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Team formulation for foster carers: a qualitative analysis

Thomas Speight

Doctorate in Clinical Psychology

Division of Health Research

Lancaster University

Word Count

	Main text	Appendices (incl. title page, references	Total
Thesis Abstract	272	-	272
Literature review	7,946	9,838	17,784
Research paper	7,982	2,552	10,534
Critical appraisal	3,997	450	4,447
Ethics section	3,623	6,105	9,728
Total	23,593	18,940	42,493

Thesis abstract

In the first chapter, a systematic literature review explored experiences of children in care (CIC) and caregivers of accessing mental health services. The importance of effective mental health support for this population has been consistently stressed across research literature. Qualitative research exploring perceptions of attempting to engage with services was synthesised using a meta-ethnographic approach. Ten papers were included for review, resulting in five superordinate themes: 1) Feeling threatened, 2) Uncertainty and mistrust, 3) Neglected and alone, 4) Lifting barriers, and 5) Connecting. The findings revealed a pattern of dynamics within the foster care and mental health services system that reflect common experiences of children's distress. Based on this, clinical implications were considered, highlighting ways to facilitate CIC engagement and retention in mental health services.

The second chapter presents a qualitative empirical study, exploring foster carers' experiences of team formulation (TF). TF has been reported as helpful for collaborative multi-disciplinary working across health and social care settings. In the present context, it was employed to support carers in a number of ways in their stressful role supporting CIC. Four carers were interviewed, the data from which were examined using Interpretative Phenomenological Analysis. Four super-ordinate themes resulted from this analysis, presented here: 1) Firefighting, 2) Everyone's in my corner, 3) It's another world for me, 4) It's not set in stone. Implications clinically and in terms of future research were discussed.

In the third chapter, the project was critically appraised, summarising the findings and implications from both papers, as well as exploring the author's reflections about the research process and implementation of qualitative research methodologies.

Declaration

This thesis records research activity taking place between January 2020 and October 2020 undertaken towards the Doctorate in Clinical Psychology at Lancaster University. The work presented here is the author's own, except where due reference is made. The work has not been submitted for the award of an academic qualification elsewhere.

Thomas Speight

16th October 2020

Acknowledgements

I would like to thank all those who offered to take part in the following study. I have tried to do justice here to your passion and commitment to the young people you have strived so hard to support. Thanks to all people who have taken time to support me in consultation about the study and recruitment of foster carers through fostering agencies, including especially Adrienne Cronin and Ian Burke. Thanks also to the field supervisor for this project, Sue Knowles, for your kindness, compassion and attentiveness during the course of this study. I'm very grateful to my academic supervisor Suzanne Hodge and clinical tutor Will Curvis, without your guidance and encouragement I would have struggled so much more during what has been a difficult year, I am eternally grateful to you both. Thanks so much. Finally, I have to acknowledge my loved ones, close friends I've made during training who have helped keep me buoyant and made this an incredible experience, it's genuinely been my privilege to go on this journey with you. Ali, Ben and Louie, thanks for your encouragement and love.

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Chapter 1: Literature Review

Echoes of distress: A qualitative meta-synthesis of caregiver and children in care experiences of accessing mental health services

Thomas Speight

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

Word count: 7,946 (Excluding references, appendices, tables and figures)

All correspondence should be addressed to:

Thomas Speight

Doctorate in Clinical Psychology

Division of Health Research, Furness College

Lancaster University

Lancaster

LA1 4YF

Tel: 01524 595970

Email: tspeight1@lancaster.ac.uk

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Abstract

Children in care (CIC) have often faced significant adversity, which has been associated with increased mental health needs and emotional distress. Given this, engagement with mental health services is recommended in promoting their emotional well-being, improving placement stability and consequently improving chances of forming lasