chapter 4. First, however, we move on in chapter 3 to discuss the ways in which practitioners can assess looked after children to identify particular difficulties that can inform the use of targeted resources and interventions.

Chapter 3: Assessments

Section 1: Introduction

In chapter 2 we reviewed the evidence on the aspects of 'ordinary care' that are related to well-being in looked after children. In chapters 3 and 4 we move on to an examination of the assessment and 'treatment' of specific mental health issues in this population. We begin with an overview of some of the most common assessment tools used with looked after children, since the power these tools may or may not possess to accurately assess the needs of children with complex difficulties and experiences can determine whether interventions are correctly targeted and evaluated. Readers should bear in mind, however, that while the instruments discussed below may give some indication of children's functioning, they do not commonly assess the aspects of their environment that might also impact on their well-being (as discussed in chapter 2).

When considering which instruments are most 'useful' for assessing the mental health and well-being of looked after children and young people, it is worth noting that the purpose in using these instruments differs between those researching interventions and practitioners. In general, those conducting research studies to evaluate the effectiveness of an intervention are interested in showing whether the intervention is linked to a decrease in negative symptoms or behaviours (or an increase in those that are positive). The focus is usually on changes in absolute scores, rather than using scores to identify clinically important issues (see Biehal et al, 2012, for an exception to this). The outcome of interest is whether or not the average scores from a sample change over time, and not on what a particular score might mean for an individual child. Intervention research is rarely concerned with the use of assessment tools to diagnose particular conditions, or to identify areas for targeted support – this, in contrast, is the very purpose of using assessment tools in a practice setting.

The research studies we discuss in chapter 4 employ a broad range of measures to assess the impact of interventions on looked after children's mental health and their social and emotional well-being. Some measures are widely used, with many researchers showing a preference for measures that encompass an assortment of indicators of well-being, such as the Strengths and Difficulties Questionnaire or SDQ (Goodman, 2001, used for example in Biehal et al, 2012), or the Child Behaviour Checklist, the CBCL (Achenbach, 1991a, used for example in Leathers et al, 2011). Other researchers have chosen to focus on specific conditions or aspects of well-being, and have accordingly used more focused measures (eg for anxiety and depression: see Reddy et al, 2013).

In the world of practice, there are a number of assessment tools that are commonly used as screening instruments, which can be administered by caregivers, clinicians or other health professionals working with looked after children and young people, or self-administered by young people. These instruments generally cover a range of internalising and externalising behaviours, as well as children's social and emotional well-being.

Evidence on the most common screening instruments is discussed below. We have chosen to focus on the instruments that are both commonly used in practice with looked after children, and that have been tested in research studies with this population, to allow us to say something about their usefulness in both contexts. We acknowledge that other instruments exist that are routinely used in clinical assessments for mental health problems or broader well-being, but that have not been the subject of published research with a looked after sample. We would, therefore, call for further research on these measures with looked after children.

We begin by discussing instruments that have been used with looked after children in general: the SDQ, CBCL and the Children's Global Assessment Scale or CGAS (Shaffer et al, 1983). We move on to discuss those that are most often used for looked after children who are experiencing difficulties: the Development and Well-Being Assessment or DAWBA (Goodman et al, 2000) and other screening tools. Further details on these instruments can be found in appendix B. Children's scores on these screening tools can help practitioners to decide whether further assessment of specific conditions (such as ADHD or anxiety) is required. Clinicians can then choose from a wide range of condition-specific assessment tools that are on offer. There is sufficient similarity between looked after children and their peers to suppose that these tools are equally capable of allowing a diagnosis in either population.

Section 2: Assessment tools

2.1 Strengths and Difficulties Questionnaire (SDQ)

The SDQ (Goodman, 2001) has been used widely with looked after children, and since 2008 has been used routinely to collect data on children looked after in English local authorities. The SDQ assesses emotional and conduct problems, hyperactivity/inattention and peer problems (which can all be summed to provide a 'total difficulties' score), as well as prosocial behaviour. It offers versions for caregivers/teachers or for self-report (for young people aged 11 and above).

Use of the SDQ with looked after children has been shown to provide a good estimate of the prevalence of mental health conditions (Goodman and Goodman, 2012). It also allows the identification of children with psychiatric diagnoses based on the DAWBA, with caregivers' and teachers' responses proving to be more useful in this regard than self-reports from looked after adolescents (Goodman et al, 2004). Its use as a screening tool during routine health assessments for looked after children doubled the detection rate of socio-emotional difficulties in one study (Jee et al, 2011). Moreover, a study conducted with three English CAMHS (Child and Adolescent Mental Health Service) teams, by Foreman and Ford (2008), which was not restricted to looked after children, suggested that the SDQ used as a stand–alone screening measure was equally reliable at helping clinicians to reach a diagnosis of hyperkinetic disorders as was the longer and much more time-intensive DAWBA.

The SDQ has also been used to study a range of issues for looked after children, in particular concerning the identification of risk and protective factors for mental health issues (Aguilar-Vafaie et al, 2011; Richards et al, 2006).

2.2 Child Behaviour Checklist (CBCL)

The CBCL (Achenbach, 1991a) is a widely-used instrument in research and practice. Although it was not developed specifically for use with looked after children, it has been extensively used with this population (eg Armsden et al, 2000). The CBCL was designed for completion by caregivers, and assesses a range of internalising and externalising difficulties. Versions for completion by teachers (the Teacher Report Form or TRF, see Achenbach, 1991b), and for self–report (Youth Self-Report or YSR, see Achenbach, 1991c) have also been devised. The CBCL has been translated into a number of different languages and regularly appears as an outcome measure in mental health studies from non-English-speaking countries.

The CBCL has been used to investigate a range of issues for looked after children, including: discrepancies between clinical–level symptomatology and rates of clinical referrals (Sainero et al, 2014); links between behavioural typologies and placement disruption (Strijker et al, 2005); and the relationship between mental health and adolescent delinquency (Woods et al, 2013).

There is some debate about the agreement between different informants using the CBCL and TRF versions of the scale, for children in general as well as those who are looked after. Studies have generally shown poor correlations between foster carers/residential workers and teachers on total problems, with agreement generally slightly higher on externalising as opposed to internalising difficulties

(Kugler et al, 2013; McAuley and Trew, 2000; Shore et al, 2002). One study by Tarren-Sweeney et al (2004) showed good agreement on externalising and total problems (internalising agreement was still low); the authors note that differences between this and other findings might be a reflection of the familiarity of informants with the child, differences in sample sizes or cultures, and the context of clinical referral. Agreement between scores on the Youth Self-Report version and foster carers' CBCL scores is generally low (Strijker and Van Oijen, 2008), and agreement may decrease as the severity of internalising problems increases (Strijker et al, 2011).

A recent study with children in foster care has shown that CBCL subscales specifically developed to assess Post-Traumatic Stress Disorder (PTSD) were poor indicators of the number and severity of clinically-assessed PTSD symptoms in this population (Rosner et al, 2012).

2.3 Children's Global Assessment Scale (CGAS)

The CGAS (Shaffer et al, 1983) assesses children's levels of general adaptive functioning over a specified period of time (usually the previous three months). It was designed for clinical use, but in research studies it has been completed by researchers, residential home managers and children's keyworkers (eg Green et al, 2014; Hukkanen et al, 2003). Rather than reflecting specific symptoms, the intention for the CGAS is to assess children's adjustment in functional terms: its scoring system requires assessors to judge the level of children's functioning and assign them a score that falls somewhere between 'doing very well' and 'extremely impaired'. Functioning in the areas of home and school, with friends and during leisure time, are all taken into account.

The CGAS has been used to compare the effectiveness of Multidimensional Treatment Foster Care (MTFC; see chapter 4) to 'treatment as usual' (Biehal et al, 2012; Green et al, 2014). It has also been used to study behavioural and emotional problems of those in Finnish children's homes (Hukkanen et al, 2003; 2005). Use of the CGAS with young people in residential homes has shown that low general functioning relates to levels of suicidal ideation and behaviour (Hukkanen et al, 2003). Scores given by the head of the children's home and the child's keyworker indicated high levels of agreement (Hukkanen et al, 1999).

2.4 Development and Well-Being Assessment (DAWBA)

As with the CBCL, the DAWBA (Goodman et al, 2000) was not developed specifically for use with looked after children but has recently begun to be used more widely with this population. The DAWBA is delivered online, gathering information from caregivers, teachers and young people (for those aged 11 and above). It is used to assess common behavioural, emotional and hyperkinetic disorders, recording symptoms and their impact, with a view to generating psychiatric diagnoses. The DAWBA package incorporates the Strengths and Difficulties Questionnaire, which can be used as a stand-alone instrument (discussed in section 2.1).

The DAWBA has been used with looked after children to assess prevalence of mental health conditions (Meltzer et al, 2003) and comorbidity of and risk factors for disorders (Lehmann et al, 2013). The online delivery method allows clinicians to rapidly assess children who need to wait for referral, but is also good for predicting a formal diagnosis (Foreman et al, 2009).

2.5 Other screening tools

The Revised Child Anxiety Depression Scales or RCADS (Chorpita et al, 2000) and the Behavioural and Emotional Reactivity Index or BERI (Bartle and Sabatelli, 1995) are both commonly used with looked after children. However, we could not find any research that examined this population's mental health assessment using these tools.

Many services in England, working across CAMHS, local authorities and third sector organisations working with the mental health needs of children are part of the Children and Young People's Increasing Access to Psychological Therapies programme (CYP-IAPT) and, as such, are making use of the assessment tools offered within that. These tools can be derived from the CORC website[55] and are free to use. The main clinical assessment tools in CYP-IAPT are the SDQ (described in section 2.1) and the Revised Children's Anxiety and Depression Scale or RCADS (Chorpita et al, 2000). The RCADS gives information on a range of internalising problems, including depression, separation anxiety, social phobia, generalised anxiety disorder, obsessive compulsive disorder and panic (but not PTSD), and includes cut-off points for normal, raised and high scores by age group for both boys and girls from 8–18 years.

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55 www.corc.uk.net/resources/measures/child/

CYP-IAPT stresses the importance of collaborative working and as such places great emphasis on two other types of measure. The first, Goal-Based Outcomes (GBOs), provides user-defined measures of the issues that are important to the young person or to their carer. This is likely to be especially useful for looked after children, because some of the difficulties they target may not fall within the usual diagnostic categories. Secondly, and most usefully for direct work with the child or young person, are the session-rating measures, which are a way of assessing whether the young person feels involved and engaged with any treatment being offered.

Finally, a different kind of measure has been designed that can be used to supplement diagnostic tools, for the collection of information about the wider range of difficulties that some looked after children can have. The Assessment Checklist for Children or ACC (Tarren-Sweeney, 2007) and the Assessment Checklist for Adolescents, the ACA (Tarren-Sweeney, 2013b) were designed to fill a perceived gap in the assessment tools available for looked after children. Their originator recognised that looked after children can present with a range of difficulties (such as dissociation and inappropriate sexual behaviour) that were not always evaluated by standard assessment tools. The ACC (and subsequently the ACA) were, therefore, developed specifically for use with looked after children and young people to provide a measure of the difficulties that can be present in this population. Although the scales were originally intended for completion by caregivers (Tarren-Sweeney, 2007), their originator has since revised this position and stated that the full-length versions should only be used by CAMHS practitioners or researchers (Tarren-Sweeney, 2013c). The scales assess common difficulties as well as less frequent but more critical issues, such as self-harm.

Clinical scores on both the ACC and the ACA correlate well with the CBCL total problems score ($r = .89$ for boys and $r = .90$ for girls, see Tarren-Sweeney, 2007), and have been shown to differentiate between children who have and who have not been referred for mental health services (Tarren-Sweeney, 2013b).

Briefer, 20-item versions of the ACC and ACA have recently been developed: the BAC-C and the BAC-A (Tarren-Sweeney, 2013c) are designed for screening use by non-clinicians and to monitor young people's progress. The brief forms are accurate at predicting scores on the longer versions, have good internal consistency and compare well with the SDQ and the short version of the CBCL.

The ACC has more recently been used to examine the risk factors for mental health issues in looked after children (Tarren-Sweeney, 2008) and seeks to provide information about trauma- and attachment-related behavioural profiles (Tarren-Sweeney, 2013a). Given their recent publication dates, further studies testing the usefulness of the ACA and the briefer forms are not currently available.

Section 2 Messages

- Assessment tools that have been tested with looked after children include the SDQ, CBCL, CGAS, and DAWBA.

- The SDQ, CBCL and CGAS are also widely used in research on interventions.

- CYP-IAPT in England includes a range of assessment measures but also records young people's treatment goals and sense of engagement.

- The ACC and ACA have been recently developed to measure some of the difficulties that may be relevant for looked after children.

Section 3: Which assessment tool is most useful according to the evidence?

In practice, the 'usefulness' of assessment instruments *in research* depends on their ability to detect change in individuals over time; their usefulness as clinical screening tools depends on whether they are capable of predicting mental health service need (when used by non-clinicians) or, for clinicians, whether they can help to select and direct the allocation of resources or further diagnostic assessments. Ease of use is also an important consideration. This summary takes account of these issues as presented in research evidence; any points drawn from this do not take account of personal practice experiences in using a particular instrument.

The SDQ and CBCL have been shown to detect change in children's difficulties over time in a number of studies of interventions for mental health and well-being, which will be discussed in chapter 4. For example, Briskman et al (2012) showed reduced problems on the SDQ following the Fostering Changes carer training programme, while Leathers et al (2012) found reductions in internalising and externalising behaviours for children in the 'KEEP' programme. Research showing the ability of the CGAS to detect change includes Green et al's (2014) discovery of an interaction between treatment type (usual care versus MTFC: see chapter 4) and levels of anti-social

behaviour before receiving the intervention, and Hukkanen et al's (2005) finding that girls in Finnish residential care experienced a rise in psychosocial problems over the course of three years, which brought them in line with boys' scores. The DAWBA and the ACC/ACA have not as yet been used to evaluate the effectiveness of targeted interventions.

Each of the instruments reviewed here can also be used to inform clinical diagnoses of behavioural, emotional and hyperkinetic conditions. We focus here on factors relating to the 'usefulness' of those instruments that are designed to screen for the mainstream mental health disorders for which CAMHS offer services.

The CBCL incorporates 'clinical' cut-off scores, and scores on the CGAS scale can be used to distinguish clinical from non-clinical cases. The SDQ has a cut-off for 'abnormal' scores that indicate high risk of meeting the criteria for psychiatric diagnoses. The DAWBA computes the likelihood of a clinical diagnosis and produces output that is then collated and rated by clinicians. A limitation of these commonly-used tools is that, in general, they are only designed for use with children aged 3–5 years and older; arguably, there is a need for validated assessment tools that are sensitive to the particular needs of looked after infants, which would enable early interventions (Silver and Dicker, 2007).

The evidence on the ability of instruments to predict service need or to detect specific conditions in the looked after population is mixed. Differences in SDQ scores for looked after children have been shown to relate to differences in mental health and to diagnoses of psychiatric disorders. The CBCL has been widely used with the looked after population; however, there has been some question about its usefulness as a screening measure for PTSD in foster care (Rosner et al, 2012). There is little evidence on the clinical use of the CGAS or the DAWBA with looked after children, though the latter has provided the most thorough picture of their mental health in the UK (Meltzer et al, 2003). In addition, the DAWBA has the advantage over checklist-based measures in that it allows for the detailed investigation of patterns of symptoms, their duration and impact on children's functioning (Lehmann et al, 2013). Unlike checklists, it contains a mix of structured and open-ended questions that may make it a more useable and sensitive tool when used by experienced clinicians (Aebi et al, 2012).

Anyone using these (or other) tools should bear in mind that a number of looked after children can present with difficulties that do not form part of traditional diagnostic systems; it is for this reason that complementary checklists like the ACC and ACA were developed. Children may also have a broad range of sub-clinical symptoms that have a significant impact on their daily functioning but which,

taken separately, do not place them above diagnostic thresholds for a particular condition (DeJong, 2010).

The ability of assessment tools to predict service need or particular conditions may depend on who completes them. Analysis of the SDQ suggested that caregivers' and teachers' responses are best at predicting children's psychiatric diagnoses, particularly since looked after young people seem poor at recognising their own externalising behaviours. The reliability of CBCL scores reported in different contexts (school versus home) and by different informants (caregiver, teacher, or self-report) has been called into doubt. In contrast, the CGAS has shown good levels of agreement between keyworkers and children's home managers. The DAWBA relies on completion by caregivers and teachers (and, where children are old enough, self-report). Clinicians treat informants' responses as complementary, but in case of contradiction will judge which informant seems most reliable (Lehmann et al, 2013).

Finally, there are variations in the extent to which different tools may be considered 'user-friendly'. The SDQ offers a useable short format of assessment for caregivers to complete, whereas the length of the full 118-item version of the CBCL (which has generally been favoured over the short version) might put some caregivers off. The DAWBA is also lengthy, but its advantage is in being completed online, allowing for rapid assessments without caregivers having to wait for children to be referred to senior clinicians (although review by an experienced clinician is likely to be especially helpful). The CGAS requires an overall judgement of children's functioning rather than responses on specific symptoms, and as such may benefit from being completed by someone who can take a broader view of the child outside of a specific relationship (ie clinicians rather than caregivers).

Section 3 Messages

- The SDQ, CBCL, CGAS, and DAWBA can be scored and assessed to determine children's clinical needs.

- The SDQ, CBCL, and CGAS may be more useful as broad measures of well-being than for assessing specific conditions.

- The DAWBA's use of different types of questions and added focus on patterns, duration and impact of symptoms may make it more 'useful' for clinicians.

- The CGAS offers an assessment of children's overall functioning rather than number or severity of particular symptoms.

- The reliability of assessments can depend on who is completing the instrument and in what context.

Chapter 4: Specific interventions

Section 1: Introduction to the intervention review

In chapter 2 we argued that early removal from a dysfunctional home could increase the chances of 'successful' outcomes in the care system. For a number of reasons, early removal is not always possible, and children can enter care with a range of complex needs and difficulties. Chapter 2 gave an overview of the aspects of 'ordinary care' that can impact on looked after children's social and emotional well-being, but some children will require more targeted support. Having considered some of the ways of assessing their mental health in chapter 3, we now move on to survey the evidence on specific interventions that might result from these assessments. Our literature search on this topic (see appendix C) was directed by the findings of the Meltzer et al (2003) study into the mental health of looked after children in England, which revealed that 37 per cent of the sample had conduct disorders, 12 per cent had emotional disorders, and 7 per cent had hyperkinetic disorders. Other types of disorder were less prevalent, and so are not covered here. We recognise, however, that it is uncommon for those delivering interventions to looked after children to limit their use to those individuals who have clinically diagnosed conditions. Our review, therefore, covers any interventions that were listed as targeting behavioural, emotional or hyperkinetic outcomes for looked after children and young people. We stress here, as in chapter 1, that while using the phrases 'behavioural problems' and 'emotional problems' we also acknowledge the fact that the outcomes that are defined as 'problematic' in a normative context have often developed as adaptive responses to dysfunctional environments. Moreover, outcome measures are limited by professional perspectives, and young people themselves may identify aspects of well-being that go beyond those adopted here.

Our search uncovered 12,476 original research articles and literature reviews on interventions specifically tested with looked after children, and we discuss the findings in terms of children's outcomes and, where they have been reported, the financial costs involved. We acknowledge that our search was not exhaustive: we did not search for articles published on non-English language databases or websites; our panel of international experts did not cover all continents (South America and Asia in particular were neglected); and due to time limits we could not screen for citations of each article, which might have uncovered more recent updates.

It was not possible to review every treatment available for every mental health issue, since there are many treatments that have been tested in the general population but for which there is no specific evidence on efficacy with looked after children. This chapter does not cover the evaluation of interventions with young people who are not in the care system or of adult outcomes for those who have graduated from the interventions. Nor does it cover the outcomes for others involved in the interventions (eg carers' stress levels). In addition, the short time available in which to conduct our review has led us to restrict our discussion here to interventions for which we found two or more articles evaluating the approach. We did not apply quality 'ratings' in order to exclude any studies from the review. Readers are, therefore, urged to note the discussion on the state of the evidence for each intervention.

Our review covers 106 studies. The results are grouped according to the target of the intervention, under several levels:

1. At the highest level, studies are grouped by the predominant **type of well-being** that is targeted by the intervention. We have opted for the headings of behavioural, emotional, and hyperkinetic interventions, in line with the Meltzer et al (2003) findings. Where an intervention targets more than one type, we have listed findings under the predominant type (to allow for a less disjointed discussion on the state of the evidence) and cross-referenced the work in the other relevant section(s). For the purposes of this review, attachment style is classed as a behavioural response.

2. At the next level, grouping occurs according to the general **age range** the intervention has been used with (0–6 years versus 7 years or over). Although this division may seem arbitrary, the majority of the interventions discussed have either been designed for younger or older children and there are reasons to believe that different approaches will work better for different age groups (which will be discussed below). Where an intervention has been tested on a wide range of ages, we have grouped it either according to the age group for which it was designed or, if not specified, for which it has been the subject of most research.

3. The final level of grouping reflects whether the child is **directly or indirectly targeted** by the intervention. Some interventions, such as Multidimensional Treatment Foster Care or MTFC) are primarily targeted at caregivers as agents of change, whereas others (eg mentoring) focus on direct work with the child or young person in order to improve

their well-being. Others (eg Middle School Success) offer a mix of direct and indirect approaches. Where more than one intervention exists within this final level, they have either been listed in alphabetical order (where a range of evidence exists) or grouped with 'other' interventions of the same type (eg 'other therapeutic interventions').

For brevity and ease of reading, this chapter presents a brief synthesis of the research findings (with illustrative references) for each intervention, coupled with notes on the state of the evidence. The purpose of the latter is to draw readers' attention to some of the limitations that can affect the interpretation of whether a particular intervention is 'effective'. Notable limitations in this sense include the use of small and/or diverse treatment samples, or those drawn from a particular context (such as the youth justice system in the US), which can limit the scope for generalising the results of a study. Variation in the presence and quality of comparison groups can also make it difficult to see whether the intervention offered is better than an alternative intervention or 'treatment as usual'. The measures used to assess effectiveness can also be problematic: particular care should be taken when considering carer-reported 'problems', which may in fact be a reflection of changes in their confidence rather than children's behaviour, or an artifact of their investment in the programme. Effectiveness measures should also be taken at periods after the intervention is complete, to assess the longevity of any effects. Finally, readers may wish to exercise caution where a particular intervention has been tested only by one research group, particularly where the same group has designed the intervention: ideally, any results of this kind should be verified by independent work.

Readers who wish to know more about individual studies can consult the table of included papers in appendix D (which lists details of sample sizes, comparison groups, randomisation, measures, and follow-up periods). Descriptions of the interventions and a more detailed discussion of the findings presented for individual studies can be found in appendix E.

The chapter ends by reviewing some of the general messages that can be drawn from the evidence on mental health interventions for looked after children. In constructing these messages we draw on the research presented in this chapter, along with previous literature reviews on the topic. Our aim in doing so is to summarise what the evidence presented here would suggest are the key features of effective interventions, insofar as this can be done given the state of the evidence.

Section 1 Messages

- This chapter reviews the evidence on specific interventions targeting behavioural, emotional, and hyperkinetic disorders in looked after children.

- Interventions are grouped according to type of well-being, age range, and whether they work with children directly or indirectly (through caregivers).

- Notes on the state of the evidence show the limitations of the evidence that might affect interpretations of how 'effective' a particular intervention is.

Section 2: Behavioural interventions for young children (0–6 years)

In this section we examine the interventions that have been designed to improve behavioural functioning in looked after children under the age of seven. Issues that are addressed by this type of training include externalising behaviours, such as aggression and violence, and attachment behaviours (ie attachment security). At its extreme, behavioural dysfunction is represented in forms of conduct disorder, which was found in 37 per cent of looked after children in an English national survey (Meltzer et al, 2003). The same survey showed that 36.5 per cent of 5–10-year-olds in care had conduct disorders (rates for younger children were not collected). Subclinical behavioural difficulties are assumed to be even more widespread.

2.1 Direct interventions for young children

Our search did not reveal any studies on interventions for young looked after children designed to target behavioural disorders through direct work with them.

2.2 Indirect interventions for young children

Attachment and Biobehavioral Catch-up (ABC)

Intervention: This 10-week training programme is based on attachment theory. It aims to help foster carers develop nurturing caregiving; to understand children's 'difficult' behaviour; and to help them with self-regulation.

For ages: *12–24 months (or older, with modifications).*

Children's outcomes tested: *stress; attachment; internalising and externalising behaviours; cognitive flexibility; theory of mind.*

Findings with looked after children and young people:
Research studies have compared children in foster care with other fostered children who were either in waitlist control groups or whose carers received education-based training. The evidence suggests that ABC is related to lower levels of cortisol – a hormone indicating stress – in children (Dozier et al, 2008); less avoidant attachment behaviour (Dozier et al, 2009); fewer internalising and externalising behaviours (Sprang, 2009); and improvements in the kind of cognitive abilities that are important for adaptive social behaviour (Lewis-Morrarty et al, 2012).

State of the evidence:
There are several limitations with the evidence on ABC. Findings have been drawn from US studies, largely conducted by those who developed the intervention (except Sprang, 2009). Sample sizes are modest: a maximum of 46 in ABC (Dozier et al, 2008), and are not always well-matched (eg Lewis-Morrarty et al, 2012). Two-thirds of the studies lacked the baseline measures that are needed to evaluate change (eg Dozier et al, 2009), and most included only short follow-ups or were unclear about when follow-up measures were taken (eg Dozier et al, 2008).

Multidimensional Treatment Foster Care for Preschoolers (MTFC-P)

Intervention: A specialised form of treatment Foster Care, MTFC-P is based on theories of social learning and behavioural reinforcement, and provides specially trained foster carers and the children they look after with a wraparound team of social workers, therapists, skills workers and managers. Its key principles involve the use of clear boundaries; an emphasis on consequences through the reinforcement of prosocial behaviours; close supervision by caregivers; and efforts to avoid the influence of anti-social peers.

For ages: *3–7 years.*

Children's outcomes tested: *problem behaviours; cognitive control; response monitoring; attachment; stress; costs of placement.*

Findings with looked after children and young people:
The link between MTFC and behavioural issues is weaker for young children than for adolescents (see section 3.2). Only one study of young children in the Netherlands showed that carer-reported behavioural problems decreased from the start of placement over the following 12 months, but did not compare MTFC to other types of placement (Jonkman et al, 2012). In the US, MTFC was linked to increased secure and decreased avoidant attachment behaviour. However, there were no significant differences between the two groups either at the start or the end of the study (Fisher and Kim, 2007). Children in regular foster care were more likely to have a placement disruption within the first 12 months if above a threshold of five carer-reported problem behaviours in a 24-hour period; the same was not true of those in MTFC, who also had fewer disruptions overall (Fisher et al, 2011). Some studies examined the physiological responses underlying behaviours, suggesting that children in MTFC show responses to performance feedback and daily stress levels that are similar to their non-fostered peers (Bruce et al, 2009). Finally, an analysis of incremental net benefits by Lynch et al (2014) took into account both the difference in costs for MTFC and regular foster care (RFC), and the costs associated with changes in outcomes (eg placement permanency). Using placement outcomes from a randomised sample, they found that the value of the benefits for MTFC versus RFC exceeded the costs.

State of the evidence:
Most of the evidence cited comes from the US, with one study (Jonkman et al, 2012) from the Netherlands. Sample sizes are modest: a maximum of 57 in MTFC (Fisher and Kim, 2007; Fisher et al, 2011). Most US studies have used random assignment to MTFC or regular foster care (eg Bruce et al, 2009). Most studies rely on carer-reported behaviour (eg Fisher and Kim, 2007; Fisher et al, 2011; Jonkman et al, 2012), which may introduce a source of bias. Follow-up measures have generally been taken 12 months after entry to MTFC (eg Fisher and Kim, 2007; Jonkman et al, 2012).

2.3 Mixed interventions for young children

Parent-Child Interaction Therapy (PCIT)

Description: This short-term intervention encourages caregivers to shape children's behaviour through the use of positive and negative reinforcement. It focuses on the use of positive attention in order to shape the child's behaviour and discipline, establishing consistent, positive commands and contingencies for behavioural compliance.

For ages: *2–8 years.*

Children's outcomes tested: *problem behaviours.*

Findings with looked after children and young people:
Case studies on the use of PCIT with foster children provided promising findings relating to children's behaviour (Timmer et al, 2006a; Fricker-Elhai et al, 2005). A larger-scale trial that compared the use of PCIT in foster and birth families showed that improvements in problem behaviours were equally likely in both groups (Timmer et al, 2006b). Moreover, a modified two-day version of PCIT was also linked to a reduction in problem behaviours (McNeil et al, 2005).

State of the evidence:
Evidence on PCIT is drawn from the US. The maximum sample size was 75 (Timmer et al, 2006b), though some studies report only on case studies (Fricker-Elhai et al, 2005; Timmer et al, 2006a). Most did not include a control group. Measures of change are reported by carers, with the longest follow-up taken just one month after the intervention ended (McNeil et al, 2005).

Section 2 Messages

- Behavioural interventions for younger children consist of indirect (ABC, MTFC–P) and mixed approaches (PCIT).

- Whereas ABC focuses on attachment and improving the carer–child relationship, the emphasis in MTFC–P and PCIT is on behaviour management.

- ABC is linked to positive outcomes, but the research has been limited in terms of samples, baseline measures and follow-ups.

- The evidence on MTFC–P is weaker than for the equivalent programme for older children.

- PCIT has promising links with behavioural outcomes, but the research has also had problems with samples and short follow-ups.

Section 3: Behavioural interventions for older children and adolescents (7–17 years)

In this section we examine the interventions that have been designed to improve behavioural functioning in looked after children aged seven and above. Our definition of behavioural issues is as stated in section 2. Meltzer et al (2003) found that 36.5 per cent of 5–10-year-olds, 40.5 per cent of 11–15-year-olds and 30 per cent of 16–18-year-olds in care in England had conduct disorders (an extreme form of behavioural problem). Subclinical behavioural difficulties are assumed to be even more widespread.

3.1 Direct interventions for older children and adolescents

Besides the interventions discussed here, see also animal–assisted therapy (AAT) and its links to attachment (section 5.1).

Attachment, Regulation and Competency (ARC)

Description: ARC offers a flexible framework for interventions with maltreated children, targeting the key domains of attachment, self-regulation and developmental competencies. ARC is a way of thinking about working with young people, rather than an intervention programme. The ARC framework consists of 'building blocks' or treatment targets, and is designed to work not just with the child, but also with the caregivers and the context surrounding them. The ARC framework can be used with different age groups living in a range of settings, and offers flexibility in specific practice, within the fixed framework of building blocks.

For ages: *early childhood to young adulthood.*

Children's outcomes tested: *problem behaviours; Post-Traumatic Stress Disorder (PTSD) symptoms; internalising and externalising behaviours.*

Findings with looked after children and young people:
Use of the ARC framework has been linked to reductions in problem behaviours (Arvidson et al, 2011) and PTSD symptoms (Hodgdon et al, 2013).

State of the evidence:
The evidence cited comes from the US, and used modest to large sample sizes: a maximum of 126 (Hodgdon et al, 2013). No studies used a comparison group. Evaluation may be difficult as specific intervention practices within the framework differ across sites (Hodgdon et al, 2013).

Life story work

Description: Life story work operates to help looked after and adopted children create a record of their experiences, and involves working with a trusted adult. There are variations in techniques, with boxes, books and online programmes being used to record experiences.

For ages: *3–17 years.*

Children's outcomes tested: *child-carer relationship; identity; externalising behaviours.*

Findings with looked after children and young people:
Qualitative work suggests that children and their caregivers can value life story work as an opportunity to work through emotions and explore identity, and to improve their relationships (Shotton, 2010; Willis and Holland, 2009). One study linked life story intervention to decreases in children's externalising behaviours (Haight et al, 2010).

State of the evidence:
The evidence cited comes from the US and the UK. Sample sizes are very small: a maximum of 12 (Willis and Holland, 2009), as research on life story work has been largely qualitative to date. Most measures are qualitative; measures of changes in children's behaviour were rated by carers (Haight et al, 2010).

Mentoring

Description: Mentoring schemes pair a child or young person with a non-related adult for regular social meetings. Some programmes include additional skills training.

For ages: *six years to adulthood.*

Children's outcomes tested: *family and social functioning; behaviour at school; stress; mental health and service use; self-reflection; self-esteem; resilience.*

Findings with looked after children and young people:
The evidence on mentoring schemes with looked after children suggests that they can be of benefit for social and emotional well-being and self-determination, particularly when paired with skills training (eg Geenen et al, 2013; Taussig and Culhane, 2010). There is some indication that having limited access to a mentor is worse than receiving no mentoring at all (Johnson et al, 2011). Mentoring may work best when it offers a consistent presence and the chance to develop an emotional attachment, and includes good support for mentors and mentees (Spencer et al, 2010).

State of the evidence:
The evidence cited comes from the US and the UK. Sample sizes range from two (Woodier, 2011) to 262 (Johnson et al, 2011), but only studies by Taussig and colleagues (Taussig and Culhane, 2010; Taussig et al, 2012, 2013) included a comparison group. Some studies used measures from a range of sources: caregivers, teachers and children (Taussig and Culhane, 2010; Taussig et al, 2013), whereas Woodier's (2011) case studies were based on personal reflection. Success can depend on whether measures are taken from carers or young people (Geenen et al, 2013).

3.2 Indirect interventions for older children and adolescents

Fostering Attachments

Description: This training programme for carers combines social learning theory and attachment theory, and focuses on developing the skills foster carers need to work with children who have attachment difficulties. Carers are given an in-depth introduction to attachment theory, and there is an emphasis on practising attunement, empathy and consistent discipline strategies. Fostering Attachments has now changed its name to Nurturing Attachments (Golding, 2013).

For ages: *4–14 years.*

Children's outcomes tested: *problem behaviours.*

Findings with looked after children and young people:
An initial pilot study, with seven foster carers attending over 18 months (Golding and Picken, 2004) showed reductions from baseline to the end of the programme in carer-rated peer difficulties, hyperactivity, and total difficulties on the Strengths and Difficulties Questionnaire (SDQ, see chapter 3). In contrast, studies in which the programme was delivered over 18 weeks have shown no change in children's social, emotional or behavioural well-being (Laybourne et al, 2008), with the exception of a significant reduction in hyperactivity from baseline to a follow-up three months after completion (Gurney-Smith et al, 2010).

State of the evidence:
All of the evidence cited comes from England. Sample sizes are small: a maximum of 13 in the Fostering Attachments group (Gurney-Smith et al, 2010), and only one study (Golden and Picken, 2004) included a comparison group. Outcomes are carer-reported, and only one study (Gurney-Smith et al, 2010) included a follow-up, three months after completion of the programme.

Fostering Changes

Description: This 12-week course for foster carers is based on social learning theory and attachment theory. It offers behaviour management strategies, and aims to help carers build positive relationships with the children in their care. Carers are taught to encourage desirable behaviours through the use of positive reinforcement and the setting of clear limits and consequences for behaviour.

For ages: *2–17 years.*

Children's outcomes tested: *problem behaviours; attachment quality.*

Findings with looked after children and young people:
The two reports on the initial trial of Fostering Changes training showed a reduction in children's problem behaviours – particularly those identified as personal concerns of the carers at the beginning of the course – and in emotional problems (Pallett et al, 2002; Warman et al, 2006). However, there was no reduction in conduct problems or hyperactivity. A subsequent randomised controlled trial (RCT) showed a significantly greater reduction in the intervention group's reports of children's problem behaviours, and a greater improvement in the carer-reported quality of attachment between the child and carer, in comparison to the control group (Briskman et al, 2012). Whereas problem behaviours and hyperactivity decreased over time in the intervention group, they increased in the control group (but baseline scores also differed, so that the scores at the end of the course were similar for both groups). There was no difference between groups on children's emotional symptoms, conduct problems, peer relationships or prosocial behaviour.

State of the evidence:
All of the evidence is drawn from England. Sample sizes are moderate to large: a maximum of 95 (Warman et al, 2006). Only Briskman et al (2012) included a control group and random allocation. Measures are reported by carers at the start and end of the course, with no follow-ups.

Incredible Years carer training (IY)

Description: IY is a 12-week training programme, the aim of which is to improve parenting skills, in order to prevent or reduce children's problem behaviours and to improve their social skills. There is a focus on helping children to learn through the use of praise, incentives, play, and limit-setting. An alternative version for use with children rather than carers helps young children to develop the skills of emotion understanding and regulation, and problem-solving.

For ages: *2–17 years.*

Children's outcomes tested: *problem behaviours; hyperkinetic behaviours; self-control.*

Findings with looked after children and young people:
Findings for caregivers attending IY training have been mixed. Two UK studies have shown a decrease in the intensity of children's problem behaviours (McDaniel et al, 2011) and a greater reduction in children's problem behaviour and hyperkinetic behaviours compared with control groups (Bywater et al, 2010), whereas another from the US reported a difference only in conduct symptoms rather than more general aggressive or hyperactive behaviours (Nilsen, 2007). An alternative version of IY produced improved co-parenting strategies between foster carers and birth parents (Linares et al, 2006), whereas another alternative for use with children showed no difference between those taking IY and a control group in externalising behaviours (Linares et al, 2012).

State of the evidence:
The evidence is drawn from the US and the UK. Sample sizes are small to moderate: a maximum of 49 in the IY group (Linares et al, 2012). Comparison groups have generally not received a comparison intervention, making it difficult to determine whether any effects were down to the content of the programme or simply attending any form of training. Measures are reported by carers, and follow-ups are short: a maximum of six months after baseline (Bywater et al, 2010).

Keeping Foster Parents Trained and Supported (KEEP)

Description: KEEP developed as an offshoot of MTFC (see below) for regular foster and kinship carers. This 16-session programme aims to strengthen the behaviour management skills of carers. Carers are taught how to use behavioural contingencies; set effective limits; and balance encouragement with limits. Sessions focus on difficult behaviour, as well as school success, peer relationships, and managing carer stress.

For ages: *5–12 years.*

Children's outcomes tested: *behavioural problems.*

Findings with looked after children and young people:

US studies of KEEP have shown that children had fewer carer-reported behavioural issues compared with those in control groups (Chamberlain et al, 2008; Price et al, 2012), but there was no effect of receiving the intervention on carers' ratings of the child's integration into the foster home or their desire to adopt the child (Leathers et al, 2011; 2012). KEEP appears to be most effective in groups where carers are highly engaged (DeGarmo et al, 2009).

State of the evidence:
All of the evidence so far comes from the US. Sample sizes range from small: 18 young people with carers in KEEP (Leathers et al, 2011; 2012) to large (359 in Chamberlain et al, 2008). However, comparison groups do not receive a placebo intervention. This is problematic, as the outcome measures are carer-reported. Follow-ups have been short: a maximum of two months later (Leathers et al, 2011; 2012) – a 12-month follow-up had too few children to analyse.

Multidimensional Treatment Foster Care for Adolescents (MTFC-A)

Description: A specialised form of treatment foster care, MTFC-A is based on theories of social learning and behavioural reinforcement, and provides specially trained foster carers and the children they look after with a wraparound team of social workers, therapists, skills workers and managers. Its key principles involve the use of clear boundaries, an emphasis on consequences through the reinforcement of prosocial behaviours, close supervision by caregivers, and efforts to avoid the influence of anti-social peers.

For ages: *12–17 years.*

Children's outcomes tested: *anti-social and violent behaviour; delinquency; risky sexual behaviour; substance use; mental health; peer relationships; depression; self-harm; school involvement; costs of placement.*

Findings with looked after children and young people:[56]
In general, trials from the US have shown that MTFC relates to lower delinquent and anti-social behaviour in boys (eg Eddy and Chamberlain, 2000) and girls (eg Chamberlain et al, 2007), and less frequent use of illicit substances (Smith et al, 2010); the former was linked to fewer associations with delinquent peers (Van Ryzin and Leve, 2012). Girls in MTFC have been shown to experience reduced depressive and other mental health symptoms relative to a control group (Harold et al, 2013). Boys and those not completing treatment are most at risk of poor outcomes (Smith, 2004). Leve et al (2009) summarise some of the work presented here by stating that, overall, evidence from MTFC and KEEP studies (see above) shows the interventions are successful in increasing carers' positive interactions with the child; increasing secure attachment behaviour; encouraging more adaptive peer relationships during and after treatment – which mediates the link with lower delinquency; increasing regulation of stress levels (see also Fisher et al, 2006, on stress and MTFC-P); and reducing problem behaviours.

In England, results have generally been more equivocal. The programme was piloted with young people for whom the alternative was prison. Delinquency during the year in which they were supposed to be in placement was very much lower than for the control group who had been discharged from prison. However, in the year subsequent to discharge from MTFC the delinquency rate was the same as for the prison comparison group in the year after their discharge (Biehal et al, 2011). In a larger trial with young people in the care system (which included an RCT embedded within a larger cohort study), the main benefit shown for MTFC appeared to be for those who had scored highly for anti-social behaviour at baseline: those with lower scores at this point actually did worse in MTFC than in usual treatment settings (Biehal et al, 2012; Green et al, 2014). One brief report suggests that a reduction in the amount of high-risk behaviours could not be clearly linked to graduation from MTFC (Kirton and Thomas, 2011).

A US comparison with results from England suggests there are benefits during time spent in MTFC in both settings, but the study does not statistically compare the size of any effects across the two countries; the extent to which the different questions used in England and the US can be said to measure the same construct is also debatable (Rhoades et al, 2013).

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56 An overview of the findings on MTFC-A is also provided in chapter 2.

Behavioural evidence from Sweden is mixed. One sample suggests benefits of MTFC for internalising and externalising behaviours (Kyhle Westermark et al, 2011). However, although a second sample from the same research group showed greater clinical change during the year after placement in MTFC than a control group, they showed no difference in this outcome by the second follow-up a year later (Hansson and Olsson, 2012).

Finally, the cost of implementing MTFC is initially higher, but might be offset by the potential for MTFC to increase placement stability (Holmes et al, 2012). Maintenance costs are lower than for residential care. An internet-based system for recording behaviour and monitoring fidelity to the programme has received largely positive feedback (Feil et al, 2012).

State of the evidence:
Most of the evidence cited comes from the US, with some studies from England and Sweden. Random assignment is common in the US studies, whereas English studies have combined an RCT with a large-scale observational design. Sample sizes range from small – 13 young people in MTFC (Smith et al, 2012) – to large (112 in Biehal et al, 2012). Comparison groups have included young people in group care (eg Chamberlain et al, 2007), 'treatment as usual' (Green et al, 2014; Hansson and Olsson, 2012), or those given custodial or supervised community sentences (Biehal et al, 2011), though some studies had no comparison group outside of MTFC (Rhoades et al, 2013; Smith, 2004).

A wider variety of informants are used (carers, social workers, young people, justice statistics), but the use of different measures across studies makes it difficult to compare findings. Follow-up periods are generally better than for other types of intervention, and most include measures taken one year after entry to the placement; some also include follow-ups at 24 months after entry (eg Biehal et al, 2011; Chamberlain et al, 2007; Hansson and Olsson, 2012).

MTFC studies conducted in different countries have shown a difference in findings, which may be linked to differences in populations and the comparison groups used (Green et al, 2014). MTFC placements might produce their effects by means of change of environment and close supervision (Biehal et al, 2011; Van Ryzin and Leve, 2012). However, so far there has been little examination of the key factors of MTFC that might explain its effectiveness (Kirton and Thomas, 2011).

See: Fostering Attachments (section 3.2)

Other types of treatment foster care

Description: MTFC is a particular version of treatment foster care, but is by no means the most widely used: Farmer et al (2010) state that as one of over 2,000 types of treatment foster care in use in the US, MTFC is used by only a small minority of foster care agencies. Many sites across the US use treatment foster care models that share key features with MTFC (eg wraparound support; close monitoring of children's behaviour). Differences between the models reviewed, where stated, are outlined below.

For ages: *early childhood to adulthood.*

Children's outcomes tested: *internalising and externalising behaviours; strengths; delinquency; social well-being; engagement with education and therapy; emotional functioning.*

Findings with looked after children and young people:
Findings on versions of treatment foster care other than MTFC have been very mixed, which may be a reflection of differences in individual programmes. Different versions of treatment foster care share some key principles (intensive short-term foster placements offering training and 24-hour support to foster carers of children), but can differ on aspects like the proactive teaching of strategies for handling difficult behaviour. Graduates of treatment foster care have been rated as showing improvements in social and emotional well-being, and internalising and externalising behaviours (Cross et al, 2004; Farmer et al, 2010), and there is some suggestion that young people's engagement with education or therapy may be improved (Gilbertson et al, 2005). However, a study of arrest rates found no difference between treatment foster care, therapeutic group homes and inpatient psychiatric programmes (Robst et al, 2013).

It has been suggested that the key features for success in treatment foster care are that: carers provide authoritative, sensitive parenting and have greater levels of training and support; carers rate themselves more as a parent than a professional; they think the child would feel the relationship between them was 'good quality'; there is a good 'fit' between the child and the foster family; and that treatment and delivery models are clearly defined (Redding et al, 2000; Southerland et al, 2009).

State of the evidence:
Most of the evidence cited comes from the US, with one study from Australia (Gilbertson et al, 2005). Sample sizes range from small – eight young people in treatment foster care (Gilbertson et al, 2005) – to a maximum of 384 (Cross et al, 2004). Most studies include comparison groups, with the exception of Cross et al (2004). Measures are reported by carers or workers, and follow-ups have been taken straight after the placement ends (Cross et al, 2004) or up to 12 months after baseline (Farmer et al, 2010).

3.3 Mixed interventions for older children and adolescents

Middle School Success (MSS)

Description: MSS is a training programme for children and their carers that takes place during the summer prior to middle school entry. Children's sessions focus on setting personal goals, peer and adult relationships, decision making and problem-solving strategies, and reinforcing adaptive behaviours. Carers' sessions teach a behavioural reinforcement system drawn from MTFC. Follow-up training and support are offered to carers during the first year of middle school.

For ages: *targeted at those transitioning to middle school.*

Children's outcomes tested: *internalising and externalising behaviours; prosocial behaviour; substance use; health-risking sexual behaviour.*

Findings with looked after children and young people:
Three studies have looked at one sample of girls following the MSS programme, which offers child and carer training and support. Girls randomly allocated to MSS showed fewer internalising and externalising difficulties than girls in a control group, but were no different in their prosocial behaviour (Smith et al, 2011). Substance use and levels of self-reported health-risking sexual behaviour were both lower in MSS girls at a 36-month follow-up (Kim and Leve, 2011; Kim et al, 2013).

State of the evidence:
All studies are from the US, and were conducted by the programme's originators. The three studies covered one moderate-sized sample of 48 girls. The control group received no intervention. Measures were a mix of carer- and self-report, and follow-ups have been taken up to 36 months after baseline.

Section 3 Messages

- Behavioural interventions for older children consist of the ARC framework; life story work; mentoring; Fostering Attachments; Fostering Changes; IY; KEEP; MTFC-A; other treatment foster care and MSS – these represent a mix of social learning and attachment theory approaches.

- Studies of the ARC framework in use show differences in practice and samples, making comparisons difficult.

- Life story work is viewed positively by young people and carers, though much of the research is qualitative and there has been little examination of 'hard' measures of well-being.

- Larger trials of mentoring schemes are needed to confirm the promising findings relating to improvements in social and emotional well-being.

- Fostering Attachments has been linked to positive outcomes, but trials have been small in scale.

- Fostering Changes shows improvements in carer-rated behaviours, including in one RCT, but lacks a longer-term follow-up.

- Findings on IY training for carers and children are mixed, and research designs suffer from a lack of control intervention and short follow-ups.

- KEEP studies from the US suggest behavioural improvements, but also require longer follow-up data.

- The designers of MTFC-A present a large body of evidence from RCTs showing links to behavioural improvements, but independent studies in England and Sweden suggest a more complex picture: benefits appear not to last beyond the end of the placement and the intervention may only be suitable for those who initially show high levels of anti-social behaviour.

- Other forms of treatment foster care have produced mixed results, probably due to differences in practice.

- MSS appears to be linked to behavioural improvements, but studies beyond the initial sample are needed.

Section 4: Emotional interventions for young children (0–6 years)

In this section we examine the interventions that have been designed to improve emotional functioning in looked after children under the age of seven. Issues that are addressed by this type of training include internalising behaviours, such as anxiety and depression, emotion dysregulation, and self-concept. Clinically significant emotional dysfunction was investigated in Meltzer et al's (2003) English national survey, which showed that 11.7 per cent of looked after children had some form of emotional disorder, with some overlap in type: 11 per cent had anxiety disorders and 4.3 per cent had depression. The same survey showed that 11 per cent of 5–10-year-olds in care had anxiety disorders and 0.9 per cent had depression (rates for younger children were not collected). As with behavioural disorders, subclinical emotional difficulties are assumed to be even more widespread.

Our search of the literature did not reveal any studies with young looked after children using interventions whose focus was on directly or indirectly targeting emotional disorders. However, see ABC and MTFC-P in section 2.2 for studies that captured internalising outcomes as part of their measures.

Section 5: Emotional interventions for older children and adolescents (7–17 years)

In this section we examine the interventions that have been designed to improve emotional functioning in looked after children aged seven and above. Our definition of emotional issues is as stated in section 4. Meltzer et al (2003) found that 11 per cent of 5–10-year-olds; 10.8 per cent of 11–15-year-olds and 11.2 per cent of 16–18-year-olds in care in England had anxiety disorders; for depression the figures were 0.9 per cent, 5.1 per cent and 8.3 per cent, respectively. Subclinical emotional difficulties are assumed to be even more widespread.

Besides the interventions discussed here, see also ARC and its links to PTSD, and life story work and its links to identity (both summarised in section 3.1).

5.1 Direct interventions for older children and adolescents

Animal-assisted therapy

Description: The use of animals as part of group or individual therapy sessions is designed to enhance the therapeutic process and can help to create trust and acceptance. The ways in which animals are used is flexible: generally, children are encouraged to bond with the animals, sometimes by providing care, and in some cases, stories about the animals are related to the children's experiences.

For ages: *7–17 years.*

Children's outcomes tested: *trauma symptoms; attachment.*

Findings with looked after children and young people:
Work where dogs and horses have been an integral part of the therapeutic process has shown links to decreases in trauma symptoms and an increase in felt attachment security (Balluerka et al, 2014; Dietz et al, 2012).

State of the evidence:
The evidence cited comes from the US (Dietz et al, 2012) and Spain (Balluerka et al, 2014). Sample sizes are moderate: a maximum treatment group of 60 (Dietz et al, 2012), but the comparison groups in both studies were not well matched (Dietz et al, 2012). The longevity of any effects is unclear, since studies have taken follow-up measures directly after or only two weeks after the intervention.

Arts therapy

Description: Holistic arts-based group therapy with children runs for 12 weekly sessions, using arts-based and mindfulness-based methods. The aim of the intervention is to help children learn how to develop their skills of attention and imagination; how to recognise and understand their feelings, thoughts and behaviour; and how to develop their strengths.

For ages: *8–15 years.*

Children's outcomes tested: *self-concept; resilience.*

Findings with looked after children and young people:
Qualitative feedback from young people taking part in these groups and their caregivers suggests that they find them 'fun' and that they feel they have developed new skills (eg Coholic, 2009a; 2011). In a study that staggered treatment into three streams, the only difference found was on emotional reactivity, which appeared to improve during the period of the intervention (Coholic et al, 2012).

State of the evidence:
All of the evidence comes from Canada, and from the same research group. Much of the work to date has been qualitative. The quantitative work had a moderate sample size of 36 (Coholic et al, 2012), though only 21 of these children completed the programme and all data collection. Children were not randomly assigned: groups were matched on age and gender and there were no other demographic differences.

Cognitively-Based Compassion Training (CBCT)

Description: This six-week training programme is delivered directly to children. CBCT encourages the individual to explore their existing assumptions about their feelings and their behaviour towards others. Its goal is to promote empathy and compassion for self and others. The sessions offer a mixture of teaching, discussion, and meditation practice.

For ages: *13–17 years.*

Children's outcomes tested: *inflammation (which is linked to adult physical and mental health outcomes); anxiety; depression; hopefulness; emotion regulation.*

Findings with looked after children and young people:
Research on CBCT to date consists of two studies using the same sample. The studies found no effect of group or time on concentrations of CRP (the protein marker for inflammation), nor any interaction between the two, though children who practised CBCT more often were more likely to have reduced levels of CRP (Pace et al, 2013). CBCT did not produce bigger changes in depression or anxiety than a control group. Researchers also found no difference post-treatment in children's hope or emotion regulation scores, though frequency of practice may be linked with lower anxiety and higher hopefulness (Reddy et al, 2013). Most young people's feedback suggested they had found the treatment helpful.

State of the evidence:
The evidence cited comes from the US. Random assignment was used. The sample size in CBCT was 37 but eight young people dropped out of each condition during the studies. The studies do not include a longer-term follow-up after the intervention ended.

5.2 Indirect and mixed interventions for older children and adolescents

Our search did not reveal any studies with older looked after children using interventions with components designed to indirectly target emotional disorders. However, see MTFC-A and other treatment foster care in section 3.2, and MSS in section 3.3, for studies that captured internalising outcomes as part of their measures.

> **Section 5 Messages**
>
> - Emotional interventions for older children consist of animal-assisted therapy, arts therapy and CBCT.
>
> - Animal-assisted therapy may offer a way of enhancing the therapy process for vulnerable children, but study designs require stronger control groups.
>
> - Findings on arts therapy are largely qualitative and preliminary, and require testing beyond the originating research group.
>
> - CBCT studies have shown little effect on children's well-being, except where it is practised frequently outside of sessions, and suffer from small samples with high drop-out rates.

Section 6: Hyperkinetic interventions

We searched for interventions that have been designed to improve hyperkinetic behaviours (eg hyperkinesis/ADHD) in looked after children. The English national survey (Meltzer et al, 2003) showed that 7.3 per cent of looked after children had a hyperkinetic disorder; broken down by age, this was true for 11.1 per cent of 5–10-year-olds; 7.1 per cent of 11–15-year-olds and 1.4 per cent of 16–18-year-olds (rates for younger children were not collected).

Our search did not reveal any interventions that were specifically designed to target hyperkinetic disorders and had been tested with looked after children. However, see details above on Fostering Attachments and Incredible Years carer programmes (section 3.2), which measures changes in hyperkinetic symptoms as part of their outcomes.

Section 7: What makes a 'successful' intervention?

Our literature review has covered a range of interventions tested with looked after children, with the aim of improving their behavioural and emotional well-being. While the review was not exhaustive, it offers a broad picture of some of the common approaches taken for interventions with this population. A number of commonalities have emerged, both in terms of the interventions and the studies that have evaluated them. It is important to reiterate the limitations of the evidence base before drawing any conclusions in terms of 'successful' interventions.

7.1 Factors that limit our ability to answer this question

Samples are not sufficiently representative of the population

A number of the approaches reviewed above suffer from evaluations using small to moderate sample sizes. Even where samples are large, they are sometimes drawn from such specific groups of children or contexts as to make the results difficult to generalise to other groups or contexts. Samples may be further skewed when children who are most in need of services disengage and drop out of the studies. Rork and McNeil's (2011) review of foster carer training programmes notes that differences need to be taken into account not just of the foster children but also the foster families (eg presence of birth children), and that studies are needed that report on training experiences and the effects for foster fathers, and for diverse ethnicities and cultures. Moreover, most of the research reviewed here has involved samples from foster care. Evidence-based interventions in residential care settings can be effective, but are less often researched (James et al, 2013); they require staff 'buy-in' for success.

Lack of randomisation

Interventions with promising results need to be subjected to large scale, RCTs where possible (as seen with MTFC-A) in order to substantiate any claims of efficacy. The use of randomised processes in addition to larger samples would also overcome the issue of poorly matched or absent comparison groups, which is a common feature of research in this field. In constructing comparison groups, researchers need to be aware that there may be geographical differences, owing to variation between different areas on other risk factors (eg poverty); differences in thresholds for taking children into care, and variations in quality of services (Clyman et al, 2002).

Overreliance on caregiver reporting

The majority of studies reviewed here used as their primary outcome measures of children's behavioural or emotional problems as reported by caregivers. While it is interesting to discover the extent to which interventions might shape carers' understanding of children's issues and their confidence in dealing with them, separating these factors from actual behavioural and emotional change in young people is difficult when studies use carer-reported measures alone: carers will not be blind to whether they are part of a treatment or control group, and may, therefore, have a personal investment in ensuring that the intervention is a 'success'. Moreover, where interventions are aimed primarily at changing caregivers' behaviour or attitudes with an expectation that this will translate to improvements in children's well-being (eg Fostering Changes, Incredible Years), measures of caregiver outcomes should be used alongside measures of children's outcomes, since they may provide better or earlier indicators of change. A number of studies have included such measures (eg Briskman et al, 2012; Bywater et al, 2010).

We would advocate the use of triangulated data on child and caregiver outcomes as reported by carers, social workers, school staff and the young people themselves. Gathering information from multiple sources is important, since assessments that are completed only from one perspective (for example, carers versus schools) could indicate either a clinical condition that exists across contexts or a problem with a particular relationship (Silverman and Saavedra, 2004). There is, however, little research that incorporates the views of looked after children (Scott, 2004). The perspectives of young people are particularly important in the case of emotional difficulties, which may be less likely to come to the attention of adults working with them than more observable issues like aggressive behaviour.

Overreliance on symptom reduction

Crucially, studies also need to include measures of functioning as well as symptom reduction, since it is important to know what kind of impact any changes might have on quality of life (Becker et al, 2011). This could be achieved through the use of measures like the Children's Global Assessment Scale or CGAS (see chapter 3), as used in the English MTFC studies (Biehal et al, 2012; Green et al, 2014). In general, studies are less likely to include measures of functioning than of symptoms/behaviours, and where they do they are less likely to show change.

Follow-up assessments are limited

Finally, claims about the 'success' of any intervention in affecting the well-being of looked after children should take account of the period of any follow-up assessments and whether this is acceptable given the focus of the intervention. The majority of the research reviewed here used either no follow-up or had only a short period of follow-up (generally a maximum of 12 months after baseline). Where the unit of change is the individual child (as in MTFC) then a follow-up that extends well beyond the end of the intervention is desirable. The results of the English trial of MTFC-A have shown that an intervention that might be beneficial during treatment can lose its effect further down the line. On the other hand, where the focus is on changing a carer's behaviour without reference to a *specific* target child (as in Incredible Years training), a longer-term follow-up that ignores potential changes in family dimensions and context would be less helpful.

7.2 Common principles

With these limitations in mind, we have attempted to draw out some common principles of 'effective' interventions. This task was made more difficult by the fact that so few studies have examined the specific factors within an intervention that are linked to success. For example, MTFC-A consists of a broad range of factors including carer training, use of a token economy, limit-setting, close supervision of the child, therapeutic work, etc – yet attempts to investigate which of these factors might explain behavioural improvements have been limited to isolating the contribution of reduced exposure to delinquent peers (Van Ryzin and Leve, 2012) and to an analysis that combined youth and carer reports of adult supervision and discipline; positivity in the adult-youth relationship; and association with deviant peers (Eddy and Chamberlain, 2000). Alongside the other limitations mentioned above, this limits our claims to be able to produce an *evidence-based* list of recommended principles. Instead, what we offer are some *evidence-informed* principles (below, in bold), which are based on a consideration of some of the commonalities between the 'successful' approaches reviewed here. Where applicable, we have stated how these are supported by other reviews of mental health interventions with looked after children. We wish to stress, however, that none of the research reviewed here (with the exception of Van Ryzin and Leve, 2012, as stated earlier) has tested whether these are indeed the components that make an intervention 'work'. Tests of the *mechanisms* by which interventions may effect change lag behind tests of their effectiveness (Henggeler and Sheidow, 2012), and this gap in the knowledge base should be a priority for future research.

By far the greatest amount of evidence uncovered in the review was on interventions for behavioural issues. This is in keeping with the prevalence of behavioural disorders over other types of disorder in this population (Meltzer et al, 2003) but may also reflect the greater 'visibility' of externalising over internalising problems (Tarren-Sweeney et al, 2004), which can threaten carers' feelings of self-efficacy and the stability of placements (Sinclair et al, 2004). In chapter 2 we argued that placement instability can be avoided by reducing the number of planned moves; targeted interventions for behavioural issues offer a way for local authorities to influence the number of unplanned moves by addressing some of the factors that make disruption more likely. Interventions for emotional issues were fewer in number, and none were identified that had been tested with younger children. It is difficult to assess from the state of the evidence whether this is due to recognition of these issues or to a lack of appropriate interventions.

Behavioural interventions for young children were on the whole delivered indirectly through caregivers. Older children did receive some direct approaches (eg through life story work and mentoring), but the preferred approach was still via caregivers. In contrast, emotional interventions (for older children only) were delivered directly.

Caregiver training programmes appeared to work well where they offered **a structured programme of core components with some flexibility to meet individual needs**, and **a 'joined-up' approach from services**, with **follow-up support** once the intervention had ended. This illustrates the distinction between interventions that target particular 'symptoms', such as attachment or self-regulation, and those that aim to change the system around the child, such as MTFC (Racusin et al, 2005).

Indirect approaches were largely based on a **combination of attachment theory and social learning theory** (Leve et al's 2012 review suggests these feature in 'successful' interventions). A number of the caregiver training programmes followed principles of relationship-building through **caregiver sensitivity and attunement**. Chaffin et al's (2006) review states that interventions targeting attachment issues should be based on attachment theory; ideally, these should be short-term behavioural interventions targeting caregivers' sensitivity. Dozier et al (2002a) also recommend working with foster carers on children's attachment, concluding that the evidence shows the benefit of developing stable, nurturing and responsive care. Similarly, Cornell and Hamrin (2008) suggest that a key component of attachment interventions for looked after children is to help caregivers 'repair' children's internal working models. Kerr

and Cossar (2014) concluded that this is most effective when directed at very young children, to prevent rather than react to difficulties.

Besides attachment theory, many of the studies reviewed here also included social learning principles, such as **positive reinforcement, behavioural consequences and limit-setting** (in line with reviews by Knorth et al, 2007, and Pearl, 2009). The latter was found to be an effective component for curtailing anti-social behaviour through reduced contact with deviant peers in MTFC-A (Van Ryzin and Leve, 2012).

Previous reviews of indirect interventions have reported mixed findings. A systematic review of training and support programmes for foster carers found that those that were most successful in terms of children's behavioural changes were of longer duration, had shorter follow-ups, occurred in the US, and used carers with younger children (Everson-Hock et al, 2012). In contrast, Kinsey and Schlösser's (2013) review of interventions in foster care suggested weaker support for carer training programmes but good support for wraparound services and relationship interventions. Similarly, a Cochrane review of behavioural and cognitive-behavioural training programmes for foster carers indicates little advantage in attending them (Turner et al, 2007), but acknowledges that true effects might be obscured by wide variation in results. This suggests that **it is not enough for providers to simply run or develop these groups, but to ensure that effective ones are used**.

Direct approaches were similar to indirect attachment approaches in that they focused on **developing relationships and understanding**, the difference lying in whether the approach targeted the caregiver's **understanding of the causes of children's behaviour** or the young person's **understanding of their own emotions and identity**. This focus on self-awareness is also evident in Black et al's (2012) list of therapeutic techniques employed in treatments for trauma symptoms in adolescents: psychoeducation, developing coping skills, cognitive restructuring, and creating a trauma narrative and a post-treatment plan.

Although the research we unearthed for this review made limited use of mixed approaches, key messages raised in a number of other reviews would suggest that **mixed interventions that target both the child and the system around them** might be most useful. Interventions have often focused on reducing problem behaviours over developing the relationship between child and caregiver (Van Andel et al, 2014). This is an issue, given the importance young people place on relationships for their emotional and behavioural well-being (Dickson et al, 2010). The principles of the Care Inquiry (2013a) and NICE/SCIE (2010) reports discussed in chapter 2 also emphasise the importance of building and sustaining relationships for

young people in the care system. Pearce and Pezzot-Pearce (2001) also advocate a mixed approach, stating that interventions that are directed solely at the child are unhelpful, as contextual issues can serve to reinforce problematic internal working models.

Finally, the 'success' of interventions depends to some extent on **consistency**, whether this be in terms of **fidelity to a particular treatment approach** (Henggeler and Sheidow, 2003; 2012) or specific practices like the **use of discipline**. It also depends on the **commitment** of caregivers and young people; a clear example of this is the detrimental effect of having only a limited amount of contact with a mentor (Johnson et al, 2011).

7.3 Conclusion

Golding (2007) has noted a number of questions on the evidence base for parent-training of caregivers of looked after children, which might be equally applied to any of the interventions we have covered in this review:

- Do caregivers find the intervention useful?

- Do the children benefit when their caregivers participate?

- Which programme(s) are most beneficial for those caring for children who have experienced very adverse early experience?

- Are existing programmes used with other populations helpful for caregivers of looked after children?

- What is the optimum length of time for caregivers to attend the group?

Golding (2007) commented that at that time only the first question has been answered to any extent in published research. Our review suggests that programmes like PCIT and Fostering Changes (for example) can produce benefits in the form of changes in children's outcomes; the fact that social learning theory approaches are common to many of the programmes supports the idea that there is crossover between looked after children and other populations. However, we are still limited in our ability to state which programme might be the 'most beneficial'. We have outlined a number of factors that constrain us in making any statements about the most 'effective' aspects of interventions. Future research needs to employ study designs, modes of delivery, samples and measures that are equal to the task, so that robust claims can be made about which interventions are most effective and by which mechanisms their effects might operate.

Ultimately, however, Dozier et al (2002a) point out that given developmental and individual differences, it is unlikely that one intervention will suit all looked after children; interventions should target specific needs, taking into account children's developmental level and their particular difficulties. Caregiver training programmes may allow carers to acquire skills that can be transferred across placements, but should also acknowledge these differences. Despite the complex issues that looked after children often have, much of the research is focused on time-limited interventions that are targeted at a single issue (Scott, 2004). Interventions need to develop to address these complex needs, and research must develop too if it is to provide a true test of effectiveness.

Section 7 Messages

- Limitations with the research make it difficult to say a particular intervention or factor has been shown to 'work', leaving us with a set of common principles that require more rigorous testing.

- Behavioural interventions are largely delivered through caregivers, consistent with the evidence base for the disorders. The programmes reviewed that appear to have some 'success' have in common a structured programme of core components with some flexibility to meet individual needs; a 'joined-up' approach from services; and follow-up support.

- They are largely based on a combination of attachment theory and social learning theory.

- The accompanying principles include caregiver sensitivity and attunement; positive reinforcement; behavioural consequences, and limit-setting.

- Emotional interventions are delivered directly.

- They embody principles of developing relationships and understanding, both in the caregiver's understanding of the causes of children's behaviour and the young person's understanding of their own emotions and identity.

- Success can also depend on consistency and commitment.

- There are still gaps in our knowledge about what makes a 'successful' intervention, and about the mechanisms by which they might work. More robust research designs are needed to investigate these issues.

- Looked after children have complex histories and needs, and it is unlikely that a single intervention will address all of these.

Chapter 5: Conclusions

Section 1: The review

This review has covered the aspects of 'ordinary care' that have been linked to looked after children's well-being; some of the more common assessments that are used to determine their needs and progress, and the interventions for behavioural and emotional issues that have been researched in a looked after population. In this final chapter we draw together some of the key messages from the report, highlighting the issues that are relevant for practitioners both in their decisions about care placements and in their use of resources to target individuals experiencing particular behavioural or emotional difficulties. Before doing so, it is important to provide a reminder of the scope of the review.

Our review of the evidence in this report is not exhaustive: we have focused on general aspects of 'ordinary care' (chapter 2); assessment instruments that are commonly used with looked after children in England and that have had published reports on their use with these children (chapter 3), and specific interventions for behavioural and emotional issues in looked after children that have been the subject of at least two separate published reports (chapter 4). There is a vast body of literature on the well-being of looked after children and the assessment and treatment of mental health issues in other groups of children, which have not been included in this review. We need to remember that there are more commonalities than differences between looked after young people and their peers who are not in care, and it is important to recognise that in spite of some distinctive experiences, many of the mental health interventions that 'work' with the general population are also likely to be successful with this group. Our conclusions should, therefore, not be taken as the 'definitive' answer on the situation.

There is a tension between qualitative and statistical approaches to the issues we have covered, and although we have paid most attention to statistical results (which are easier to summarise), we have tried to be fair to both. However, we have not employed the systematic review technique of 'quality rating' studies and excluding some from the discussion on this basis. Moreover, our report does not present statistical information such as effect size calculations (Karlsson et al, 2014) to compare the effectiveness of a very disparate group of interventions.

The review can be seen as a study of resilience – what it is that enables children in care to do well despite challenging circumstances – but while it has inevitably drawn on resilience studies, we have not made explicit use of 'resilience theory', partly on the grounds that even if it is possible to have such a theory, it is not yet sufficiently defined to guide our work (Ungar, 2004). Most looked after children already possess 'resilience' in the sense that they have developed behavioural and emotional responses that have enabled them to survive what are often extremely harsh environments. The perspective on outcomes that we have taken has been, to some extent, determined by those who hold the power in decisions about care placements, assessments and interventions – looked after children themselves may find the emphasis on 'bad behaviour' and negative outcomes difficult to take. These things are important to them, but we would also stress that more attention should be paid to what promotes positive outcomes.

Section 2: What have we learned about achieving good mental health for looked after children?

Chapters 2 and 4 have looked at the evidence on mental health and well-being in different ways, yet both have uncovered a number of key principles. We outline these here in no particular order.

1. Many aspects of looked after children's well-being are amenable to change

In chapter 2 we argued that the quality of children's placements could influence their well-being. Similarly, the interventions discussed in chapter 4 are all based on the assumption that children's behavioural and emotional difficulties are not 'fixed' characteristics. By arguing that such issues are due largely to an atypical caregiving environment, services assume that high-quality caregivers – with the addition of targeted direct and/or indirect intervention support where necessary – might effect positive change in children's well-being.

The evidence presented in chapters 2 and 4 supports this position. Both chapters suggest that some characteristics are difficult to change in some children. However, the happiness and well-being of children in different foster homes and residential units varies greatly with the way staff or foster carers look after them. On leaving these units or homes, the new environment also has a great effect. Moreover, as we saw in chapter 4, targeted interventions can be successful in reducing the incidence or severity of behavioural and emotional problems.

2. Early interventions are more likely to promote good mental health

Chapter 2 presents evidence indicating that where children are identified as needing to be removed from their families and taken into care, this should be done as early as possible to reduce the damaging effects of ongoing maltreatment. Dealing with issues in a timely way is an important principle that also arose in subsequent chapters.

In chapter 3 we discussed the use of mental health assessment and screening tools as a means by which practitioners can identify looked after children's difficulties and, subsequently, direct resources and interventions. These instruments can be used as part of the regular system of checks that authorities use to monitor looked after children's progress in care, enabling services to pick up on any issues at an early stage. The SDQ, for example, comes in a short and user–friendly format that enables it to be completed on a regular basis by caregivers or primary healthcare staff. It provides an easy way of monitoring children's well-being over time, and could give a broad indication of those who are having significant difficulties and may need further assessment. SDQ data are currently collected for looked after children in England, and although a number of children's service managers currently make use of local data to identify children needing early interventions, there is further potential for this practice to be developed. Mental health measures may also be used by clinicians with looked after children who have already been identified as having particular difficulties. In such cases, the type of broad well-being indicator that is represented by a particular score on the SDQ is less useful than a rounded assessment such as can be gathered using the Development and Well-Being Assessment (DAWBA). Using both assessment tools can ensure that children receive the right kind of support at the right time. Given that the assessment tools discussed in chapter 3 deal with the individual child, there is further room for the development of tools that assess the child *in their context*, to enable practitioners to identify where the interaction between child and context might be especially problematic and, therefore, require early intervention.

A number of the interventions discussed in chapter 4 deal with issues (eg general aggressive behaviour, insecure attachment) that Rao et al (2010) argue may not warrant referral to specialised mental health services (eg England's specialist CAMHS teams) unless they are accompanied by specific mental health disorders, such as conduct disorder, depression or anxiety. Programmes like the Attachment and Biobehavioral Catch-up (ABC) and Fostering Changes might, therefore, be used to address broader or lower-level issues of well-being, as a way of preventing further escalation and the involvement of more intensive mental health services.

'Early' interventions can be understood not just in terms of the stages of a process, but also in terms of children's age. The evidence in chapter 4 suggests that interventions targeted at young children have the potential to effectively improve their mental health and well-being. However, more work is needed to determine whether targeted interventions are likely to be more effective at an early rather than a later age. There are relatively few well-researched interventions for children under seven years old compared to older children (three behavioural interventions vs 10 for older children; nil emotional interventions vs three for older children). This is particularly concerning, since the gap in the prevalence of diagnosable mental disorders between looked after children and their peers is greater for those aged between five and 10 years than for older children (McAuley and Davis, 2009). In addition, researchers have generally either ignored or controlled for children's age, rather than analysing the size of any effects for different age groups (though this may be problematic where sample sizes are small).

The arguments for early intervention, then, include the moral imperative to prevent mental ill health at as early a stage as possible, and the potential for reducing the likelihood of an escalation in problems. A final pragmatic argument lies in the assumption that intervening early can reduce long-term costs. The development and evaluation of interventions for mental health and well-being will cost money at a time when resources are scarce. However, in the long run they may have the potential to save money if they reduce the likelihood of disruption and hence the need for the later use of costly services, such as Multidimensional Treatment Foster Care (MTFC) and residential care. In practice, the likelihood that interventions will 'work' in this way depends on them being effective and targeted at the 'right' children – eg, not using a costly intervention with children who have a low likelihood of placement disruption. The link between the use of early targeted interventions and a reduced risk of placement disruptions and reduced overall costs requires further investigation to make a stronger case for this process in policy and practice.

3. Developing relationships is crucial for children to make progress

In chapter 2 we presented evidence to show that the quality of the child's relationship with the caregiver is key to their well-being. This is in keeping with the importance young people place on relationships for their emotional and behavioural well-being (Dickson et al, 2010) and also with the principles of the Care Inquiry and NICE/SCIE reports discussed in chapter 2, which place great emphasis on the importance of building and sustaining relationships for young people in the care system.

Interventions targeting looked after children's behavioural problems have been criticised for focusing on reducing problem behaviours rather than developing the relationship between child and caregiver (Van Andel et al, 2014) – though this may be a reflection of the outcomes measured in their evaluations rather than the content of the programmes. Indeed, several approaches outlined in chapter 4 (eg Fostering Changes and life story work) do focus on developing relationships and understanding, both in terms of the caregiver's understanding of the causes of children's behaviour and the young person's understanding of their own emotions and identity. Time-limited interventions like MTFC may be more problematic in this respect, since the relationship is only ever intended to be short-term, and young people may be forced to move on just when they have developed a bond with carers.

Comparison of the evidence in chapters 2 and 4 suggests that what may be needed is not interventions that are aimed solely at behaviour or relationships nor, for that matter, interventions that work either solely with the child or the carer. Difficult behaviour on the part of the child can lead to a breakdown of relationships and hence to disruption. So, interventions need to take account of the behaviour, the way it is interpreted, and the relationship within which this interpretation takes place, as well as measuring how improvements in behaviour can translate into improvements in the relationship. Interventions like MTFC, which target behaviour, are, therefore, appropriate in part because behaviour can affect relationships. However, they should not risk this good effect by deliberately ignoring relationships in the rules they set for moving on.

In practice, the research we unearthed for this review made limited use of mixed approaches, even though mixed interventions that target both the child and the system around them might be the most useful. Pearce and Pezzot-Pearce (2001) advocate this type of mixed approach, stating that interventions that are directed solely at the child are unhelpful, as contextual issues can serve to reinforce problematic internal working models. Therapists delivering direct interventions should also bear in mind the importance of developing relationships. Given that looked after children and young people can be sceptical about mental health services, it is important to ensure positive engagement and good working relationships in any direct work that is done with them (Davies and Wright, 2008).

Interventions that seek to address mental health and well-being should, therefore, place equal focus on improving the quality of the relationship between the child and their caregivers, since this is likely to indirectly affect children's behaviour and emotional state. In addition, researchers aiming to evaluate the effectiveness of such interventions should ensure that they measure changes in

the caregiver–child relationship (including from the young person's point of view) alongside their measures of behavioural and emotional change. Interventions that include components where adult and child work together for part of the time offer a promising avenue for future work in this respect.

4. Carer training is a promising method for influencing children's outcomes

Although chapter 2 reveals that we lack good models for what works in the training of caregivers, including both foster carers and residential staff, the evidence reviewed in chapter 4 suggests several training programmes that might be effective in promoting looked after children's mental health. Some programmes, eg Fostering Changes and Middle School Success (MSS), can teach skills to the carer that are not only beneficial for their current situation, but can also be transferred across different contexts and placements, and over time. Feedback from carers attending training sessions generally indicates that they welcome the opportunity to problem-solve with others who have similar experiences (Luke and Sebba, 2013).

Previous reviews of carer training have reported mixed findings. A systematic review of training and support programmes for foster carers found that those that seemed most successful in terms of children's behavioural changes were of longer duration, and involved carers responsible for younger children (Everson-Hock et al, 2012). However, they also had short follow-ups and were based in the US so that it was not clear whether they would also enable UK carers to bring about lasting change. In contrast, Kinsey and Schlösser's (2013) review of interventions in foster care showed only weak support for carer training programmes. Similarly, a Cochrane review of behavioural and cognitive-behavioural training programmes for foster carers indicated little advantage in attending them (Turner et al, 2007), but acknowledged that true effects might be obscured by wide variation in results. Moreover, the experience, skills and support of foster carers could influence the effectiveness of a particular intervention (Leve et al, 2012). This suggests that it is not enough for providers to simply run or develop these programmes. They also need to ensure that effective ones are used and that carers are supported to make the most of them.

5. Continuity (in terms of permanence, stability and consistency) can influence success

Placement stability is important. In chapter 2 we argued that local authorities can directly influence planned moves and should seek to do their planning in a way that provides permanence and stability earlier, reducing the number of moves a child makes during their time in care. In theory, if not necessarily in practice, they should also be able to influence unplanned moves, through the quality of care provided. Targeted interventions for behavioural issues may offer another way for local authorities to influence the number of unplanned moves, by addressing some of the factors that make disruption more likely.

The 'success' of interventions depends to some extent on the use of a **consistent approach and the commitment** of caregivers and young people to the programme; the evidence on mentoring interventions illustrates how discontinuity can be particularly damaging to children's well-being. Consistency is difficult to achieve if the young people are continually moving, yet unplanned placement moves are more likely where children have behavioural problems. The interrelatedness of behavioural issues, emotional well-being and placement disruptions makes it difficult to tease apart whether the problem lies with the factors that bring about instability or with the instability itself. So, interventions may thus be needed both to prevent disruption and to deal with its causes or consequences.

Unfortunately, placement instability can also affect whether looked after children receive referrals for assessments and interventions, with some services inappropriately restricting their acceptance of new clients to those with stable placements, which may be difficult to achieve for the most challenging children. Moreover, referrals can be delayed or lost in the move between placements (McAuley and Davis, 2009), particularly where these involve a move between local authorities (McAuley and Young, 2006). Disruptions can create difficulties with incomplete information on children's mental health arriving at the new placement, which even in the smoothest transition is a source of dissatisfaction among carers (eg Spielfogel et al, 2011), and children can lose valuable advocates for their access to services in the process (Jones et al, 2012).

All this implies that great care has to be taken, first to ensure that any placement intended to be long-term is suitable for the child involved and, second, that once this is done the placement is well supported. Evidence from chapter 2 suggests that as far as possible both child and carer should feel that they have had some choice over the placement, so they are 'signed up' to it. There should be a formal procedure for recognising the placement as long-term, rather than simply allowing it to drift into becoming so. And there should be some kind of 'probationary period' during which the placement

is tested out. Caregiver training and other ways of intervening that enable difficulties to be addressed before they can become serious are also important. Such interventions were surveyed in chapter 4, which found some promising models, although robust evidence was lacking.

6. Efforts to improve mental health should be systematic and sustained

As discussed in chapter 2, children in care are affected by their past history, their current carers, their school and their relationship with their biological family. The transience of individual children and their responsible adults within the care system, coupled with the presence of complex issues that might normally attract the input of separate services, make teamwork crucial in assessing and intervening with this population (Chambers et al, 2010). Gilligan (2009, p112) describes an approach to services that sees 'helping' as "a partnership between [young] people in need, people in their social networks and professional systems". MTFC offers one example of an intervention in which coordinated working is key, though as yet there is little evidence to show whether this is one of the factors that helps it to produce effects. Practice examples like TEAMSPACE (Swann and York, 2011) show how workers from CAMHS, Children's Services and the Primary Care Trust can come together to plan for and support their most vulnerable children. Foster carers in Spielfogel et al's (2011) study felt that joint training should be offered to carers and social workers, to encourage working together, and this avenue could be pursued in future interventions.

There is a need not only for services to work together to support the mental health needs of looked after children, but for assessments and interventions to take account of the whole picture to include not just the individual child but also their relationships and environment. Ecological approaches that target the individual, their family/care placement, and the level of service delivery have the potential to increase the engagement of young people in mental health services (Kim et al, 2012). As we have already noted, there are limitations in the extent to which the assessment instruments and intervention programmes reviewed in chapters 3 and 4 do this.

This need for a 'joined-up approach' applies to services before and after a placement as well as during it. Chapter 2 and appendix A provide the example of young people ageing out of the care system, and the difference that good planning and follow-up support can make to their well-being. Similarly, in chapter 4 we reported the need for follow-up support after interventions had ended, in order to sustain any positive effects. Evaluations of interventions should also include follow-ups to determine whether any effects outlast a particular environment.

7. Children and young people should be treated as individuals

The need for integrated interventions targeting the systems surrounding the child does not negate the need to take account of the individual, albeit within context. There are well-established measures for identifying mental health disorders in all children and young people, including looked after children, and there is evidence to support their utility in this population, too.

In this context it is important to think about and formulate the whole range of a young person's strengths and difficulties. Looked after children may have problems that are below conventional thresholds for meeting diagnoses but which cumulatively have a significant impact upon their well-being, or do not easily map on to psychiatric diagnoses. Despite the complex issues that looked after children often have, much of the intervention research is focused on time-limited programmes that are targeted at a single issue (Scott, 2004). Interventions need to develop to address these complex needs, and research must develop too if it is to provide a true test of their effectiveness.

Children interact with their worlds in very different ways, and it is important to understand the individual meaning that they will attach to relationships, events and losses in their lives (Gilligan, 2009). There is not a one-size-fits-all approach, either in the 'best' type of placement or the 'most successful' intervention. Looked after children have complex histories, needs and motivations, all of which will affect the likelihood of success. Moreover, some interventions might have better or worse effects for looked after children with particular needs, such as siblings in care (McBeath et al, 2014). Approaches to placing and working with children should take account of this complexity and offer an option that suits their individual circumstances. Interventions also need to be developmentally appropriate (Dozier et al, 2002a): for example, interventions that rely on self-reflection may be more appropriate for older children and adolescents than for younger children (Holmbeck et al, 2004).

8. Professionals need to listen to children and young people

Bearing in mind this complexity of individual needs, young people should be active in their own development (Gilligan, 2009). As discussed in chapter 4, young people who do not want to be in a particular placement, or perhaps in any care placement, are less likely to succeed there. Yet, in general, placement and intervention planning has had little involvement from young people. Much of the intervention work is delivered via carers, with little room for the voice of young people.

It is important for future research to investigate what looked after children and young people see as important for their well-being, and what they want from care and mental health services (McAuley and Davis, 2009). For example, work by Stanley (2007) suggests that young people value choice in services, and positive role models in the form of 'successful' care leavers; intervention research should, therefore, investigate the possibility of employing young adults with care experience as part of the delivery team. More generally, many young people feel that choice and control are lacking in their experiences within the care system (Wigley et al, 2011), affecting their willingness to engage with mental health services, so there is a pressing need to explore how they can be given more of it.

9. Caregivers' attitudes can affect the take-up and success of mental health services

Looked after children who struggle with behavioural or emotional well-being need a supporting adult who can advocate for them in accessing mental health assessments and interventions, though such a person may not be available to them (Jones et al, 2012). A study conducted with foster carers in England showed that both the mental health literacy of carers (defined as their ability to recognise disorders coupled with knowledge about how to access services) and their attitudes towards help-seeking predicted whether or not they would seek help from a service provider for a child with a mental health issue (Bonfield et al, 2010). Further reasons why foster carers may not seek help include a fear of 'labelling' the child and the belief that problems like depression are only 'natural' for these children (Arcelus et al, 1999). Similarly, caregivers' attitudes to the importance of attachment issues can influence their recognition of symptoms and their willingness to access help (Dozier and Sepulveda, 2004).

Caregivers also need to 'buy in' to the techniques used in indirect interventions. Evaluation studies may discuss fidelity to training programmes, but few survey carers' thoughts about the skills they are learning, despite the potential importance of this factor for the effectiveness of any intervention. Kirton and Thomas (2011), for example, describe carers' attitudes to the token economy used in MTFC as generally positive, but note that some carers felt the techniques would be ineffective with particular individuals. This belief may to some extent be supported by the finding that MTFC is worse than 'treatment as usual' for young people who show little anti-social behaviour before entering placements (Biehal et al, 2012; Green et al, 2014).

We argued in chapter 4 that carer-reported measures of children's outcomes might be assessing the carers' increased confidence as a result of training, rather than actual changes in children's behaviour. However, since feelings of parenting efficacy have been shown to mediate the relationship between carer-reported challenging behaviour and carers' levels of stress, anxiety and depression (Morgan and Baron, 2011), arguments about what exactly has changed may be less important than any immediate benefits in terms of placement stability. If the change lies in carer confidence rather than children's behaviour, this would only create difficulties if the young person they looked after moved on to less sensitive or experienced carers who had not gained the transferable skills and the increased confidence from these training programmes. This offers further support for our argument that interventions and evaluations are needed that take account of the caregiver, the child, and the transaction between them.

10. Interventions need a clear theoretical base but should be open to more than one interpretation of children's behaviour

Chapter 2 suggested that children and young people tend to do best in settings where the adults are committed to them; like or perhaps even love them; encourage them, but are also clear about what they expect of them. Such 'authoritative parenting' fits with two of the main theories that underpin the interventions described in chapter 4, which relate to attachment and social learning. It is important to note that neither of these theories is sufficient on its own to describe this parenting approach, and also that the individual problems of children in care often need to be interpreted in other ways. For example, children can be unhappy because they are being bullied, or because they do not feel that they are as attractive as their peers; they are not then necessarily best understood as suffering from problems of attachment or social learning.

Attachment theory offers a useful framework for understanding children's adjustment to and relationships within placements, and our review in chapter 4 showed that many interventions for looked after children's mental health borrow elements of this theory. However, Barth et al (2005) highlight the limited evidence base for predicting the long-term behaviour of maltreated children using attachment theory, and caution against its misdirected use in justifying a one-sided focus on getting children to adjust their behaviour to caregivers. Teaching carers that acceptance and understanding of children's behaviour are at least as important as practising the kind of sensitive attunement that can encourage 'secure' behaviour should, therefore, be a priority. Programmes like ABC, which aims to develop both sides of this relationship, might address this need. Barth et al (2005) recognise the strong wish for attachment treatments, but acknowledge that

this can prevent access to other interventions that could help sustain a placement and the relationship, and, thereby, indirectly promote attachments.

There is also a sense that a little knowledge can be a dangerous thing: interviews with Australian foster carers and workers from child protection, mental health and education services revealed a number of misconceptions about attachment theory, including the views that attachment is a limited capacity and that some children will never 'achieve' attachment to an adult (McLean et al, 2013). Barth et al (2005) recommend making foster carers aware of alternative theoretical explanations for children's behaviour.

Social learning theory offers a theoretical approach that is compatible with attachment theory by placing an emphasis on the need for carers to change their behaviours to be more contingent and sensitively attuned to the child, in order to shape the child's behaviour. Again, this approach should be used appropriately, without overly emphasising children's behaviours at the expense of understanding the feelings, thoughts and motivations that might be driving them. Interventions that help carers to understand these and work on ways of developing the relationship may be more fruitful than focusing on the children's behaviour alone.

The interventions we have reviewed in chapter 4 that combine attachment and social learning theory approaches focus on features like developing caregiver sensitivity and attunement, positive reinforcement, behavioural consequences and limit-setting. They fit well with the evidence from chapter 2 that children in care do best with 'authoritative parenting', where carers are clear and agreed about what they expect, encouraging, and firm, but also warm, committed to their foster children and sensitive to their needs.

Attachment and social learning theories may not offer the whole package for the full range of looked after children's problems: for example, children with complex issues like PTSD may require additional approaches in the form of psychotherapeutic interventions that tackle their internal world of feelings and beliefs. Practitioners should, therefore, adopt the approach (or combination of approaches) that is most appropriate to an individual child's needs, rather than adopting a blanket theoretical approach for all looked after children.

Section 3: What do we still need to learn?

The research on 'ordinary care' reported in chapter 2 has brought understanding of the factors that relate to looked after children's mental health and well-being. We can be reasonably sure that if children are to be received into care, earlier decision making is preferable. There is a consensus on the kinds of practice that are most likely to strike a reasonable balance between the risks of remaining at home and the rights and wishes of the parents and their children. We also understand, at least generally, the kind of care in which they are most likely to flourish. And we know that the benefits of this care can be put at risk when they leave this placement. What we do not have are the proven tools to exploit this knowledge. Specifically, we lack proven tools and methods for:

- identifying children at risk if they remain at home, doing so as early as possible and assessing the extent of the risks themselves

- selecting, training, supervising and quality-assuring foster carers or residential workers

- ensuring that the benefits children gain in one setting are transferred to another.

These gaps in our knowledge should not be permanent. It seems we have the understanding that is necessary to design these tools and methods; we also have promising examples of what they might be. What is required is a determined effort to test them out and then ensure they are adopted on a wide scale. Without this effort, those responsible for children's services will not be able to bring about the good practice on which these services depend.

Turning to chapters 3 and 4, there is limited research on the use of screening instruments for mental health in looked after children and young people, particularly with regards to more general measures of subjective well-being rather than those designed to screen for particular conditions. As mentioned above, there is also a lack of tools that take into account the role of the child's context. To some extent this is because there is sufficient similarity between looked after children and their peers to suppose that tools used with a broader population will be equally applicable to those in care. However, it also remains to be seen whether researchers evaluating the effectiveness of interventions will stick to traditional measures like the Strengths and Difficulties Questionnaire (SDQ) and the Child Behaviour Checklist (CBCL), or will embrace more holistic measures like the DAWBA.

In intervention research, there is a lack of robust evaluation studies. The strongest evidence base is on the use of indirect approaches, particularly for the targeting of behavioural issues in older children. This seems appropriate, given what we know about the importance of the carer's role. We know less about interventions for younger children and work that targets children directly, without involving caregivers, though it is likely that much of this goes on for issues like depression and anxiety, and as such would likely replicate existing evidence-based treatments for these issues.

A number of interventions lack a clear theoretical basis. We argued earlier that interventions should have a theoretical base that includes at minimum attachment and social learning theories, but which also leaves open the possibility of interpreting behaviour in other ways. The evidence suggests that such interventions are more likely to succeed. At the same time, evaluation of the intervention can feed back into theory. For example, the Fostering Changes training intervention appears to be reasonable given what we know about how foster care works. Evaluations of Fostering Changes have so far been positive. Further positive evaluations would reinforce this position, whereas a negative one might lead to a re-evaluation.

Lack of randomisation into groups for comparison is probably the most serious barrier to the acquisition of knowledge in this field. This kind of randomisation is the most robust way of determining whether any subsequent effects are down to the intervention rather than systematic differences in the individuals being studied. In chapter 2, we noted that some factors of 'ordinary' care are not amenable to randomisation (eg the decision to remove children from home, or – to some extent – the type of placement they receive). However, the training programmes and approaches that are developed in the light of what is known about these features can be evaluated in this way. In keeping with this, we argued in chapter 4 that targeted interventions for looked after children's mental health and well-being both can and should use randomisation in order for any claims about their effectiveness to be justified; yet only a minority of interventions have been tested in randomised controlled trials (RCTs).

We have outlined a number of other limitations of the current knowledge base, including the lack of adequate samples and control groups; the general emphasis on carers' reports of children's well-being, and the lack of adequate follow-up periods (for the child, carer, or both, as relevant to the function of the programme) to assess the effectiveness of interventions.

The measurement of outcomes is particularly important. Evaluations of care, assessments and interventions generally ignore the points of view and feelings of the young people they claim to serve. In our view this is rarely acceptable. Researchers and practitioners also need to be clear what the focus of an intervention is, and then measure that accordingly. The focus may be an identifiable disorder for looked after children, in which case it will likely follow much the same process as for other children. Alternatively, the aim may be to promote placement stability, or to provide carers with skills to cope with a particular child or children in general. Whatever the focus or aim of the intervention, the value of a particular assessment tool is bound up with it.

As we have argued, gaps remain in our knowledge about 'what works' in preventing and treating poor mental health in looked after children. Research is needed that:

- randomises caregivers and children into intervention and comparison groups, where possible

- uses adequate sample sizes to allow for results to be generalised

- is clear about what is the target of treatment, and measures that target specifically with appropriate instruments while also taking account of the views of the children and young people

- for similar reasons, samples children and caregivers from across a range of contexts

- offers a reasonable comparison group (eg one receiving an unrelated intervention of similar length)

- investigates the particular components of an intervention that might cause its effects; which children benefit and which do not or even do worse with this intervention

- uses a range of informants (eg caregiver, young person, social worker, teacher) to triangulate data on outcomes

- employs long-term follow-ups to assess the longevity of effects as appropriate to the intervention.

Section 4: Recommendations for policy, practice and research

Recommendations for policy and practice relating to ordinary care

The ethical principles that are the foundation of the Care Inquiry and NICE/SCIE reports require that practitioners:

- place the children's relationships at the heart of all they do

- listen to and empower children, young people and their families

- tailor specific interventions to their particular circumstances.

These principles offer a basis for a wide variety of practical recommendations for policy and practice – for example, that children should have a say in what kind of placement they have and, if possible, to test out particular placements before committing to them. Where rotating, shared or respite care takes place, the same carers rather than a succession of different ones should be involved. Finally, the harm done by failed reunifications should be reduced by enabling children to remain in touch with and return to former carers with whom they have a good relationship.

The ethical principles outlined above should also inform the use of the evidence given in chapter 2. In relation to the findings on 'before and after care', these suggest that:

- Local authorities should attempt to identify children at risk of entering care as early as possible, since this will enable early decision taking.

- All authorities should adopt the 'consensus model' as a basis for their work with children of whatever age, and whether in or out of care, and resource it appropriately, ensuring, for example, that there is adequate provision for those with drug addiction problems.

- Local authorities should be particularly careful to ensure that the return of children at high risk to their parents is adequately resourced.

- They should monitor their performance in these respects with particular reference to the numbers of moves children experience before a permanent placement and the age at which the relevant decisions are taken.

- Evaluation of the effects of schemes using the consensus model should include long-term follow-ups and an examination of the effects on the well-being of the child.

A range of permanent and other placements need to be in place in order to support this model, to enable young children to move out of the care system if they cannot go home, and to enable others to remain within it on a long-term basis. The evidence suggests that more permanent placements are needed, and will need to include:

- adoption by strangers and foster carers

- special guardianship orders (SGOs), largely to kin, but also to foster carers

- residence orders

- properly supported fostering by kin

- permanent fostering by stranger foster carers drawing on the work of Schofield et al (2012), a more clearly delineated option with greater delegation of responsibility to the foster carer and more possibility of staying on for the child.

Other placements that are needed include:

- permanent care by foster carers and kin, with greater delegation of responsibility to the foster carer and more possibility of staying on beyond 18 years (something promoted by national policy but requiring reallocation of resources both nationally and at local authority level)

- 'ordinary' foster carers who are trained in the techniques derived from the principles underlying intensive fostering systems so that their capacity to care for challenging children without costly interventions is enhanced

- long-stay residential care options that are less costly and less intensive than current models and can accommodate those who would choose residential care but do not require intensive adult support

- MTFC and treatment residential care for those who are expected to return home or move to a long-stay placement and whose families will be offered intensive support when they do so.

Above all, there is a need to improve the quality of placements, not because they are poor, but because this is the key to how the children do in care. So there is a need to select good carers, residential staff and heads of home; to train them appropriately; to supervise them so that short-run cycles of trouble do not occur or are addressed promptly, and to make their performance the focus of quality assurance and to ensure that poor quality provision is not used. In practice, there are a variety of ways of approaching these issues and proven methods of doing them are not available. As discussed below, some models of training are more promising than others and there is an urgent need to build on these. In the meantime, the highest priority should be given to developing and testing models for selecting, training, supervising and quality-assuring foster carers and residential staff.

Recommendations for policy and practice relating to assessments

The review of assessments suggests that local authorities should note the following in promoting the mental health and well-being of looked after children:

- The assessment instruments considered in this review are helpful as part of the regular system of checks that local authorities use to monitor looked after children's progress in care, enabling services to pick up on any issues at an early stage.

- The SDQ, for example, comes in a short and user-friendly format that enables it to be completed on a regular basis by caregivers or primary healthcare staff.

- The SDQ provides an easy way of monitoring children's well-being over time. It could give a broad indication of those who are having significant difficulties and may need further assessment, though the data collected could be much more extensively used.

- There is further room for the development of tools that assess the child *in their context*, to enable practitioners to identify where the interaction between child and context might be especially problematic and, therefore, require early intervention.

Recommendations for policy and practice related to interventions

This review of the interventions targeted at preventing problems and enhancing the mental health and well-being of looked after children suggests that policy makers and care providers need to consider the conditions under which interventions are effective and the longer-term sustainability of the reported effects. The key messages to emerge from the review suggest that:

- Interventions should be selected that offer evidence of flexibility to meet individual needs; a 'joined-up' approach from services, and follow-up support.

- Attachment theory should not be regarded as the sole framework for understanding children's behaviour: many effective programmes also incorporate social learning theory and some emotional issues may require alternative approaches.

- Those designing interventions should explore the opportunity to include components where adult and child work together for part of the time, as these offer a promising avenue for future work for some children.

- Efforts should be made to ensure that support to children and carers is consistent; for some interventions this support should extend beyond the end of the intervention.

- Foster carer training should also be complemented by ongoing 'consultation' in order to ensure that carers can generalise what they have learned in the context of a specific carer-child relationship and apply this to their work with other children.

Recommendations for future research

Overall, research should focus more on the positive outcomes that looked after children want, how these can be achieved, and less on the problems. Conversely, more is needed on what maintains problems and allows gains (eg greater ability to control one's behaviour) to transfer across settings. There is insufficient robust research that addresses the key problem of how to ensure that care is of high quality – whether this is through selection, training, supervision, intervention at key points, or quality assurance. Future research needs to:

- Incorporate more robust research designs to investigate what makes a 'successful' intervention, and the mechanisms by which they might work.

- Include RCTs (while maintaining other research designs) that address previous methodological shortcomings, such as lack of attention to context or to which children (eg of a particular age, gender or with specified problems) did not benefit from the intervention.

- Include follow-ups that measure whether improvements are sustained at least one, preferably two, years after the intervention. A key challenge here is identifying the unit of change, which in MTFC, for example, is the child, but in other programmes often the carer, who may have more than one child, which leads to radical changes in the context over a longer-term follow-up. The clarification of the ways in which long-term results can be assured is a continuing and urgent task for research.

- Evaluate interventions that target both the child and those around them – including identifying the children and carers who would most benefit from them.

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Appendix A: Leaving care

Children can and do leave care at any age. The term 'care-leavers', however, is usually reserved for those who graduate out of the system at some time between the ages of 16–18, the age at which they can no longer officially be regarded as being in care at all. In the UK, this group of children was 'put on the map' by the work of a small number of researchers (Biehal et al, 1995; Broad, 1998, 2003; Stein and Carey, 1986). As a result of their work, subsequently elaborated by the same group and others, the problems of leaving care are quite well understood. These problems are clearly serious, and the young people vary in their reaction to them. Some are successfully moving on; others are 'survivors', facing considerable difficulties and often heavily dependent on services, but also defining themselves as resilient and taking pride in their ability to get by. Others still are clearly struggling, doing well neither in their own eyes or those of others (Stein, 2008)[57]. The needs of these groups and the services they may require are different, and so there is no 'magic bullet' by which the problems of after-care may be solved.

Despite these variations, young people leaving care do face some common challenges. In general, they leave care earlier than their peers leave the family home and the period of 'weaning' or trying out independence is much compressed, as is the time for accomplishing the key tasks associated with this – working out one's place in the labour market, finding somewhere to live, and, for many of these young people (particularly the young women), finding a partner (Biehal et al, 1995; Dixon and Stein, 2005; Stein, 2004; Wade, 2008). Wider social changes have created particular difficulties for all young people in the fields of employment and housing. For most, this has made the transition to adult independence more protracted and less tidy – a matter of fits and starts, rather than one move out to a flat and a job. This also means that there is a likelihood of an even greater contrast between the lengthy, untidy normal transition and the sharp, clean break potentially facing young people in care (see, for example, Wade and Dixon, 2006).

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57 This classification is probably related to another developed on the basis of young people's accounts of why they left their last foster placement. Some defined this move as positive, stressing the wish to move to a new job, to move in with their girlfriend or some other positive outcomes; others saw it as a 'quarrel', with the move being a reaction on the part of the young person to the unreasonable behaviour or restrictions of their foster carers; and yet others saw themselves as pushed out before they were ready (Sinclair et al, 2005b). Although this was not tested, it seems likely that the first group are the 'movers on', the 'quarrel group' are the survivors and the 'pushed out group' are the strugglers.

The young people face this sharp and difficult transition alongside a number of additional problems. Their educational achievements are typically much worse than those of their peers, the number of people that they know and to whom they can turn or to whom they feel close is, by most yardsticks, very small, and they often have personal difficulties like problems in forming relationships or a tendency to behave impulsively (see, for example, Biehal et al, 1995; Cheung and Heath, 1994; Munro et al, 2010; Sinclair et al, 2005b). The extent of these difficulties varies from young person to young person and there is some evidence that those who score better on a measure of mental health (SDQ) and who have a close personal relationship with at least one adult do better (Sinclair et al, 2005b), whereas, conversely, those with problems of mental health, drug abuse or criminal behaviour tend to do worse (Wade and Dixon, 2006).

Despite these differences, the immediate outcomes of leaving care are often not encouraging. Common problems include debt, frequent changes of address, homelessness, lack of employment or other meaningful occupations, and depression (eg Biehal and Wade, 1999; Sinclair et al, 2005b; and see Okpych and Courtney, 2014, for the situation in the US). In the longer term, those who have been in care continue to be disadvantaged in terms of their mental health and in other ways (Cheung and Buchanan, 1997; Hobcraft, 1998[58]). In particular, they are much over-represented among those who are homeless (Davison and Burris, 2014) or in prison[59].

Faced with these problems, a number of logical solutions have been put forward. These include:

- Independent living schemes – those leaving care need certain resources (finance, housing, access to employment and further education or training) and skills (eg budgeting, cooking, being able to present themselves for interview); they should, therefore, be trained in these skills and given access to the needed resources;

- Early planning for the child's future life and, in particular, increased emphasis on education, including steps to increase the young people's chances of going to university;

- Increased emphasis on avoiding early discharges from care and on enabling young people to stay on with their foster carers through Staying Put schemes;

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58 See Pecora et al (2010) for evidence on adult mental health of children formerly in foster care.

59 This is continually alleged and seems to be true but based on some rather shaky figures. There is a discussion on: http://fullfact.org/factchecks/were_quarter_prisoners_in_care_as_children-28547

- Increased emphasis on the support networks available to young people and, in particular, the availability of mentors, professional advisors and leaving-care schemes;

- More attention to the transition between adults and young people's needs for support (for example, by enabling carers of very disabled young people to continue caring for them under adult arrangements).

Somewhat, although not universally, neglected are the possibilities and dangers inherent within the child's own family. These include the support that can be provided by the extended family (Marsh, 1998) around discharge. Few (perhaps about one in eight) children return to live with members of their nuclear family but the great majority are in touch with at least one family member – most commonly, mothers or siblings (Wade, 2008). Unfortunately, families have the potential for ill as well as for good (see, for example, Stein, 2004; Wade, 2008). Sinclair and his colleagues (2005b) argued, on the basis of qualitative data, that young people in care had to come to terms with the unresolved hopes and resentments that they had towards their families. Failure to do this could mean that, on leaving care, they went back to families who 're-abused' them, or that they ruminated endlessly and fruitlessly about what had been done to them. Those who could resolve these issues could then come to a *modus vivendi* with their families, commit to their foster placement and move on.

Formal evaluation of these varying arrangements is difficult and rarely tried. One systematic review of independent living schemes concluded that these might indeed be helpful but that the research designs were far too weak to be sure of any conclusions (Donkoh et al, 2006). Nevertheless, as elsewhere in this review, it is possible to get some way without strictly controlled comparisons. The suggestions for practice that have been put forward make sense, they fit with what is known about what young people want, the problems they face, and the way their lives evolve. Some young people have clearly benefited from them (as seen, for example, in case studies of Staying Put schemes (Munro et al, 2010). It seems highly likely that these ideas will form part of a comprehensive approach to the problem of 'care leaving'. They have, however, difficulties.

First, many of the ideas only apply to limited subsets of care-leavers. The numbers who can be transferred from services for young people to those for adults are very small, as are the numbers who, in the near future, will go on to university[60]. Some groups face particular problems in making use of the services on offer. For example,

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60 The number of young people going from care to university has almost certainly risen from the original estimate of 1 per cent (Jackson et al, 2005; Social Exclusion Unit, 2003), but, for the foreseeable future, they are only going to be a small proportion of the total number of care-leavers.

unaccompanied asylum seekers are sometimes seen as ineligible for certain kinds of help and tend to receive lower levels of service from leaving-care teams (Wade et al, 2005). Staying Put schemes seem potentially more widely applicable but they are limited to those who are in foster care (around half of the total of care-leavers) and among these they have been limited to those who want to stay and whose carers want them to do so (Munro et al, 2010). In practice, there are also further limitations, since the majority of authorities in the pilot wanted them to apply to young people who had lived long enough with their carers to be seen as having a family relationship with them, and also imposed the further restriction that the young people should be in further education or training[61] (Munro et al, 2010).

Second, many of them are likely to provide only a partial solution at best; one that only bears fruit in the context of other provision. For example, it is undoubtedly useful if a young person living on their own can cook. This, however, may not be of much use if they are unbearably lonely or are sacked from their job, have their benefits cut and face a rapid accumulation of debt. The provision of appropriate housing is an area where there has been considerable success, which almost certainly contributes to the young person's overall well-being, but which can be threatened by drug use or criminal involvement and other events in the young person's life (Wade and Dixon, 2006). Similarly, education, of itself, may not be of much use if the young person has to take a job where it is not needed. One study (Sinclair et al, 2005b) found that the jobs of a sample of young people who had left foster care were almost always unskilled, poorly paid, 'dead end' and insecure[62]. If they lost them, it took time to sort out their benefits and their debts mounted rapidly[63]. Educational qualifications were potentially very relevant to this group of young people, but arguably not in the jobs in which they had found themselves.

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61 And even within these limitations, the young people were using the schemes in very different ways: as an integral part of their 'family for life'; or as a launch pad from a family to which they were not deeply committed but from which they could move at their own pace.

62 As Wade and Dixon (2006) note, the economic pathways of care-leavers are marked by considerable 'fluidity'. In other words, if they get a job, they often do not keep it. These young people were less likely to consider themselves as doing well if they were in employment than if they were not. Foster carers and social workers were more likely to rate the young people as doing well if they were in employment than otherwise. It is possible that these adults, along with those who make government policy, underestimate the extent of the support required if young people are to use their education and make a success of their employment.

63 In this study, the most obvious 'successes' were in the small groups who either went to university or had babies and were 'mothered' by their partner's mother. Both routes out of care could be disastrous but equally they provided a stable (if, by most standards, grossly inadequate) income, support (many of the university group stayed on with their foster carers), a meaningful present and the promise of a meaningful future.

Third, practice is patchy and resources are short and variably available[64]. There is abundant qualitative evidence that the leaving–care teams and Staying Put schemes (Munro et al, 2010) can be very helpful and that the young people appreciate the contact with their former foster carers (Sinclair et al, 2005b; Wade, 2008). There is also evidence that leaving-care workers are busy, telephone calls from care-leavers can go unanswered (Munro et al, 2010), contact with foster carers is too intermittent to make a major difference (Sinclair et al, 2005b), and, partly perhaps through their own choice, the troubled young people with insecure care careers[65] are the least likely to receive appropriate help (Munro et al, 2010; Wade and Dixon, 2006).

Against this background, there is a wide consensus on the principles that should govern practice in this area. This has driven recent policy and, in particular, the development of more mandatory legislation, accompanied by greater resources for the housing, financial support, and social work services for care leavers. This in turn has been underpinned by better inter-agency collaboration, more explicit and earlier (pathway) planning and a clearer system of case management. Although not proven by research, this consensus could fairly be said to be supported by it. Its practice principles would probably include the need to:

- See preparation for adult life as something that goes on throughout a child's time in care, and involves a wide range of skills and attributes and not simply an ability to do certain necessary tasks;

- Begin planning early in a child's care career but do so at their own pace and in the light of what they want for their life, and the skills and qualifications they need to achieve it;

- Ensure that the young people can draw on the strengths available within their families, but that they have also come to a realistic assessment of their relationship with their family with which they are comfortable;

- Ensure as far as possible that they have the secure base and education that can provide the skills and qualifications required;

- Enable them to move on at their own pace, without either being forced out of their placements or constrained to remain in them;

- Provide the practical resources (finance, access to housing, support to achieve training or employment) needed to enable this to happen;

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64 Earlier legislation on this issue (Children Act, 1989, Section 24) was permissive and so almost inevitably followed by wide variation, but this situation seems to have survived the less permissive Children (Leaving Care) Act (2000) (Broad, 2003).

65 These include those with mental health problems, persistent offenders and those who misuse drugs (Wade and Dixon, 2006).

- Appreciate that young people differ and that all can make mistakes and will need to try things out that may fail, so that support must be both consistent (they need someone available to them) and flexible (ideally, for example, they would be able to return to their foster family if needed, as other young people return home).

In essence, these points, if followed, would mean that these young people would move from the care system to independence in much the same way as other young people move out from their families. The timing is flexible, there are false starts, and sometimes they may even return after divorce or when they lose their job. Ideally, they are neither held back nor forced to feel that they are alone in a world where no one is committed to them at all.

Appendix B: Description of assessment tools

Strengths and Difficulties Questionnaire (SDQ)

- The SDQ is suitable for assessing children aged 4–16 years (with a separate version for three-year-olds). The scale has 25 items, covering five subscales:

  - emotional symptoms;

  - conduct problems;

  - hyperactivity/inattention;

  - peer problems;

  - prosocial behaviour.

- The first four subscales are often grouped to give a 'total difficulties' score; alternatively, three subscales can be grouped as 'externalising problems', with emotional symptoms representing 'internalising problems' (Aguilar-Vefaie et al, 2011).

- Responses are given by caregivers or teachers, and young people (if aged 11 or over).

Child Behaviour Checklist (CBCL)

- The CBCL is suitable for assessing children aged 4–18 years. The scale has 118 items, covering eight subscales:

  - anxious/depressed;

  - withdrawn/depressed;

  - somatic complaints;

  - social problems;

  - thought problems;

  - attention problems;

  - delinquent/rule-breaking behaviour;

  - aggressive behaviour.

- These subscales are sometimes grouped to give scores for internalising and externalising difficulties, and a 'total problems' score.

- Caregiver, teacher and self-report versions are available.

Children's Global Assessment Scale (CGAS)

- The CGAS is suitable for assessing children aged 4–16 years. Assessors are asked to consider the child's functioning in four areas:

  - at home with family;

  - at school;

  - with friends;

  - in leisure time.

- Descriptors are provided of different levels of functioning, which range from 'doing very well' to 'extremely impaired'. Assessors use these descriptors and a range of vignettes showing how children were assigned a particular score, in order to make their judgements.

- The scale was designed for use by clinicians but has also been used by researchers and staff working with children.

Development and Well-Being Assessment (DAWBA)

- The DAWBA is a web-based tool that is suitable for assessing children aged 5–16 years. It comprises a range of questionnaires, interviews and rating techniques. This diagnostic interview consists of structured and open-ended questions that cover:

  - separation anxiety;

  - specific phobias;

  - social phobia;

  - panic attacks and agoraphobia;

  - post-traumatic stress disorder;

  - generalised anxiety;

  - compulsions and obsession;

  - depression;

  - deliberate self-harm;

  - attention and activity;

  - awkward and troublesome behaviour;

  - developmental disorders;

  - eating difficulties;

  - less common problems.

- Responses are given by caregivers, teachers and young people (if aged 11 or over); a computer algorithm computes the probability that an individual child has a given disorder, and responses can also be viewed and rated by clinicians.

Assessment Checklist for Children (ACC) or Adolescents (ACA)

- The ACC scale has 120 items, covering 10 clinical and two self-esteem subscales:

  - sexual behaviour;

  - pseudomature interpersonal behaviour;

  - non-reciprocal interpersonal behaviour;

  - indiscriminate interpersonal behaviour;

  - insecure interpersonal behaviour;

  - anxious–distrustful;

  - abnormal pain response;

  - food maintenance;

  - self-injury;

  - suicide discourse;

  - negative self-image;

  - low confidence.

- As the ACC and ACA were developed specifically for use with looked after children, we report the results of validity and reliability tests with this population. The lack of such reports for other measures in this chapter should not be taken as an indication that they lack validity and reliability; merely that these have been previously established with broader samples of children and young people.

- The validity and reliability of the ACC was tested using a sample of caregivers for children aged 4–11 in long-term care in Australia (Tarren-Sweeney, 2007), though the sample size of 412 was on the low side for the statistical technique employed (factor analysis) with a scale of this length.

- The ACA was derived from the ACC for use with older children, and is suitable for assessing young people aged 12–17 years. The scale has 105 items, covering seven clinical and two self-esteem subscales (six of these replicate those in the ACC; the other three are unique to the ACA):

  - non-reciprocal interpersonal behaviour;

  - sexual behaviour problems;

  - food maintenance behaviour;

  - suicide discourse;

  - social instability/behavioural dysregulation;

  - emotional dysregulation/distorted social cognition;

  - dissociation/trauma symptoms;

- negative self-image;

- low confidence.

- The validity and reliability of the ACA was tested using a sample of caregivers of adolescents in long-term care in Australia and Canada (Tarren-Sweeney, 2013b), though again the sample of 372 was small for a factor analysis.

- Although validation of the ACC and ACA was conducted using caregiver-report, it is now recommended that these longer versions are completed by trained clinicians and that caregivers should use the shortened versions (BAC-C and BAC-A) (Tarren-Sweeney, 2013c).

Appendix C: Literature search strategy for chapter 4

Aims and scope

The literature review for chapter 4 addresses the research question:

> What is the evidence on the effectiveness of interventions/ approaches that are used to address the mental health needs of children in care?

We developed a search protocol that included our inclusion and exclusion criteria, search strings, and a list of sources to be searched. We **included** any interventions that were listed as targeting behavioural, emotional or hyperkinetic outcomes with a sample of looked after children and young people. We restricted coverage to include only those interventions for which we found two or more articles evaluating the intervention with a looked after population. We **excluded** mental health interventions tested solely with young people who are not in the care system, and studies of adult outcomes for former looked after children who had graduated from interventions. We did not report on the outcomes for others involved in the interventions (eg carers' stress levels).

Search strategy

We combined four search strings in our literature search for chapter 4. In drawing up our search strings, we attempted to strike a balance between using words and phrases that would be sensitive to a potentially broad range of interventions and definitions of mental health and well-being, and those that were sufficiently specific to ensure that we were not presented with a large number of papers that were not relevant to our research question. The search, therefore, incorporated a range of international terminology for children in care, along with a variety of mental health and well-being outcomes, and synonyms for types of intervention. Our fourth search string ensured that we would not be shown reports on adult mental health interventions.

Readers unfamiliar with the use of search strings should note that by inputting this information into research databases, we were requesting all reports that contained **a combination of at least four of the phrases listed below, at least one of which must come from each of the four headings**. For example, a report that wrote about "foster care", "resilience", "intervention" and "children" would be included, but one about "foster care", "resilience" and "intervention"

that did not mention "children", "youth", "adolescents" or "infants" would not. An asterisk indicates that we would accept any ending to the word (for example, "foster famil★" could include reports writing about "foster family" or "foster families").

1. Care status

"foster care★" OR "foster parent★" OR "foster famil★" OR "foster placement★" OR "substitute famil★" OR "family foster home★" OR "children's home★" OR "residential care★" OR "residential unit★" OR "out-of-home care★" OR "out of home care★" OR "looked after" OR "looked-after" OR "congregate care★" OR "group home★" OR "alternative care★"

2. Mental health and well-being

"anxiety" OR "depression" OR "ADHD" OR "disorder" OR "substance misuse" OR "substance abuse" OR "FASD" OR "failure to thrive" OR "PTSD" OR "autis★" OR "neurodevelopmental" OR "learning disab★" OR "learning difficult★" OR "learning impair★" OR "empathy" OR "resilience" OR "emotion dys★" OR "emotion regulation" OR "inhibitory" OR "executive function★" OR "attachment" OR "behaviour" OR "behavior" OR "psychopatholog★"

3. Interventions

"intervention★" OR "treatment★" OR "MTFC" OR "KEEP" OR "CBT" OR "medication" OR "anti-depressant★" OR "Ritalin" OR "counselling" OR "counseling" OR "life story" OR "therap★" OR "psychotherap★" OR "trauma" OR "pharmacotherap★" OR "attention★"

4. Childhood

"child★" OR "youth★" OR "adolescen★" OR "infant★"

We used these search strings on 14 electronic databases:

- Applied Social Sciences Index and Abstracts
- Australian Education Index
- British Education Index
- Conference Proceedings Citation Index
- Cochrane Library
- Education Resources Information Center
- International Bibliography of Social Sciences

- Medline
- PsycInfo
- Scopus
- Social Care Online
- Social Policy and Practice
- Social Sciences Citation Index
- Social Services Abstracts

Our database search uncovered 12,476 original research articles and literature reviews on interventions specifically tested with looked after children. The titles of all of these reports were screened for relevance to the research question. Seemingly relevant titles were further screened by reading the abstract (where one was provided) or introduction. The final stage of screening lay in reading the full report.

We also searched the websites of the following key childhood research institutions for relevant publications:

- British Association for Adoption and Fostering
- Centre for Excellence and Outcomes in Children and Young People's Services (C4EO)
- Campbell Collaboration
- Casey Family Programs
- Chapin Hall at the University of Chicago
- Department for Education (UK Government)
- Evidence for Policy and Practice Information and Co-ordinating Centre (EPPI-Centre)
- The Fostering Network
- Joanna Briggs Institute
- National Foundation for Educational Research
- National Children's Bureau
- National Society for the Prevention of Cruelty to Children (NSPCC)
- Office of Planning, Research and Evaluation in Administration for Children and Families
- What Works Clearinghouse

Finally, we contacted an international panel of foster care experts from the world of research and practice, for advice on any evidence that might not be revealed by our literature search.

All publications that evaluated interventions for looked after children's mental health and well-being were retained, and were included in the review wherever two or more reports on the same intervention existed. We did not restrict our definition of intervention outcomes, choosing to include all reports that described factors relating to intervention effectiveness. We did not apply quality 'ratings' in order to exclude any studies from the review.

We acknowledge the possibility that further reports not identified by our search strategy exist internationally. Our search was not exhaustive: we did not search for articles published on non-English language databases or websites; our panel of international experts did not cover all continents (South America and Asia in particular were neglected); and the time-limited nature of the review did not allow time to screen for citations of each article, which might uncover more recent updates.

Our review covers 106 reports that evaluated interventions for looked after children's mental health and well-being. Details of the reports are shown in appendices D and E, and they are discussed in full in chapter 4.

Appendix D: Details of intervention studies included in chapter 4

Reference	Country	Intervention	Intervention and comparison group details	Measures	Baseline and follow-up
Arvidson et al (2011)	USA	ARC	50 in ARC (21 with behavioural data); no comparison group. Aged 3–12 years at start.	Problem behaviours: Child Behaviour Checklist (CBCL; caregiver-report).	Baseline at referral. Follow-up at discharge from institution.
Balluerka et al (2014)	Spain	Animal-assisted therapy	21 in animal-assisted therapy; 25 in control group. Aged 12–17 years at start.	Attachment security, parental interference: CaMir questionnaire (self-report).	Baseline at start of intervention. Follow-up at 2 weeks after end of intervention.
Bick and Dozier (2013)	USA	ABC	44 in ABC; 52 in educational intervention. Aged 1–22 months at start. Randomly assigned.	Maternal sensitivity: Observation of interactive play.	Baseline at point of randomisation. Follow-ups at 1 month after end of intervention, and at age 12 months or 24 months.
Biehal et al (2011)	UK	MTFC–A (Intensive Fostering)	23 offenders in MTFC; 24 in custody/serving community sentences. Aged 12–17 years at start.	Offending behaviour: Official records of number and severity of criminal acts.	Baseline at point of starting placement/sentence. Follow-ups at 12 months after baseline (MTFC/community sample) or exit from custody (convicted sample) and at 12 months after end of intervention (all groups).

Reference	Country	Intervention	Intervention and comparison group details	Measures	Baseline and follow-up
Biehal et al (2012)	UK	MTFC–A	RCT arm: 20 in MTFC; 14 in treatment as usual. Aged 7–17 years at start. Randomly assigned. Observational arm: 92 in MTFC; 93 in treatment as usual. Aged 7–17 years at start.	Psychosocial functioning; Health of the Nation Outcome Scales for Children and Adolescents (researcher-report), Children's Global Assessment Scale (researcher-report), CBCL (caregiver-report), Youth Self-Report, Strengths and Difficulties Questionnaire (SDQ; carer- or MTFC worker-report), Development and Well-being Assessment – Attachment Disorder (DAWBA-AD; carer-report). School attendance and exclusions: Interviews with young person and caregiver, social worker questionnaire, official records. Offending behaviour: Carer- and social worker-reports.	Baseline at point of starting placement. Follow-ups at 3 and 12 months after baseline.
Briskman et al (2012)	UK	Fostering Changes	34 carers in Fostering Changes; 29 in control group. Caring for children aged 2–12 years. Randomly assigned.	Problem behaviours: Carer-defined problems. Emotional problems, hyperactivity, conduct problems: Strengths and Difficulties Questionnaire (SDQ; carer-report). Attachment: Quality of Attachment Relationships Questionnaire (carer-report).	Baseline at point of randomisation. Follow-up at end of intervention.
Bruce et al (2009)	USA	MTFC-P	10 in MTFC-P; 13 in regular foster care; 11 not in care. Aged 4–6 years at follow-up. Randomly assigned.	Cognitive control and response monitoring: Flanker task. Response to feedback: Electrophysiological measures (event-related potentials).	No baseline. Measured at 17–19 months after start of placement.
Bywater et al (2010)	UK	Incredible Years	29 carers in Incredible Years; 17 in waitlist control. Caring for children aged 2–17 years. Randomly allocated.	Problem behaviours, hyperkinetic behaviours: SDQ (carer-report), Eyberg Child Behavior Inventory (carer-report).	Baseline at point of randomisation. Follow-up at 6 months after baseline.

Reference	Country	Intervention	Intervention and comparison group details	Measures	Baseline and follow-up
Chaffin et al (2006)	Review	Attachment interventions	Review	Review	Review
Chamberlain et al (2007)	USA	MTFC–A	37 female chronic offenders in MTFC; 44 in group care. Aged 13–17 years at start. Randomly assigned.	Delinquency: days spent in locked settings (carer- and self-report), official records of criminal referrals, Delinquency subscale of CBCL (carer-report), Elliott Self-Report of Delinquency.	Baseline prior to placement entry. Follow-up at 24 months after baseline.
Chamberlain et al (2008)	USA	KEEP	359 children in KEEP; 341 in treatment as usual. Aged 5–12 years at start. Randomly assigned.	Problem behaviour and carers' positive reinforcement behaviour: Parent's Daily Report (carer–report).	Baseline at start of intervention. Follow–up at 5 months after baseline.
Clyman et al (2002)	Review	General intervention review	Review	Review	Review
Coholic (2011)	Canada	Arts therapy	31 children and 18 parents/foster carers; no comparison group. Aged 8–15 years at start.	Programme satisfaction, self-awareness and self-confidence: Interviews with young person and caregiver, video recorded group sessions.	No baseline. Interviewed at 2 weeks after end of intervention.
Coholic et al (2009a)	Canada	Arts therapy	38 children and 20 parents/foster carers; no comparison group. Aged 8–15 years at start.	Programme satisfaction, self-awareness, self-esteem, skills development: Interviews with young person and caregiver, video recorded group sessions.	No baseline. Interviewed at 2 weeks after end of intervention.
Coholic et al (2009b)	Canada	Arts therapy	38 children and 20 parents/foster carers; no comparison group. Aged 8–15 years at start.	Programme satisfaction, self-awareness, self-esteem, skills development, coping; Interviews with young person and caregiver, video recorded group sessions.	No baseline. Interviewed at 2 weeks after end of intervention.

Reference	Country	Intervention	Intervention and comparison group details	Measures	Baseline and follow-up
Coholic et al (2012)	Canada	Arts therapy	21 children in three waves of Arts therapy; data from 12 of these in Arts and Crafts during waitlist acted as comparison group. Aged 8–14 years at start.	Self-concept: Piers–Harris Children's Self-Concept Scale (self-report). Resiliency: Resiliency Scales for Children and Adolescents, covering sense of mastery, relatedness and emotional reactivity (self-report).	Baseline at point of study entry. Follow-ups at 7, 19, 31 and 42 weeks after baseline.
Cornell and Hamrin (2008)	Review	Attachment interventions	Review	Review	Review
Cross et al (2004)	USA	Treatment foster care	384 children leaving treatment foster care placements; no comparison group. Aged 'under 6' to 'over 14'.	Social and emotional well-being, problem behaviour (caseworker-identified): Outcomes survey (caseworker-report).	No baseline. Measured at end of placement.
DeGarmo et al (2009)	USA	KEEP	337 carers in 59 KEEP groups (no comparison group).	Problem behaviour: Parent's Daily Report (carer-report). Carer engagement: New items (group leader-report).	Baseline at start of intervention. Follow-up at 5 months after baseline.
Dickson et al (2010)	Review	General intervention review	Review	Review	Review
Dietz et al (2012)	USA	Animal-assisted therapy	60 in therapy with dogs; 61 in therapy with dogs plus stories; 32 in standard therapy. Aged 7–17 years at start.	Trauma symptoms: Trauma Symptom Checklist for Children (self-report).	Baseline at start of intervention. Follow-up at end of intervention.
Dozier et al (2002a)	Review	General intervention review	Review	Review	Review

Reference	Country	Intervention	Intervention and comparison group details	Measures	Baseline and follow-up
Dozier et al (2006)	USA	ABC	60 children in foster care, receiving ABC or educational intervention (split not given); 104 not in care. Aged 3–39 months at follow-up (non-care group aged 20–60 months). Randomly assigned.	Cortisol: Saliva sampling. Problem behaviours: Parent's Daily Report (carer-report).	No baseline. Measured at 1 month after end of intervention.
Dozier et al (2008)	USA	ABC	46 in ABC; 47 in educational intervention; 48 not in care. Aged 15–24 months at Strange Situation. Randomly assigned.	Attachment: Strange Situation. Cortisol: Saliva sampling.	Baseline on arrival at lab. Follow-ups 15 and 30 minutes after Strange Situation; additional follow-up at 2 hours for a subsample.
Dozier et al (2009)	USA	ABC	46 in ABC; 46 in educational intervention. Aged 3–39 months at follow-up. Randomly assigned.	Attachment: Parent Attachment Diary (carer-report).	No baseline. Diary completed for 3 days after end of intervention.
Eddy and Chamberlain (2000)	USA	MTFC–A	30 male chronic offenders in MTFC; 23 in group care. Aged 12–17 years at start. Randomly assigned.	Anti-social behaviour: Official records and General Delinquency subscale of Elliott Behavior Checklist (self-report). Adult supervision and discipline, adult-youth relationship, and association with deviant peers: Interviews with young person and caregiver.	Baseline prior to placement entry. Follow-ups at 3, 6, 12, 18 and 24 months after baseline.
Eddy et al (2004)	USA	MTFC–A	37 male chronic offenders in MTFC; 42 in group care. Aged 12–17 years at start. Randomly assigned.	Anti-social behaviour: Official records and General Delinquency subscale of Elliott Behavior Checklist (self-report). Violent behaviour: Official records and interview with young person.	Baseline prior to placement entry. Follow-ups at 6, 12, 18 and 24 months after baseline.

Reference	Country	Intervention	Intervention and comparison group details	Measures	Baseline and follow-up
Everson-Hock et al (2012)	Review	Foster carer training and support	Review	Review	Review
Farmer et al (2010)	USA	Treatment foster care	137 in enhanced treatment foster care in 7 agencies; 110 in regular treatment foster care in a different 7 agencies. Aged 2–21 years at start. Agencies randomly assigned.	Internalising and externalising behaviours: Parent's Daily Report, SDQ (carer-report), Behavioral and Emotional Rating Scale (Carer-report).	Baseline at point of randomisation. Follow-ups at 6 and 12 months after baseline.
Feil et al (2012)	USA	MTFC-A	20 foster carers in MTFC-A, 9 programme supervisors and 4 MTFC consultants; all using an internet-based treatment fidelity monitoring system for MTFC.	Satisfaction: Online ratings of ease of use and audio/video quality (user-report).	No baseline. Measured after a minimum of 7 days of use.
Fisher and Kim (2007)	USA	MTFC-P	57 in MTFC-P; 60 in regular foster care. Aged 3–5 years at start. Randomly assigned.	Attachment: Parent Attachment Diary (carer-report).	Baseline at start of intervention. Follow-ups at 3, 6, 9 and 12 months after baseline.
Fisher et al (2007)	USA	MTFC-P	57 in MTFC-P; 60 in regular foster care; 60 not in care. Aged 3–6 years at start. Randomly assigned.	Cortisol: Saliva sampling.	Baseline 3–5 weeks after placement. Follow-ups monthly for 12 months.

Reference	Country	Intervention	Intervention and comparison group details	Measures	Baseline and follow-up
Fisher et al (2011)	USA	MTFC–P	57 in MTFC–P; 60 in regular foster care. Aged 3–6 years at start. Randomly assigned.	Placement disruptions. Problem behaviours: Parent's Daily Report (carer-report).	Behaviour recorded during first 3 months of placement. Placement disruptions measured during first 12 months of placement.
Fricker-Elhai et al (2005)	USA	PCIT	Case study of 2 children. Aged 6 and 7 years.	Problem behaviours: CBCL (carer-report), Teacher Report Form, Eyberg Child Behavior Inventory (carer-report).	Baseline at referral. Follow-up at end of intervention (CBCL not completed by carers).
Geenen et al (2013)	USA	Mentoring (plus skills training)	60 in mentoring and skills group; 63 in control group. Aged 14–17 years at start. Randomly assigned.	Self-determination: AIR Self-Determination Scale (carer-, teacher- and self-report). School success: School Attitude Measure. Anxiety/depression/withdrawal: CBCL (carer-report), Teacher Report Form, Youth Self-Report.	Baseline at point of randomisation. Follow-ups at end of intervention and 9 months later.
Gilbertson et al (2005)	Australia	Treatment foster care	8 in treatment foster care; no comparison group. Aged 13–16 years	Social well-being, engagement with education or therapy: Official placement summaries, New items (social worker-report).	No baseline. Measured at 12 months after start of placement.
Golding (2007)	Review	Foster carer training	Review	Review	Review
Golding and Picken (2004)	UK	Fostering Attachments	7 carers in Fostering Attachments; 39 in Incredible Years. Caring for children aged 5–12 years.	Conduct difficulties, peer difficulties, hyperactivity, and prosocial behaviour: SDQ (carer-report).	Baseline at start of intervention. Follow-up at end of intervention.

Reference	Country	Intervention	Intervention and comparison group details	Measures	Baseline and follow-up
Green et al (2014)	UK	MTFC–A	RCT arm: 20 in MTFC; 14 in treatment as usual. Aged 7–17 years at start. Randomly assigned. Observational arm: 92 in MTFC; 93 in treatment as usual. Aged 7–17 years at start.	Psychosocial functioning; Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA; researcher-report), Children's Global Assessment Scale (researcher-report), CBCL (caregiver-report), Youth Self-Report, SDQ (carer- or MTFC worker-report), Development and Well-being Assessment – Attachment Disorder (DAWBA-AD; carer-report). Education: Sources as above for HoNOSCA. Offending behaviour: Carer- and social worker-reports.	Baseline at point of starting placement. Follow-up at 12 months after baseline.
Gurney-Smith et al (2010)	UK	Fostering Attachments	13 carers/adoptive parents in Fostering Attachments group; no comparison group. Caring for children aged 4–14 years.	Conduct difficulties, peer difficulties, hyperactivity, and prosocial behaviour: SDQ (carer-report).	Baseline at start of intervention. Follow-ups at end of intervention and 3 months later.
Hahn et al (2004)	Review	MTFC–A	Review	Review	Review
Haight et al (2010)	USA	Life story work	8 receiving life story work; 7 in waitlist control group. Aged 7–14 years at start. Randomly assigned.	Externalising behaviours: CBCL (carer-report).	Baseline at point of randomisation. Follow-ups at end of intervention and 7 months later.
Hansson and Olsson (2012)	Sweden	MTFC–A	19 young people with conduct disorder in MTFC; 27 in treatment as usual. Aged 12–17 years at start. Randomly assigned.	Internalising and externalising behaviours: CBCL (parent- or carer-report), Youth Self-Report. Sense of coherence: Sense of Coherence Scale (self-report).	Baseline at start of placement. Follow-ups at 12 and 24 months after baseline.

Reference	Country	Intervention	Intervention and comparison group details	Measures	Baseline and follow-up
Harold et al (2013)	USA	MTFC–A	81 female chronic offenders in MTFC; 85 in group care. Aged 13–17 years at start. Randomly assigned.	Delinquency: days spent in locked settings (carer- and self-report), official records of criminal referrals. Depression: Depression subscale of Brief Symptom Inventory (self-report).	Baseline prior to placement entry (for 81 participants) or 3 months after entry (for 85). Follow-ups at 6, 12, 18 and 24 months after baseline.
Henggeler and Sheidow (2003)	Review	Interventions for conduct disorder and delinquency	Review	Review	Review
Henggeler and Sheidow (2012)	Review	Interventions for conduct disorder and delinquency	Review	Review	Review
Hodgdon et al (2013)	USA	ARC	126 in residential units using ARC; no comparison group. Aged 12–22 years at start.	Externalising and internalising behaviour: CBCL (caregiver-report). PTSD: PTSD Reaction Index (caregiver-report).	Baseline at referral. Follow-ups at 3 months and 9 months after end of intervention.
Holmes et al (2012)	UK	MTFC–A	24 in MTFC–A in 5 Local Authorities.	Cost: Direct and indirect service/intervention costs, based on children's needs, educational history and personal characteristics, and practitioner focus groups creating activity time estimates. Costs for 6 months in MTFC compared to 6 months in previous care arrangement and to 6 months in the arrangement they would have received had MTFC not been available.	Baseline at start of intervention. Costs calculated for following 6 months.
James et al (2013)	Review	Residential care interventions	Review	Review	Review

Reference	Country	Intervention	Intervention and comparison group details	Measures	Baseline and follow-up
Johnson et al (2011)	USA	Mentoring	262 in foster care, grouped (for analyses only) according to amount of mentoring received in 6-month periods prior to each follow-up. 27 had data at 18 months. Aged 6–15 years at start.	Family and social functioning and behaviour at school, stress symptoms: Child and Adolescent Needs and Strengths–Mental Health scale (clinician-report).	Baseline at referral. Follow-ups at 6, 12, and 18 months after baseline.
Jonkman et al (2012)	Netherlands	MTFC–P	20 in MTFC–P; no comparison group. Aged 3–7 years at start.	Problem behaviours: Parent's Daily Report (carer-report).	Baseline 1 month after start of placement. Follow-up every weekday during placement (9 months) and during 3 months follow-up support period.
Kerr and Cosar (2014)	Review	Attachment interventions	Review	Review	Review
Kim and Leve (2011)	USA	Middle School Success	48 girls in MSS; 52 in treatment as usual. Aged 10–12 years at start. Randomly assigned.	Internalising and externalising behaviours: CBCL (carer-report). Prosocial behaviour: Parent's Daily Report (carer-report). Substance use: New items (self-report). Delinquency: Elliott Self-Report of Delinquency.	Baseline at start of intervention. Follow-ups at 6, 12 and 36 months after baseline.
Kim et al (2013)	USA	Middle School Success	48 girls in MSS; 52 in treatment as usual. Aged 10–12 years at start. Randomly assigned.	Substance use: New items (self-report). Risky sexual behaviour: Interview with young person.	Baseline at start of intervention. Follow-up at 36 months after baseline.
Kinsey and Schlösser (2013)	Review	General intervention review	Review	Review	Review

Reference	Country	Intervention	Intervention and comparison group details	Measures	Baseline and follow-up
Kirton and Thomas (2011)	UK	MTFC–A	Sample size not reported. Around ¾ of the sample were aged 13 years or over.	Educational outcomes, high-risk behaviours and peer relationships: Measures not stated.	Baseline and follow-up period not stated.
Knorth et al (2007)	Review	Aggression in residential care interventions	Review	Review	Review
Kyhle Westermark et al (2011)	Sweden	MTFC–A	20 young people with conduct disorder in MTFC; 15 in treatment as usual. Aged 12–18 years at start. Randomly assigned.	Internalising and externalising behaviours: CBCL (parent– or carer–report), Youth Self-Report.	Baseline at start of placement. Follow-up at 24 months after baseline.
Laybourne et al (2008)	UK	Fostering Attachments	7 in Fostering Attachments; no comparison group. Children's ages not stated.	Problem behaviours: SDQ (carer-report).	Baseline at start of intervention. Follow-up at end of intervention.
Leathers et al (2011)	USA	KEEP	18 children in KEEP; 13 in treatment as usual. Aged 4–12 years at start.	Internalising and externalising behaviours: CBCL (carer-report).	Baseline at start of intervention. Follow-ups at 3 and 6 months after baseline (a 12 month follow-up had too few children to analyse).
Leathers et al (2012)	USA	KEEP	18 children in KEEP; 13 in treatment as usual. Aged 4–12 years at start.	Internalising and externalising behaviours: CBCL (carer-report). Child's integration into the foster home and carers' desire to adopt the child: New items (carer– and caseworker-report).	Baseline at start of intervention. Follow-ups at 3 and 6 months after baseline (a 12 month follow-up had too few children to analyse).

Reference	Country	Intervention	Intervention and comparison group details	Measures	Baseline and follow-up
Leve and Chamberlain (2005)	USA	MTFC–A	73 chronic offenders in MTFC; 80 in group care. Aged 12–17 years at start. Randomly assigned.	Exposure to delinquent peers: Describing Friends Questionnaire (self-report), CBCL (carer-report).	Baseline prior to placement entry. Follow-ups at 3, 6, 12, 18 and 24 months after baseline.
Leve et al (2005)	USA	MTFC–A	37 female chronic offenders in MTFC; 44 in group care. Aged 13–17 years at start. Randomly assigned.	Delinquency: days spent in locked settings (carer– and self-report), official records of criminal referrals, Delinquency subscale of CBCL (carer-report), Elliott Self-Report of Delinquency.	Baseline prior to placement entry. Follow-up at 12 months after baseline.
Leve et al (2009)	Review	KEEP/MTFC	Review	Review	Review
Leve et al (2012)	Review	General intervention review	Review	Review	Review
Lewis-Morrarty et al (2012)	USA	ABC	17 in ABC; 20 in educational intervention; 24 not in care. Aged 4–6 years at follow-up. Randomly assigned (when aged under 20 months).	Cognitive flexibility: Dimensional Change Card Sort. Theory of mind: Penny-hiding Game.	No baseline. Measured at age 4–6 years.
Linares et al (2006)	USA	Incredible Years (plus co-parenting programme)	40 carers and paired biological parents in Incredible Years; 24 in control group. Caring for children aged 3–10 years. Randomly assigned.	Co-parenting strategies: Family Functioning Style Scale (carer– and parent-report). Externalising behaviours: CBCL (carer– and parent-report), Eyberg Child Behavior Inventory (carer– and parent-report), Sutter-Eyberg Student Behavior Inventory (teacher-report).	Baseline at start of intervention. Follow-ups at end of intervention and 3 months later.

Reference	Country	Intervention	Intervention and comparison group details	Measures	Baseline and follow-up
Linares et al (2012)	USA	Incredible Years for children	49 in Incredible Years; 45 in control group. Aged 5–8 years at start. Randomly assigned.	Physical aggression: CBCL (carer-report), Sutter-Eyberg Student Behavior Inventory (teacher-report). Self-control: Self-control scale (carer- and teacher-report). ADHD diagnoses: Computer-based Diagnostic Interview Schedule for Children (carer-report).	Baseline at point of randomisation. Follow-ups at end of intervention and 3 months later.
Lynch et al (2014)	USA	MTFC–P	57 in MTFC-P; 60 in regular foster care. Aged 3–5 years at start. Randomly assigned.	Cost: Service/intervention cost, Permanent placements, Incremental net benefit.	Baseline at start of intervention. Costs calculated for following 2 years.
Macdonald and Turner (2008)	Review	MTFC–A	Review	Review	Review
McDaniel et al (2011)	UK	Incredible Years	13 carers in Incredible Years; no comparison group. Caring for children aged 8–13 years.	Problem behaviours and intensity: Eyberg Child Behavior Inventory (carer-report).	Baseline at start of intervention. Follow-up at end of intervention.
McGuinness and Dyer (2007)	Review	MTFC–A	Review	Review	Review
McNeil et al (2005)	USA	PCIT	75 in PCIT; no comparison group. Aged 2–8 years at start.	Problem behaviours: Eyberg Child Behavior Inventory (carer-report).	Baseline at referral. Follow-up at 1 month after end of intervention.

Reference	Country	Intervention	Intervention and comparison group details	Measures	Baseline and follow-up
Nilsen (2007)	USA	Incredible Years	11 carers in Incredible Years; 7 in control group. Caring for children aged 5–12 years. Assigned dependent on being available at time of training.	Conduct symptoms, hyperactive, aggressive and externalising behaviours: Behavioral Assessment System for Children.	Baseline at start of intervention. Follow-up at end of intervention.
Pace et al (2013)	USA	CBCT	29 in CBCT; 26 in waitlist control group. Aged 13–17 years at start. Randomly assigned.	CRP: Saliva samples. Depression: Quick Inventory of Depressive Symptomatology (self-report). Anxiety: State–Trait Anxiety Inventory (self-report). Engagement in CBCT: Daily practice diary.	Baseline at start of intervention. Follow-up at end of intervention.
Pallett et al (2002)	UK	Fostering Changes	55 carers in Fostering Changes; no comparison group. Children's ages not stated.	Problem behaviours: Carer-defined problems. Emotional problems, hyperactivity, conduct problems: SDQ (carer-report).	Baseline at start of intervention. Follow-up at end of intervention.
Pearce and Pezzot-Pearce (2001)	Review	General intervention review	Review	Review	Review
Pearl (2009)	Review	Aggression interventions	Review	Review	Review
Price et al (2009)	Review	KEEP	Review	Review	Review

Reference	Country	Intervention	Intervention and comparison group details	Measures	Baseline and follow-up
Price et al (2012)	USA	KEEP	181 children in KEEP; 341 in treatment as usual (from Chamberlain et al, 2008, study). Aged 5–12 years at start.	Problem behaviour: Parent's Daily Report (carer-report).	Baseline at start of intervention. Follow-up at end of intervention.
Racusin et al (2005)	Review	General intervention review	Review	Review	Review
Redding et al (2000)	Review	Treatment foster care	Review	Review	Review
Reddy et al (2013)	USA	CBCT	29 in CBCT; 26 in waitlist control group. Aged 13–17 years at start. Randomly assigned.	Behavioural and emotional problems: CBCL (caregiver-report). Depression: Quick Inventory of Depressive Symptomatology (self-report). Anxiety: State–Trait Anxiety Inventory (self-report). Self-harm: Functional Assessment of Self Mutilation (self-report). Loving kindness, joy, compassion, acceptance towards self and others: Self-Other Four Immeasurables Scale (self-report). Hope: Children's Hope Scale (self-report). Emotion regulation: Difficulties with Emotion Regulation Scale (self-report). Callous–unemotional traits: Inventory of Callous and Unemotional Traits (self-report and caregiver-report). Engagement in CBCT: Daily practice diary.	Baseline at start of intervention. Follow-up at end of intervention.

Reference	Country	Intervention	Intervention and comparison group details	Measures	Baseline and follow-up
Rhoades et al (2013)	UK and USA	MTFC–A	58 girls in MTFC UK. Aged 12–16 years at start. *compared with* 81 female chronic offenders in MTFC USA. Aged 13–17 years at start. Randomly assigned.	All UK measures: Single items on MTFC audit form (caregiver– or social worker–report). US Offending: Official records of criminal charges. Violent behaviour: Elliott Social Behavior Questionnaire (caregiver–report), Youth Self-Report. Substance use: Interview with young person. Risky sexual behaviour: Overt Covert Aggression Questionnaire (caregiver–report). Self-harm: Youth Self-Report. Involvement in school activities: Interviews with young person and caregiver.	Baseline prior to placement entry. Follow-up at 12 months after baseline.
Robst et al (2013)	USA	Treatment foster care	1,530 episodes of treatment foster care; 1,968 of Statewide Input Psychiatric Program; 1,031 of therapeutic group home care. Aged 'under 11' to 18 years. Used propensity score matching.	Arrest rates: Official records.	Baseline at start of intervention. Follow-ups at 6 and 12 months after baseline.
Rork and McNeil (2011)	Review	Foster carer training	Review	Review	Review
Scott (2004)	Review	General intervention review	Review	Review	Review

Reference	Country	Intervention	Intervention and comparison group details	Measures	Baseline and follow-up
Shotton (2010)	UK	Life story work	5 adoptive/foster carers receiving life story work training; no comparison group. Carers looked after children aged 3–15 years.	Carer-child relationship: Interview with carer.	No baseline. Interviewed 2–3 months after training.
Smith (2004)	USA	MTFC–A	62 offenders in MTFC; no comparison group. Aged 12–18 years at start. Randomly assigned.	Pre-placement risk: substance abuse, suicidality, academic level, mental health (Brief Symptom Inventory, self-report), truancy and offending behaviour. Delinquency: Official records of criminal referrals.	Baseline prior to placement entry. Follow-up at 12 months after placement ended.
Smith et al (2010)	USA	MTFC–A	37 male chronic offenders in MTFC; 42 in group care. Aged 12–17 years at start. Randomly assigned.	Substance use: Interview with young person.	Baseline prior to placement entry. Follow-ups at 12 and 18 months after baseline.
Smith et al (2011)	USA	Middle School Success	48 girls in MSS; 52 in treatment as usual. Aged 10–12 years at start. Randomly assigned.	Internalising and externalising behaviours, prosocial behaviour: Parent's Daily Report (carer-report).	Baseline at start of intervention. Follow-up at 6 months after baseline.

Reference	Country	Intervention	Intervention and comparison group details	Measures	Baseline and follow-up
Smith et al (2012)	USA	MTFC–A (plus trauma treatment)	13 female offenders in MTFC; 17 in group care. Aged 12–17 years at start. Randomly assigned.	Delinquency: days spent in locked settings (carer- and self-report), official records of criminal referrals, Elliott General Delinquency Scale (self-report), Delinquency subscale of CBCL (carer-report). Mental health: Anxiety and Depression subscales of Brief Symptom Inventory (self-report), CBCL (carer-report), Schedule of Affective Disorders and Schizophrenia for School-Age Children (carer-report), Trauma Symptom Checklist for Children (self-report).	Baseline prior to placement entry. Follow-up at 12 months after baseline.
Southerland et al (2009)	USA	Treatment foster care	177 in treatment foster care; no comparison group. Aged 4–19 years at start.	Mental health: Brief Psychiatric Rating Scale for Children (clinician-report at intake). Behavioural and emotional functioning: Behavioral and Emotional Rating Scale (carer-report). Carer's role: Interview with carer. Carer–child relationship: Trusting Relationship Questionnaire (carer-report).	Baseline at start of placement (mental health measure only). All other measures taken at entry to study (from 'a few months' to 10 years after baseline).
Spencer et al (2010)	Review	Mentoring	Review	Review	Review
Sprang (2009)	USA	ABC	26 in ABC; 27 in waitlist control group with carers attending regular support groups. Aged 0–6 years at start. Randomly assigned.	Externalising and internalising behaviour: CBCL (carer-report).	Baseline at point of randomisation. Follow-up at end of intervention.

Reference	Country	Intervention	Intervention and comparison group details	Measures	Baseline and follow-up
Taussig and Culhane (2010)	USA	Mentoring (plus skills training)	68 in mentoring and skills group; 76 in control group. Aged 9–11 years at start. Randomly assigned.	Mental health: composite of CBCL (carer-report), Teacher Report Form, and Trauma Symptom Checklist for Children (self-report).	Baseline at point of referral (2–3 months before start of intervention). Follow-ups at end of intervention and 6 months later.
Taussig et al (2012)	USA	Mentoring (plus skills training)	56 in mentoring and skills group; 54 in control group. Aged 9–11 years at start. Randomly assigned.	Placement in residential treatment centre. Externalising behaviour: CBCL (carer-rated).	Baseline for CBCL at point of randomisation (no follow-up). Baseline for placements 3 months into intervention. Follow-up for placements 1 year after intervention.
Taussig et al (2013)	USA	Mentoring (plus skills training)	68 in mentoring and skills group; 76 in control group. Aged 9–11 years at start. Randomly assigned.	Mental health: composite of CBCL (carer-report), Teacher Report Form, and Trauma Symptom Checklist for Children (self-report).	Baseline at point of referral (2–3 months before start of intervention). Follow-up 6 months after end of intervention.
Timmer et al (2006a)	USA	PCIT	Single case study. Aged 4 years.	Problem behaviours: CBCL (carer-report), Eyberg Child Behavior Inventory (carer-report).	Baseline at referral. Follow-up at end of intervention.
Timmer et al (2006b)	USA	PCIT	75 foster children in PCIT; 98 not in care but also in PCIT. Aged 2–8 years at start.	Problem behaviours: CBCL (carer-report), Eyberg Child Behavior Inventory (carer-report).	Baseline at referral. Follow-up at end of intervention.
Turner et al (2007)	Review	Foster carer training	Review	Review	Review

Reference	Country	Intervention	Intervention and comparison group details	Measures	Baseline and follow-up
Van Andel et al (2014)	Review	Stress interventions	Review	Review	Review
Van Ryzin and Leve (2012)	USA	MTFC–A	81 female chronic offenders in MTFC; 85 in group care. Aged 13–17 years at start. Randomly assigned.	Delinquency: days spent in locked settings (carer- and self-report), official records of criminal referrals, Elliott Self-Report of Delinquency. Exposure to delinquent peers: Describing Friends Questionnaire (self-report).	Baseline prior to placement entry. Follow-ups at 12 and 24 months after baseline.
Warman et al (2006)	UK	Fostering Changes	95 carers in Fostering Changes; no comparison group. Children aged 2–17 years.	Problem behaviours: Carer-defined problems. Emotional problems, hyperactivity, conduct problems: SDQ (carer-report).	Baseline at start of intervention. Follow-up at end of intervention.
Willis and Holland (2009)	UK	Life story work	12 receiving life story work; no comparison group. Aged 11–18 years at interview.	Identity: Interview with young person.	No baseline. Interviewed if had experienced life story work (no criteria for length of intervention or follow-up).
Woodier (2011)	UK	Mentoring	Case study of 2 children. Aged 11 and 15 years.	Self-reflection, self-esteem and resilience: Mentor's reflections.	No baseline. Reflections given some time after intervention (exact period not stated).

Appendix E: Descriptions of interventions

Section 2: Behavioural interventions for young children (0–6 years)

2.1 Direct interventions for young children

Our search did not reveal any studies with young looked after children using interventions designed to directly target behavioural disorders.

2.2 Indirect interventions for young children

Attachment and Biobehavioral Catch-up (ABC)

For ages: *12–24 months (or older, with modifications)*

What the intervention entails:
The designers of ABC (Dozier et al, 2002b) identified three 'critical needs' for young children in foster care that the intervention would target: behaviour from children that can serve to alienate caregivers; lack of nurturing behaviour from caregivers; and children's behavioural and physiological dysregulation as a result of their pre-care experiences. The intervention works with caregivers to offer direct ways to encourage children's self-regulation, as well as indirect ways through providing nurturance and reducing their own frightening behaviour.

Ten weekly sessions, each of 60 minutes, are delivered in caregivers' homes by trained facilitators; the creators intended them to be delivered by foster carers or social workers, although some studies (Sprang, 2009) have used therapists. The child is present for part of each session and cared for by a familiar babysitter for the remainder. There is an overall focus on providing a nurturing, responsive and predictable environment for the distressed child. Caregivers are encouraged to recognise the transactional nature of the relationship, and the ways in which children's previous experiences and their own responsiveness can influence children's behaviour. Weekly topics cover:

1. Introduction to key concepts;

2. Providing nurturance: what about the child makes it difficult?

3. Providing nurturance: recognising shark music [interpretation of a situation];

4. Providing nurturance even when there is shark music;

5. The importance of touch;

6. Helping the child take charge;

7. Following the child's lead in play;

8. Attending to the child's signals;

9. The young child's emotions;

10. Bringing it all together.

The sessions are interactive, with room for carers to discuss concepts and practise them with the infant, and to feed back on how they have used concepts covered in previous weeks. Interactions between carer and child are video-recorded to allow carers to monitor their progress across the course of the intervention.

Findings with looked after children and young people:
Levels of cortisol, a hormone indicating children's stress, have been measured in comparisons between foster children randomly allocated to ABC and to a cognitive/linguistic intervention of the same duration (Dozier et al, 2006; Dozier et al, 2008). Cortisol levels of those in ABC were not only lower than those in the cognitive condition following the intervention, they were also comparable to those of a sample of children not in care. No differences were found between interventions on children's problem behaviours, as reported by their carers. Dozier et al (2006) reported an interaction with age, such that those in ABC reported fewer problem behaviours for toddlers than for infants (no age difference in the control group); however, there were no baseline behavioural measures against which to compare this.

Links to children's attachment behaviours have also been reported (Dozier et al, 2009). Comparing against the same cognitive/linguistic intervention, those in ABC were less avoidant (according to carers' ratings) post-intervention than the comparison group, but there was no difference in secure behaviour. Differences in attachment may be linked to changes in carer sensitivity: Bick and Dozier (2013) rated a 10-minute carer–child play session for carers' appropriate and consistent adjustment of their own behaviour in response to infant's cues, and found that those receiving ABC showed a greater increase in sensitivity over time compared to the cognitive/language group.

Another randomised control trial of ABC with 0–6-year-olds (Sprang, 2009) showed lower carer-reported internalising and externalising behaviours in the ABC group at the end of the intervention than waitlist controls, and a greater decrease from the start of the intervention.

Finally, a follow-up of ABC toddlers when they were aged 4–6 years (Lewis-Morrarty et al, 2012) suggested that ABC could also benefit the kind of cognitive abilities that are important for adaptive social behaviour. Foster care controls performed significantly worse on a measure of cognitive flexibility than both ABC and non-fostered children, who were similar to each other (after controlling for receptive language). Similar results were shown for children's theory of mind (though the measure of this – a penny-hiding game – could be said to be measuring imitative ability rather than theory of mind; moreover, the authors used transformed scores to correct for a "negatively skewed sampling distribution"; pS20).

State of the evidence:

- *Geography*: With the exception of one study (Sprang, 2009), all of the cited evidence that tests ABC with children in care has been conducted by those in the lab group that originally developed the intervention. All of the evidence comes from the US.

- *Samples*: Sample sizes range from ABC group sizes of 17 (Lewis-Morrarty et al, 2012) to 46 (Dozier et al, 2008), with roughly equivalent-sized comparison groups drawn from foster care and the wider community. Study samples in comparisons have not always been well-matched (Dozier et al, 2008; Lewis-Morrarty et al, 2012).

- *Measures of change*: Studies of ABC have used carer-reported behavioural measures (eg Sprang, 2009), along with measures of children's cortisol (eg Dozier et al, 2006) and their performance on cognitive tasks (Lewis-Morrarty et al, 2012). Although comparisons between children allocated to ABC and control groups look promising, it is difficult to attribute differences to the intervention since several studies took no baseline measures prior to the intervention starting (Dozier et al, 2006; Dozier et al, 2008; Dozier et al, 2009; Lewis-Morrarty et al, 2012). The exceptions come from Bick and Dozier (2013) and from Sprang (2009); though in the latter case the control group did not receive an intervention (just attended a regular support group).

- *Longevity*: The longevity of any effects is unclear, since studies have taken follow-up measures directly after the intervention (Sprang, 2009), just one month after intervention ends (Dozier et al, 2006) or did not state how long after the intervention they were administered (Dozier et al, 2008). Lewis-Morrarty et al (2012) and Bick and Dozier (2013) give the ages of their follow-up samples, but the interval since the intervention was not equivalent for all the individuals in their samples.

- *Other considerations*: Studies with children in care have focused on the ABC intervention being delivered to foster mothers. In addition, since ABC was designed specifically as an early intervention for young children, it may not be suitable for older children or adolescents.

Multidimensional Treatment Foster Care for Preschoolers (MTFC-P)

For ages: *3–7 years*

What the intervention entails:

MTFC was developed by the Oregon Social Learning Centre, and the original programme was targeted at chronic juvenile delinquents. The original programme is now termed MTFC for Adolescents (MTFC-A), to distinguish it from later adaptations. MTFC for Preschoolers (MTFC-P) was a downward extension of the original MTFC programme, which added a developmental framework through which behavioural and emotional problems are viewed instead as challenges arising from delayed maturation in foster children (Fisher et al, 2005).

MTFC is based on theories of social learning and behavioural reinforcement, and its key principles involve the use of clear boundaries, an emphasis on consequences through the reinforcement of prosocial behaviours, close supervision by caregivers, and efforts to avoid the influence of antisocial peers. Placements are designed to be short–term (typically six–nine months), and programme supervisors have small caseloads to enable them to be on call 24 hours a day and to have regular progress meetings that review data collected daily from carers (Chamberlain, 2003). Foster carers provide the majority of the 'treatment' in this model (Moore et al, 2001). MTFC uses a token economy, through which 'points' are gained or lost according to desirable or undesirable behaviour, and can be traded for privileges. The programme aims to reward self-regulation, with the hope that this will continue beyond the life of the placement. Foster carers and young people work closely with the supervising social worker, therapists, skills workers and managers, and carers have access to 24-hour support.

The MTFC programme offers a comprehensive model, which covers the recruitment of foster carers, pre-service training, team working, school consultation, individual and family therapy, and post–placement services (Moore et al, 2001). Fidelity to the programme is emphasised and monitored throughout; for operators other than the originators of MTFC (eg teams in England, Sweden and the Netherlands), fidelity is provided by means of distance-supervision from the Oregon team.

Findings with looked after children and young people:

The link between MTFC and behavioural issues is weaker for young children than for adolescents (see below). Only one study of young children (in the Netherlands; Jonkman et al, 2012) showed that carer-reported behavioural problems decreased from the start of placement over the following 12 months (which included nine months of MTFC and three months of follow-up support); however, this study did not include any comparison group.

Behaviour has been implicated in other MTFC findings with this age group. In the US, children in regular foster care were more likely to have a placement disruption within the first 12 months above a threshold of five carer-reported problem behaviours in a 24-hour period within the first three months; the same was not true of those in MTFC, who also had fewer disruptions overall (Fisher et al, 2011). Another study conducted around 18 months after entry into MTFC or regular foster care and using a low-income, non-fostered comparison group (Bruce et al, 2009) showed no difference in behavioural measures of cognitive control and response monitoring (both of which have been linked to Conduct Disorder and ADHD). However, electrophysiological measures taken during the children's task showed that the MTFC and non-care groups had a similar response to ongoing feedback on accuracy of responses, and that both groups had a greater response to feedback than those in regular foster care.

Attachment behaviours may be more salient for this age group than problem behaviours. An analysis of carer-rated attachment behaviours over time showed that those in MTFC displayed more secure behaviour and less avoidant behaviour from the start of the placement up to 12 months later, than did those in regular foster care (Fisher and Kim, 2007). Resistant behaviour in both groups declined. In MTFC, children whose first foster placement came at a later age showed the greatest increase in secure behaviour (this was true for earlier placements in regular foster care). However, there were no significant differences between the two groups on any of the attachment behaviours either at the start or the end of the study.

Biological markers for stress levels offer another area for comparison in this age group. Fisher and colleagues (Fisher et al, 2007) tested the morning and evening cortisol levels of 3–6-year-olds in MTFC, regular foster care and a comparison low-income community group. They found that MTFC and the community sample became more similar over the course of 12 months, whereas the RFC sample showed a flattening of cortisol activity over time; a pattern linked to chronic stress. However, there was considerable individual variation in cortisol levels within the samples.

Finally, one study examined the cost of MTFC for young children. Lynch et al (2014) investigated the incremental net benefit of the MTFC-P, which takes into account both the difference in costs for MTFC and regular foster care, and the costs associated with changes in outcomes (eg placement permanency). Using placement outcomes from a randomised sample, they found that the value of the benefits for MTFC versus RFC exceeded the costs.

State of the evidence:

- *Geography*: Most evidence cited comes from US, with one study (Jonkman et al, 2012) from the Netherlands.

- *Samples*: The US studies have generally used random assignment to conditions. Comparison groups have consisted of regular foster care (Bruce et al, 2009; Fisher and Kim, 2007; Fisher et al, 2011) and a low-income, non-fostered community sample (Bruce et al, 2009). Sample sizes ranged from 10 in MTFC (Bruce et al, 2009) to 57 (Fisher and Kim, 2007; Fisher et al, 2011); a large proportion of the sample in Bruce et al's (2009) study were excluded due to issues with performance or poor electrophysiological data (12 in total, including six from MTFC).

- *Measures of change*: Most studies rely on carer-reported behaviour (eg Fisher and Kim, 2007; Fisher et al, 2011; Jonkman et al, 2012), which may introduce a source of bias since MFTC carers might be more likely to report bad behaviours (as they have to keep a daily list of them) or more likely to report a reduction (as they have been monitoring both more and less severe behaviours and may be more inclined to believe that there has been a change). Behavioural measures might not pick up on subtler responses, as shown in electrophysiological responses (Bruce et al, 2009).

- *Longevity*: Follow-up measures have generally been taken 12 months after entry to MTFC (Fisher and Kim, 2007; Fisher et al, 2011; Jonkman et al, 2012); an exception lies in the sole measure taken at around 18 months after entry with no baseline (Bruce et al, 2009).

2.3 Mixed interventions for young children

Parent-Child Interaction Therapy (PCIT)

For ages: *2–8 years*

What the intervention entails:
PCIT (Hembree-Kigin and McNeil, 1995) is a short-term intervention that was developed for parents dealing with young children displaying disruptive behaviour. The approach is based on the assumption that children's behaviour can be influenced through their interactions with caregivers, and that parenting behaviours can be shaped by children. Caregivers are encouraged to shape children's behaviour through the use of positive and negative reinforcement. The first step of PCIT focuses on the relationship between caregiver and child, using a play context to teach strategies for using positive attention in order to shape the child's behaviour. The second step focuses on discipline, building consistent, positive commands and contingencies for behavioural compliance. Homework is given in each session, and discussed at the following session. Sessions typically last 1–2 hours per week and are usually delivered for 12–14 weeks.

Findings with looked after children and young people:
Fricker-Elhai et al (2005) present case studies of two foster children referred to PCIT because of a range of social, emotional and behavioural problems. Carers were satisfied with the intervention and reported that children's behaviour had improved by the end of it, but the small sample size and lack of returned follow-up questionnaires from carers mean that no conclusions can be made about the effectiveness of PCIT. Similar limitations hold for the single case study presented by Timmer et al (2006a).

McNeil et al (2005) used a modified 2-day version of PCIT with 30 fostered children (no control group) aged 2–8 with behavioural problems. This reduced-scale version included carers on the first day and added the children on the second day. Follow-ups were conducted one month after training; a further five-month follow-up returned only eight sets of data, largely due to children having returned home. There was a reduction in carer-reported problem behaviours from before training up to the one-month follow-up.

The largest-scale test of PCIT so far comes from a comparison of 75 foster carer-child dyads with 98 non-maltreating birth parent-child dyads (children aged 2–8 years) receiving the same intervention (Timmer et al, 2006b). Both groups showed decreases in caregiver-rated problem behaviours from baseline to the end of treatment, suggesting that PCIT was equally effective for birth families and foster families.

State of the evidence:

- *Geography*: Evidence is drawn from the US.

- *Samples*: Sample sizes range from single or dual case studies (Fricker-Elhai et al, 2005; Timmer et al, 2006a) to 75 in the foster care group (Timmer et al, 2006b). Most studies did not include a control group. The exception was Timmer et al (2006b), which compared outcomes for a group of birth families receiving the same intervention.

- *Measures of change*: Measures are reported by carers.

- *Longevity*: The longest follow-up was taken one month after the intervention ended (McNeil et al, 2005).

Section 3: Behavioural interventions for older children and adolescents (7–17 years)

3.1 Direct interventions for older children and adolescents

Besides the interventions discussed here, see also Animal–assisted therapy and its links to attachment (section 5.1).

Attachment, Regulation and Competency (ARC)

For ages: *early childhood to young adulthood*

What the intervention entails:
ARC is a way of thinking about working with young people, rather than an intervention programme. ARC was developed to provide a flexible framework for interventions with maltreated children, targeting the key domains of attachment, self-regulation and developmental competencies. The framework consists of 'building blocks' or treatment targets that are grouped under the key domains of improving carer child interactions:

1. Attachment includes: caregiver management of affect; attunement; consistent response; and routines and rituals;

2. Self-regulation includes: affect identification; modulation; and affect expression;

3. Competency includes: executive functions; and self-development and identity;

4. A final building block on 'trauma experience integration' brings these skills together and includes strategies for addressing the ongoing effects of maltreatment.

The framework is designed to work not just with the child, but also with the caregivers and the context surrounding them. For example, approaches to children who reject comfort in times of distress will address the caregiver's reaction as well as the child's behaviour. Hodgdon et al (2013) claim that for children in residential care, complex difficulties require an approach that extends beyond the therapeutic session, that they cannot rely on a supportive family to supplement the work done in therapy sessions and that they are at risk of exposure to further trauma. Training all staff involved in children's care – including administrative staff as well as support staff, counsellors, clinicians, nurses and teachers (in residential school settings) – can increase awareness of the effects of maltreatment, to encourage positive change in the children and young people they serve.

The ARC framework includes an element of flexibility, allowing it to be used with different age groups living in a range of settings. It also offers flexibility in specific practice, within the fixed framework of building blocks outlined above.

Findings with looked after children and young people:
Two studies have examined the use of ARC with looked after young people. Arvidson et al (2011) studied children aged 3–12 receiving outpatient mental health services, and their caregivers. Children received an average of 50 sessions, and saw a significant decrease in 'total problems' scores on the Child Behaviour Checklist (CBCL; see chapter 3) from baseline to discharge; this was better than for those who ended treatment early. Of those completing treatment, 92 per cent went on to a permanent placement (adoption, reunification, or permanent kinship placement), compared with the state-wide figure of 40 per cent.

Hodgdon et al (2013) used ARC with young women aged 12–22: one group in an intensive residential treatment programme and the other in a residential school; over 90 per cent had had multiple out-of-home placements. The two settings used different interventions, which lasted for 16 and 22 sessions. Participants showed change over time on most caregiver-rated internalising, externalising and PTSD outcomes; for most, the change occurred between baseline and first follow-up (approximately three months after intervention), and was maintained until third follow-up (another six months later).

State of the evidence:

• *Geography*: Evidence cited comes from the US.

- *Samples*: Neither study used a comparison group. Samples consisted of 21 young people from an initial 50 (Arvidson et al, 2011; uncompleted treatment was due largely to relocation or reunification with family) and 126 self-selected young women (Hodgdon et al, 2013).

- *Other considerations*: Evaluation may be difficult as Hodgdon et al's (2013) residential study showed that specific intervention practices within the framework differed across sites.

Life story work

For ages: *3–17 years*

What the intervention entails:
Life story work operates to help looked after and adopted children create a record of their experiences, and involves working with a trusted adult. There are variations in techniques, with boxes, books and online programmes being used to record experiences.

Findings with looked after children and young people:
Two small-scale qualitative studies conducted with looked after young people (Willis and Holland, 2009) and with foster carers/adoptive parents (Shotton, 2010) suggest that both actors in the relationship can value this work, as feedback has generally been positive. Looked after adolescents used the opportunity to work through emotions and explore their identity, while carers felt that using the approach had helped to improve their relationships with the children they looked after.

A culturally-sensitive life story therapeutic intervention for 7–14-year-old children from methamphetamine-involved families in foster care was evaluated in a small-scale study by Haight et al (2010). They found that caregiver-rated externalising behaviours increased for those in the control group but decreased for those in the intervention group, and then remained steady to a seven-month follow-up.

State of the evidence:

- *Geography*: Evidence cited comes from the US and the UK.

- *Samples*: Sample sizes are very small (a maximum of 12; Willis and Holland, 2009) as research on life story work has been largely qualitative to date.

- *Measures of change*: Most measures are qualitative; measures of changes in children's behaviour were rated by carers (Haight et al, 2010).

Mentoring

For ages: *6 years to adulthood*

What the intervention entails:
Pairing a child with a non-related adult for regular social meetings. Some programmes include additional skills training.

Findings with looked after children and young people:
A therapeutic mentoring programme in the US offered weekly 3–5 hour meetings for 6–9 months (Johnson et al, 2011). The scheme benefitted young people in foster care (aged 6–15 years) who received substantial amounts of mentoring (as opposed to limited amounts or none) in terms of their family and social functioning, behaviour at school, and stress symptoms. Limited mentoring appeared to be worse than none at all. A large attrition rate after six months makes follow-up analyses (to 18 months) less powerful, but still suggested better adjustment to trauma with substantial mentoring input.

A randomised controlled trial (RCT) of a nine-month programme for fostered children aged 9–11 years that combined mentoring and manualised group skills training (on social, emotional and cognitive skills) showed that the intervention group had fewer mental health difficulties (as reported by caregivers, teachers and children) and had used fewer mental health services than controls at a six-month follow-up (Taussig and Culhane, 2010). Outcomes did not differ according to severity of physical neglect experienced pre-placement (Taussig et al, 2013). Receiving the intervention attenuated the link that otherwise existed between baseline externalising difficulties and subsequent placement in residential treatment centres one year later (Taussig et al, 2012).

TAKE CHARGE, a self-determination intervention, similarly combines individual coaching in self-determination skills (around achievement, partnership and self-regulation) and group mentoring from foster care alumni. Geenen et al (2013) tested the intervention with 14–17-year-olds in foster care. Carer-rated (but not youth-rated) self-determination showed a greater improvement in the treatment than in the control group to a nine-month follow-up; they also saw a greater rise in self-attribution of educational success. The treatment group also had lower carer-reported anxiety/depression than controls at follow-up; the same was true for withdrawn/depressed. There was no difference on youth-reported depression.

In the UK, two case studies presented by Woodier (2011) show how the mentoring guidance of a teacher can be used to promote self-reflection, self-esteem and resilience in looked after children, but is based solely on the mentor's view.

Spencer et al's review (2010) draws out several important factors in the mentoring relationship that appear to affect outcomes. These include being of longer duration, offering a consistent presence and the chance to develop an emotional attachment, and having good support for mentors and mentees. The authors argue that the individual benefits of mentoring should be supplemented with system-level interventions to best meet the needs of vulnerable looked after youth.

State of the evidence:

- *Geography*: Evidence cited comes from the US and the UK.

- *Samples*: Sample sizes range from two (Woodier, 2011) to 262 (Johnson et al, 2011), but only studies by Taussig and colleagues (Taussig and Culhane, 2010; Taussig et al, 2012, 2013) included a comparison group.

- *Measures of change*: The Taussig studies (Taussig and Culhane, 2010; Taussig et al, 2013) used measures from a range of sources (caregivers, teachers and children), whereas Woodier's (2011) case studies were based on personal reflection. Success can depend on whether measures are taken from carers or young people (Geenen et al, 2013).

3.2 Indirect interventions for older children and adolescents

Fostering Attachments

For ages: *4–14 years*

What the intervention entails:
Fostering Attachments (Golding and Picken, 2004) combines social learning theory and attachment theory, focusing on developing the skills foster carers need to work with children who have attachment difficulties. Operated as a manualised group programme, Fostering Attachments shares with other programmes the aim of increasing carers' understanding and confidence while providing support. Carers are initially given an in-depth introduction to attachment theory and are encouraged to discuss it in relation to their own experiences with the children in their care. Subsequent monthly sessions use teaching, role-play and discussion to explore ways of creating a positive atmosphere in the foster home, with the goal of developing a secure base for children to encourage their emotional regulation and self-reflection. Attunement, empathy and consistent discipline strategies are emphasised. Fostering Attachments has now changed its name to Nurturing Attachments (Golding, 2013).

Findings with looked after children and young people:

The seven carers with complete data from the first trial of Fostering Attachments (who attended for up to 18 months) (Golding and Picken, 2004) were compared with a group of 39 carers in Incredible Years (IY) training (which lasted for nine weeks; see below) at the end of the programme. The two groups differed in which problem behaviours had changed from the start to the end of the programme: IY carers rated children's conduct difficulties as having reduced, whereas for those in Fostering Attachments the reductions were in peer difficulties, hyperactivity, and total difficulties on the Strengths and Difficulties Questionnaire (SDQ; see chapter 4). The authors do not report any interaction analyses (ie whether one group changed more over time than another). In contrast, a study of eight foster carers (with no comparison group) showed no significant change from baseline to the end of the programme when it was delivered over 18 weeks (Laybourne et al, 2008).

A further study with 13 foster carers and adoptive parents of children aged 4–14 (no comparison group) who attended 18 weekly (rather than monthly) sessions also added a follow-up three months after completion (Gurney-Smith et al, 2010). Caregiver reports did not show any change from baseline to follow-up in children's conduct or emotional difficulties, peer problems or prosocial behaviour, but there was a significant reduction in hyperactivity.

State of the evidence:

- *Geography*: All of the evidence comes from England.

- *Samples*: Sample sizes range from Fostering Attachments group sizes of seven (Golding and Picken, 2004) to 13 (Gurney-Smith et al, 2010).

- *Measures of change*: Outcomes were carer-reported. It is difficult to make comparisons, given the different length of time between the interventions (nine weeks for IY versus 18 weeks to 18 months for Fostering Attachments).

- *Longevity*: Only Gurney-Smith et al (2010) included a follow-up, three months after completion of the programme.

Fostering Changes

For ages: *2–17 years*

What the intervention entails:
Fostering Changes was developed in England as a method of teaching foster carers the skills they need to deal with children's disruptive behaviours (Pallett et al, 2002). The provision of practical behaviour management as an integral part of the course grew from consultations with foster carers about what they felt was missing from existing training. The programme was revised in light of developing knowledge on the importance of attachment and emotion dysregulation; also added were components on encouraging educational achievement, reflective listening and problem-solving (Briskman et al, 2012).

Weekly, three-hour group training sessions are delivered over the course of 12 weeks. The content is a balance between theoretical information to help carers understand children's behaviour, and practical strategies for working with looked after children. Carers identify the problems they would like to work on during the course of the training, and are given activities and role-plays to practice skills both in the session and at home. Carers are taught to encourage desirable behaviours through the use of positive reinforcement and the setting of clear limits and consequences for behaviour. Separate sessions can be run for carers of children aged under five, under 12, and teenagers (Warman et al, 2006).

Findings with looked after children and young people:
The 55 foster carers in the initial trial of Fostering Changes (Pallett et al, 2002) and the larger sample of 95 included in Warman et al (2006) reported a reduction in children's problem behaviours – particularly those identified as personal concerns at the beginning of the course – and in emotional problems; however, there was no reduction in conduct problems or hyperactivity.

A subsequent randomised controlled trial was run in England (Briskman et al, 2012) with 34 carers of children aged between two and 12 years (29 carers in a control group received no intervention). The study showed a significantly greater reduction in the intervention group's reports of children's problem behaviours, and a greater improvement in the carer-reported quality of attachment between the child and carer, in comparison to the control group. Whereas problem behaviours and hyperactivity decreased over time in the intervention group, they increased in the control group (but baseline scores also differed, so that the scores at the end of the course were similar for both groups). There was no difference between groups on children's emotional symptoms, conduct problems, peer relationships or prosocial behaviour.

State of the evidence:

- *Geography*: Evidence is drawn from England.

- *Samples*: Sample sizes ranged from 34 (Briskman et al, 2012) to 95 (Warman et al, 2006). Only Briskman et al (2012) included a control group; random allocation was used in this study.

- *Measures of change*: Measures are reported by carers.

- *Longevity*: Measures were taken at the start and end of the course. No follow-ups were reported.

Incredible Years carer training (IY)

For ages: *2–17 years*

What the intervention entails:
IY was developed for use with biological parents (Webster-Stratton et al, 1988) but has been augmented for use with foster carers, to reflect the unique context of caring for looked after children (Nilsen, 2007). IY is a 12-week training programme, in which carers attend a weekly two-hour group session consisting of group discussion, videotaped scenarios and role-play of strategies for dealing with difficult behaviour. The aim of the sessions is to improve parenting skills, in order to prevent or reduce children's problem behaviours and to improve their social skills. There is a focus on helping children to learn through the use of praise, incentives, play, and limit-setting. The importance of programme fidelity for achieving outcomes with looked after children has been stressed, while encouraging flexibility in the choice of particular activities or focus relevant to the population (Webster-Stratton and Reid, 2010).

An alternative version for children (Webster-Stratton et al, 2004) helps young children to develop the skills of emotion understanding and regulation, and problem-solving. Linares et al (2012) selected 12 out of the 18 possible lessons, and added a lesson to the programme to promote a sense of belonging in the foster family.

Findings with looked after children and young people:
Foster carers in Wales who received Incredible Years training reported a greater reduction in problem behaviours in the children they looked after (aged 2–17 years) at a follow-up six months after the start of the intervention, when compared with controls (Bywater et al, 2010). They also reported a greater reduction in hyperkinetic behaviours.

A smaller-scale study in Northern Ireland worked with 13 foster carers (children's ages 8–13 years) but included no control group (McDaniel et al, 2011). From the start to the end of the training, carers reported a decrease in the intensity of children's problem behaviours.

In the US, 11 foster carers (for children aged 5–12 years) received IY training (Nilsen, 2007) and were compared to seven control carers. At the end of the intervention, carers in the IY group reported greater reductions in children's conduct symptoms than did controls. There were no significant group differences in changes on hyperactive, aggressive, or general externalising behaviours. Carers were very positive about the programme.

A version of IY with an added co-parenting programme that ran concurrently for one hour a week was delivered to pairs of 40 foster carers and a biological parent of a child they looked after (aged 3–10 years) (Linares et al, 2006). The IY group reported more improved co-parenting strategies three months after the intervention ended than control caregivers, but differences in behavioural improvements were non-significant.

In contrast, a US study that delivered IY training to foster children (aged 5–8 years) showed no difference between those taking IY and a control group at a three-month follow-up, as both groups experienced a reduction in carer-rated externalising behaviours (Linares et al, 2012). Contrary to expectations, the control group actually saw a greater improvement in children's ADHD diagnoses, self-control, and physical aggression.

State of the evidence:

- *Geography*: Evidence is drawn from the US and the UK.

- *Samples*: Sample sizes range from 11 (Nilsen, 2007) to 49 (Linares et al, 2012). Comparison groups have generally not received a comparison intervention, making it difficult to separate the effects of attending training from the content of the programme. One study (McDaniel et al, 2011) did not include a control group. In another study (Nilsen, 2007), the control group consisted only of carers whose schedules did not allow them to attend IY training, which may mean that this group was different to those in the intervention condition.

- *Measures of change*: Measures are reported by carers; it is debatable whether a carer-reported measure of children's behaviour after training is a reflection of reductions in the behaviour itself or rather in the carers' increased confidence in dealing with them.

- *Longevity*: Follow-ups have been taken immediately after the intervention ended (McDaniel et al, 2011; Nilsen, 2007) or up to six months after baseline (Bywater et al, 2010).

Keeping Foster Parents Trained and Supported (KEEP)

For ages: *5–12 years*

What the intervention entails:
KEEP (Chamberlain et al, 1992) developed as an offshoot of MTFC (see below) for regular foster and kinship carers, and was designed by the same team in Oregon. Over 16 group-based sessions of 90 minutes, the intervention aims to strengthen the behaviour management skills of carers. Carers are encouraged to view themselves as agents of change in children's lives. They are taught how to use behavioural contingencies, set effective limits, and balance encouragement and limits. The content of sessions includes a focus on difficult behaviour, as well as school success, peer relationships, and managing carer stress. Techniques employed include role-plays, videotapes and homework. Group facilitators keep in weekly contact with carers to give advice on tackling any issues and to collect data on children's behaviour.

Findings with looked after children and young people:
A large-scale study of 359 children aged 5–12 in KEEP and 341 in treatment as usual showed that children whose carers received KEEP training had fewer carer-reported behavioural issues at the end of the intervention (five months after baseline); this was mediated by greater positive reinforcement behaviour by the KEEP carers (Chamberlain et al, 2008). This link with carers' behaviour appeared to be especially salient for children whose carers rated them as being higher in problem behaviours at baseline. A follow-up implementation with 181 children in KEEP did not have its own control group, so used the same control group as the Chamberlain et al (2008) study (Price et al, 2012). Although this group was younger and more likely to be in kinship care, these factors were controlled for in the analyses. Being in KEEP predicted fewer carer-rated behavioural problems at the end of the intervention compared to controls, even after accounting for problems at baseline. Again, the reduction was greatest for those with the highest number of problem behaviours at the outset.

Leathers and colleagues (Leathers et al, 2011; Leathers et al, 2012) piloted KEEP for children with behavioural needs in foster care. They found that carer-rated internalising and externalising behaviours were reduced six months after baseline for those involved in KEEP, but not for those in a control group. However, there was no effect of receiving the intervention on carers' ratings of the child's integration into the foster home or their desire to adopt the child, both of which related to lower externalising (but not internalising) behaviours.

A multi-level analysis of 59 KEEP groups in the US showed that for children with higher numbers of prior placements, KEEP was most effective in terms of behavioural issues in groups where carers were highly engaged (as reported by group facilitators) (DeGarmo et al, 2009).

State of the evidence:

- *Geography*: All of the evidence so far comes from the US.

- *Samples*: Sample sizes range from 18 young people with carers in KEEP (Leathers et al, 2011; 2012) to 359 (Chamberlain et al, 2008). Comparison groups do not receive a placebo intervention; this is problematic, as the outcome measures are carer-reported.

- *Longevity*: Follow-ups have been taken at the end of the training (Chamberlain et al, 2008; DeGarmo et al, 2009) or two months later (Leathers et al, 2011; 2012 – a 12-month follow-up had too few children to analyse). A review of the US findings so far seems promising, but acknowledges that longer follow-ups are needed (Price et al, 2009).

Multidimensional Treatment Foster Care for Adolescents (MTFC-A)

For ages: *12–17 years*

What the intervention entails:
Outlined in the above section on young children.

Previous reviews of MTFC research suggest it could be effective (Hahn et al, 2004; Macdonald and Turner, 2008; McGuinness and Dyer, 2007), particularly for preventing violent behaviour in young people with histories of chronic delinquency. Feedback from interviews with foster carers and team members working in MTFC in England (Kirton and Thomas, 2011) revealed that they generally felt the model 'worked' and that young people's engagement was generally high, but that some flexibility was needed for the English culture and for individual circumstances. MTFC has had a similarly positive reception in Sweden (Kyhle Westermark et al, 2007), although a small group of carers found the programme difficult; these tended to be carers who wanted the programme to fit the family's rules and felt it operated with too much top-down governance of daily activities.

Findings with looked after children and young people:

There is a wealth of evidence on behavioural outcomes from MTFC with this age group. First, we present the literature from trials in the US – which has been conducted with single-gender groups as well as both genders together. Eddy and Chamberlain (2000) found that 12–17-year-old boys in MTFC showed less anti-social behaviour than their peers in group care 12 months after the end of the placement, and that this relationship was mediated by a factor that combined youth- and carer-reports of four areas from three months into the placement: greater adult supervision and discipline, a more positive adult-youth relationship, and less association with deviant peers. Followed up again at 24 months (Eddy et al, 2004), the boys from MTFC showed fewer referrals for and less self-reports of violent behaviour, compared with their group care peers, even after controlling for pre-baseline arrests/delinquency, age at first arrest and age at first placement. Boys in MTFC also showed lower self-reported use of drugs other than tobacco, marijuana or alcohol at a 12-month follow-up than boys in group care; at 18 months they also had lower tobacco and alcohol use (Smith et al, 2010).

Girls aged 13–17 in MTFC showed a greater decrease in the amount of time spent in locked settings and in carer-reported (but not self-reported) delinquency at 12 months after the start of placement than a sample of girls in group care (Leve et al, 2005). Chamberlain et al (2007) followed up this sample and found that, controlling for age 24 months after the start of the placement, those in MTFC had lower rates of delinquency and had shown a greater decrease over time than those in group care. The MTFC programme in this case included some added gender-specific components (eg avoiding social–relational aggression). Van Ryzin and Leve (2012) combined this with another sample of delinquent girls and found that those in MTFC had fewer criminal referrals and had spent fewer days in locked settings at a 24-month follow-up; this link to later delinquency was mediated by reduced exposure to delinquent peers at a 12-month follow-up.

The US implementation of MTFC has also included depression as an outcome. Harold et al's (2013) US study showed that girls in MTFC had a greater reduction in self-reported depressive symptoms over 24 months than those in group care; the results suggest that MTFC was particularly beneficial for those whose depression levels were initially highest.

Smith, Chamberlain, and Deblinger (2012) have further adapted MTFC by adding a trauma treatment component based on trauma–focused CBT (MTFC+T); this new version was piloted with 12–17-year-old delinquent girls and compared with group care. Girls in MTFC+T had fewer mental health symptoms at follow-up, after controlling for baseline mental health, childhood trauma, age, and

pre-baseline arrests. They also had lower levels of delinquency after controlling for baseline variables.

Examining both genders, Smith (2004) followed 12–18-year-olds in MTFC until 12 months after their placement had ended. She found that staying in the MTFC placement for at least six months was predicted by having lower pre-placement risk (in terms of substance abuse, suicidality, academic level, mental health, truancy and offending behaviour) and scoring more 'points' during their first two weeks. Gender and treatment completion were both related to subsequent offending behaviour: boys who did not last for six months were most likely to have reoffended by the 12-month follow-up, whereas girls who had completed six months of treatment were least likely to have done so. Finally, Leve and Chamberlain (2005) showed that MTFC was linked to a lower likelihood of 12–17-year-olds associating with delinquent peers during placement, and that this in turn predicted fewer associations with delinquent peers than for adolescents in group care at a 12-month follow-up.

Behavioural evidence from England comes from one pilot and one main trial, and outcomes have been compared with the US. Biehal, Ellison, and Sinclair (2011) compared young offenders (with a mean age of 15 years) in Intensive Fostering (the name of the MTFC pilot for young offenders in England) to others in custody or serving supervised community sentences. Comparisons of offending rates in the year after entry (IF/community sample) or exit (convicted sample) – ie when the opportunity to reoffend was present – showed fewer and less serious offences and fewer reconvictions in the IF group; the latter was unrelated to placement length. However, these differences disappeared when comparing outcomes in the year after exit from placement/custody, at which point the frequency and severity of offences for the IF group, and their likelihood of reconviction, were similar to those of the group that had spent time in custody. Both groups had seen similar improvements since baseline.

A larger trial in England of MTFC-A included a smaller randomised sample and an observational cohort of 7–17-year-olds (Biehal et al, 2012; Green et al, 2014). It compared those in MTFC with a 'treatment as usual' (TAU) group in regular foster or residential care placements. The study showed that both groups improved over 12 months in their psychosocial functioning; those in MTFC did not do any better or worse than their TAU peers. There was also no difference in their school attendance or exclusion, or in their offending behaviours. The only benefit shown for MTFC over TAU was in the improved functioning of those who had scored highly for anti-social behaviour at baseline; in contrast, those with lower scores at this point actually did worse in MTFC than in TAU.

Kirton and Thomas (2011) provide a brief report on outcomes as part of an article whose focus is on the implementation of MTFC in one English local authority; they report that with their adolescent sample, there was a reduction in the amount of high-risk behaviours, but that this could not be clearly linked to graduation from MTFC. Moreover, young people continued to have difficulties with their peer relationships. Details of the sample, comparison group(s) and duration and type of measures are not provided.

Rhoades et al (2013) examined outcomes of MTFC for 12–16-year-old girls in England and for 13–17-year-old girls in MTFC or group care in the US. They report reductions from baseline to 12 months after placement in offending and violent behaviour, risky sexual behaviour and self-harm, and increased involvement in school activities in the English sample; the US MTFC sample showed similar changes, plus a reduction in substance use. The largest effect size for both groups was in offending behaviour. However, the study does not statistically compare outcomes across the two countries, and the extent to which the different questions used in England (where most constructs were measured using a single item) and the US (where researchers selected from a number of items the one conceptually closest to that used in England) can be said to measure the same construct is debatable.

Behavioural evidence from Sweden comes from two studies. Kyhle Westermark et al (2011) found that 12–18-year-olds receiving MTFC had a significant reduction in self- and carer-reported internalising and externalising behaviours from baseline to 24 months later, and that the extent of this reduction was greater than for a group receiving treatment as usual (residential or foster care or home-based treatment). This lies in contrast with the later report by Hansson and Olsson (2012) on outcomes from 24 months after placement for a sample of 12–17-year-olds in MTFC and treatment as usual. They found no differences between the groups in youth- and caregiver-reported behavioural problems, and both groups showed reductions over time. An analysis of clinical change (which excluded those scoring within the 'normal' range) showed that MTFC youth made greater improvements during the first 12 months after placement, but that the difference was no longer present at 24 months.

Finally, the cost and feasibility of implementing MTFC have been studied. Holmes et al (2012) compared the cost of MTFC to foster and residential care in England and found that maintaining the placement was more expensive than for regular foster care, but was cheaper than for residential care (which would more often be the placement choice for the type of children who would go into MTFC). MTFC carried a much higher cost at the point of finding a placement, but the authors pointed out that this might be offset by the potential for MTFC

to increase placement stability. Feil et al (2012) have developed an internet-based system through which foster carers and staff can record and review young people's behaviour (offering an alternative to the usual telephone report), and can monitor fidelity to the programme by recording and playing back clinical and carer meetings. The reaction from foster carers and supervisors to a pilot run was largely positive.

State of the evidence:

- *Geography*: Most of the evidence cited comes from the US, with some studies from England and Sweden.

- *Samples*: Random assignment is more common in the US studies (where MTFC is usually an option for young people involved in the juvenile justice system), whereas English studies (where it is used for delinquents but also for young people in care due to parental abuse or neglect) have combined an RCT with a large-scale observational design. Sample sizes range from 13 young people in MTFC (Smith et al, 2012) to 112 (Biehal et al, 2012). Comparison groups have included young people in group home care (Chamberlain et al, 2007; Eddy and Chamberlain, 2000; Harold et al, 2013[66]), 'treatment as usual' (Green et al, 2014; Hansson and Olsson, 2012), or those given custodial or supervised community sentences (Biehal et al, 2011). Some studies did not include a comparison with young people outside of MTFC (Rhoades et al, 2013; Smith, 2004).

- *Measures of change*: The use of different measures across studies (for example, objective versus self-reported measures of delinquency) (Biehal et al, 2011; Eddy and Chamberlain, 2000[67]) makes it difficult to compare findings. Rhoades et al (2013) note that US measures are more extensive than those used in England and so selected questions from the US test batteries that were the closest match to the English items. It is debatable whether or not they were comparable: for example, offending behaviour in England was coded as none/caution/conviction/three or more convictions, whereas in the US the measure was the number of criminal charges. In addition, the practice of creating composite scores (eg a 'mental health' score from self- and caregiver-reported anxiety, depression, PTSD and trauma symptoms) (Smith et al, 2012) assumes that these outcomes can be combined.

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66 However, Harold et al (2013) note that group analysis is done on the basis of initial allocation to MTFC or group home care, regardless of whether individuals switched from one to the other over time.

67 Some of the individual questionnaire items and constructs in Eddy and Chamberlain's (2000) model were left in the analysis, despite showing only a poor statistical relationship with other items.

- *Longevity*: Follow-up periods for MTFC studies are generally better than for other types of intervention, and most include measures taken one year after entry to the placement; some also include follow-ups at 24 months after entry (Biehal et al, 2011; Chamberlain et al, 2007; Hansson and Olsson, 2012; Harold et al, 2013).

- *Other considerations*: MTFC studies conducted in different countries have shown a difference in findings, with studies from the US tending to show a more positive picture. Macdonald and Turner's (2008) review cautions that there is the possibility of bias where programme developers are involved in its evaluation. Biehal et al (2011) suggest that MTFC placements provided a protective effect by means of a change of environment and close supervision; interviews suggested a reduction in contact with deviant peers – whereas those in custodial sentences were largely in contact with deviant peers. This would seem to be borne out by the findings from Van Ryzin and Leve's (2012) study. Also, the wide geographical spread of placements meant that some young offenders were physically removed from their anti-social peer group but returned to it when the placement ended. The authors also suggest that inadequate follow-up support (as reported by parents, intended to be provided for three months after placement) might have contributed to the increased likelihood of reoffending at follow-up. Green et al (2014) point out that there are differences in the populations being studied; their research included those at risk of placement disruption or conviction, rather than seasoned offenders. They also note the importance of comparison groups: firstly, the group care used as a comparison in some US studies is akin to juvenile custody; and secondly, that residential care in England can be more 'therapeutic' (and, therefore, more similar to MTFC) than regular foster care. Indeed, further details from the English evaluation provided by Biehal et al (2012) suggest that residential care staff employed a number of similar strategies in working with young people (rewarding positive behaviour, discouraging negative peer relationships, etc) as those that are embedded in the MTFC programme. Kirton and Thomas (2011) also note differences in the populations being served, with the UK operating on voluntary use of MTFC, in comparison with the predominantly offender-sentencing selection of MTFC in the US. Kirton and Thomas (2011) also highlight a number of limitations with the evidence base for MTFC: (1) the use of quantitative behavioural data may not detect more subtle behavioural patterns; (2) the use of correlational data cannot be taken to imply causal relationships, though studies using random allocation can avoid this criticism; (3) trials show what works without explaining why, ie there is little coverage of the key factors of MTFC that might explain its effectiveness.

Nurturing Attachments: see Fostering Attachments

Other types of treatment foster care

For ages: *early childhood to adulthood*

What the intervention entails:
MTFC is a particular version of treatment foster care, but is by no means the most widely used: Farmer et al (2010) state that as one of over 2,000 types of treatment foster care in use in the US, MTFC is used by only a small minority of foster care agencies. Many sites across the US use treatment foster care models that share key features with MTFC (eg wraparound support, close monitoring of children's behaviour). Differences between the models reviewed, where stated, are outlined below.

Findings with looked after children and young people:
Cross et al (2004) described the use of 'specialised' foster care (SFC) in the US – an intensive short-term foster placement offering training and 24-hour support to foster carers of children with serious emotional needs. SFC includes MTFC and similar programmes whose key features are: behaviour management training involving positive reinforcement; one carer at home full-time; only one child per home; agency monitors and reviews plans; encourages collaboration between foster and birth families. Caseworkers rated over half of those leaving SFC as having improved in social and emotional well-being and difficult behaviours, but there was no baseline measure against which to compare this. Analyses suggested that children did better the longer they stayed in SFC.

'Together Facing the Challenge' used an evidence base (including principles of MTFC) to enhance regular treatment foster care in the US. The programme's originators found that the elements lacking in regular treatment foster care were intense supervision and support of carers, and the proactive teaching of strategies for handling difficult behaviour – otherwise, regular treatment foster care was similar to MTFC. An RCT with 2–21-year-olds by Farmer et al (2010) found that, unlike regular treatment foster care, those in enhanced treatment foster care showed improvements on carer-reported internalising and externalising behaviours at six months (when most were still in placement); these differences remained at a 12-month follow-up when using one measure (Parent Daily Report) but not another (Strengths and Difficulties Questionnaire). Similarly, the six-month difference on children's strengths did not remain at 12 months.

A large-scale study in the US found that arrest rates following treatment in treatment foster care versus therapeutic group homes and in-patient psychiatric programmes was no different in the six months after treatment, using propensity score matching to allow for differences in the likelihood of ending up in a particular programme and controlling for arrest rates during treatments (Robst et al, 2013); however, the authors do not report on whether this type of treatment foster care shared particular components with MTFC.

In Australia, the Special Youth Carer programme uses treatment foster care principles (though is not a time-limited placement) but adds the novel feature than should the placement disrupt, it is the carer rather than the child who leaves the home (since carers do not own the home). Gilbertson et al (2005) reviewed outcomes for the first eight participants (aged 13–16) and found that social workers reported positive changes in most with regard to social well-being, or engagement with education or therapy. A large-scale quantitative trail of this programme is still required.

Reviewing the research on treatment foster care, Redding et al (2000) concluded that it works best when carers provide authoritative, sensitive parenting and have greater levels of training and support, and when the treatment and delivery models are clearly defined. Having a good 'fit' between the child and the foster family was also important. In line with this, a sample of 4–19-year-olds in treatment foster care in the US showed better carer-reported behavioural and emotional functioning where their carer rated themselves more as a parent than a professional, and where the carer thought the child would feel the relationship between them was higher quality (Southerland et al, 2009).

State of the evidence:

- *Geography*: Most of the evidence cited comes from the US, with one study from Australia (Gilbertson et al, 2005).

- *Samples*: Sample sizes range from just eight (Gilbertson et al, 2005) to 384 (Cross et al, 2004). Most studies include comparison groups, with the exception of Cross et al (2004).

- *Measures of change*: Measures are reported by carers or workers.

- *Longevity*: Follow-ups have been taken straight after placement ends (Cross et al, 2004) or up to 12 months after baseline (Farmer et al, 2010).

3.3 Mixed interventions for older children and adolescents

Middle School Success (MSS)

For ages: *targeted at those transitioning to middle school*

What the intervention entails:
MSS takes place during the summer prior to middle school entry and consists of six manualised sessions, run separately for children and their carers. Children's sessions focus on setting personal goals, peer and adult relationships, decision-making and problem-solving strategies, and reinforcing adaptive behaviours. It includes role-plays, activities, discussions and a final ceremony that includes the foster carers. Carers' sessions include teaching a behavioural reinforcement system drawn from MTFC. Follow-up training and support are offered to carers during the first year of middle school.

Findings with looked after children and young people:
A sample of girls in foster care was randomly assigned to either the Middle School Success intervention (48) or a control group (52) (Kim and Leve, 2011; Kim et al, 2013; Smith et al, 2011). Six months after baseline, MSS girls had fewer internalising and externalising difficulties than girls in the control group (after controlling for baseline difficulties), but were no different in their prosocial behaviour (Smith et al, 2011). Thirty-six months after baseline, self-reported substance use in MSS girls was lower than in controls; but in the path from intervention to substance use, only the links from greater prosocial behaviour during the first year via lower internalising and externalising symptoms during the second were significant mediators (Kim and Leve, 2011). At the same follow-up, MSS girls showed lower levels of self-reported health-risking sexual behaviour than controls, and this link was mediated by fewer placement changes during the first year and less frequent use of tobacco and marijuana at 36 months (Kim et al, 2013).

State of the evidence:

- *Geography*: All studies are from the US.

- *Samples*: This was one sample of 48 girls. The control group received no intervention.

- *Measures of change*: Measures were a mix of carer- and self-report.

- *Longevity*: Follow-ups have been taken up to 36 months after baseline.

- *Other considerations*: All studies were conducted by the programme's originators.

Section 4: Emotional interventions for young children (0–6 years)

Our search of the literature did not reveal any studies with young looked after children using interventions whose focus was on directly or indirectly targeting emotional disorders. However, see ABC and MTFC-P in section 2.2 above for studies that captured internalising outcomes as part of their measures.

Section 5: Emotional interventions for older children and adolescents (7–17 years)

Besides the interventions discussed here, see also ARC and its links to PTSD symptoms, and Life story work and its links to identity (both section 3.1).

5.1 Direct interventions for older children and adolescents

Animal-assisted therapy

For ages: *7–17 years*

What the intervention entails:
The use of animals as part of therapy sessions is designed to enhance the therapeutic process and can help to create trust and acceptance. Children can find it easier to tell an animal about their abuse, because they feel safer (Dietz et al, 2012). In Dietz et al (2012), group therapy of 12 sessions was held with therapy dogs and handlers available at about one-third of the therapy sessions, both before the session and for a fixed time in the session itself. In some cases, the session included stories about the dogs that were followed up by questions that related the dog's story to the children's experiences. In Balluerka et al (2014), it was 12 weeks of attachment-focused group and individual therapy, using dogs and horses as therapeutic animals (plus other guided interactions with animals on the farm that was the location for the therapy). Working with animals was designed to help children develop attachment relationships and included working towards the child providing care to the animal.

Findings with looked after children and young people:
Dietz et al (2012) studied 7–17-year-olds with documented child sexual abuse (in care or with a protective parent). Young people were allocated to standard group therapy, group therapy with dogs, or group therapy with dogs that used therapeutic story-telling. Caregiver-rated trauma symptoms were measured before the first session and at the end of the group sessions. Both groups using dogs showed greater decreases in symptoms from pre- to post-intervention than standard group therapy, but the dogs with stories group was the most effective.

Even after controlling for pretest scores, prior abuse, ethnicity, and location of therapy, being in the dogs and stories group made a unique contribution to post-intervention trauma scores.

Balluerka et al's (2014) study looked at 12–17-year-olds in residential care with mental health difficulties. They found a significant change in scores for the treatment group in felt attachment security. However, while the paper presents moderate effect sizes for the difference between the AAT group and the controls on change in security and parental interference, the authors state that these were not significantly different; moreover, they do not present significance tests or standard deviations – suggesting there was a lot of variance in the results.

State of the evidence:

- *Geography*: The evidence cited comes from the US (Dietz et al, 2012) and Spain (Balluerka et al, 2014).

- *Samples*: Samples range from treatment group sizes of 21 (Balluerka et al, 2014) to 60 (Dietz et al, 2012), with a smaller comparison group drawn from group therapy without animals. Drop-out in the Balluerka et al (2014) study (original sample size = 58) included eight young people who refused to complete follow-up measures because they found them too taxing or upsetting. Comparison groups have not been well-matched (Dietz et al, 2012); Balluerka et al (2014) compared against a no-therapy group rather than therapy without animals, making it difficult to determine whether any change was due to the use of animals or just therapy itself.

- *Longevity*: The longevity of any effects is unclear, since studies have taken follow-up measures either directly after or only two weeks after the intervention.

Arts therapy

For ages: *8–15 years*

What the intervention entails:
Holistic arts-based group therapy consists of 12 weekly, two-hour manualised sessions with children, using arts-based and mindfulness-based methods. The aim of the intervention is to help children learn how to develop their skills of attention and imagination, how to recognise and understand their feelings, thoughts and behaviour, and how to develop their strengths. In Coholic et al's (2012) study the group size was four children and two facilitators (social workers, youth workers and psychology graduates).

Findings with looked after children and young people:
Qualitative feedback from young people taking part in these groups suggests that they find them 'fun', while children and their foster carers/parents noted perceived developments in children's self-awareness and self-confidence (Coholic, 2011). Child and carer feedback from an earlier six-week version used with children in foster care also highlighted the sense of enjoyment, developing self-awareness, self-esteem, coping and new skills that accompanied the programme (Coholic et al, 2009a; Coholic et al, 2009b).

Coholic et al (2012) conducted sessions with 8–14-year-olds, staggering treatment across the sample into three streams. The only difference between the three streams was on emotional reactivity; the sample was too small to examine this statistically, but the authors suggest from descriptive data that for each stream, emotional reactivity improved during the period of the intervention (though it appears that for the third stream, it returned to baseline levels in the following 12 weeks).

State of the evidence:

- *Geography*: Evidence comes from Canada, and from the same research group.

- *Samples*: The quantitative work (Coholic et al, 2012) had a sample of 36 children – only 21 of these completed the programme and all data collection. This was a diverse sample as it was drawn from two sources (mental health and child welfare referrals); referring practitioners did not identify any behavioural problems in almost half the children. Children were not randomly assigned, but groups were matched on age and gender and there were no demographic differences. The authors refer to a non-therapeutic arts and crafts group as a comparison group but these children also went on to do the therapeutic programme – it is possible that earlier participation in the other arts and crafts classes could have affected their results.

- *Measures of change*: Much of the work to date has been qualitative.

Cognitively-Based Compassion Training (CBCT)

For ages: *13–17 years*

What the intervention entails:
CBCT encourages the individual to explore their existing assumptions about their feelings and their behaviour towards others. Its goal is to promote empathy and compassion for self and others (Pace et al, 2013). Young people receive six weeks of treatment, consisting of two one-hour sessions per week. The sessions offer a mixture of teaching, discussion, and meditation practice. Young people were encouraged to practice meditation for 30 minutes per day outside of the sessions.

Findings with looked after children and young people:

Pace et al (2013) compared adolescents in foster care in CBCT to waitlist controls. Morning and evening saliva samples were taken before and directly after the intervention, and adolescents completed self-reported measures of anxiety and depression at these points too. They also kept a diary noting when they had engaged in CBCT outside of sessions. There was no effect of group or time on concentrations of CRP (the protein marker for inflammation), nor any interaction between the two. But children who practised CBCT more often were more likely to have reduced levels of CRP (though this finding could reflect the opposite direction of effect, ie that those with lower inflammation are more likely to practice CBCT more). Depression fell in both groups over the six weeks; this did not differ by group. Anxiety did not change over time, but tended to be lower in the CBCT group than in controls when time was ignored (ie not a bigger change, just lower in general).

Reddy et al (2013) studied the same sample, and found that in addition to depression and anxiety, there was no difference post-treatment in children's hope or emotion regulation scores when controlling for age, ethnicity, gender and baseline scores. Frequency of practice in the second half of the treatment only was correlated with lower anxiety and higher hopefulness. Most young people's feedback suggested they had found the treatment helpful. Despite measuring them, the paper does not report on any changes in loving kindness, joy, compassion, acceptance towards self and others, or on callous and unemotional traits or self-harm.

State of the evidence:

- *Geography*: The evidence cited comes from the US.
- *Samples*: Random assignment was used. The sample size was 29 in CBCT after eight young people dropped out of each condition; drop-outs were no different from completers on age, sex, depression or anxiety scores.
- *Longevity*: The studies do not include a longer-term follow-up after the intervention ended.

5.2 Indirect interventions for older children and adolescents

Our search did not reveal any studies with older looked after children using interventions with components designed to indirectly target emotional disorders. However, see MTFC-A and TFC in section 3.2, and MSS in section 3.3, for studies that captured internalising outcomes as part of their measures.

Section 6: Hyperkinetic interventions

Our search did not reveal any interventions that were specifically designed to target hyperkinetic disorders and had been tested with looked after children. However, see details above on Fostering Attachments and Incredible Years carer programmes (section 3.2), which measured changes in hyperkinetic symptoms as part of their outcomes.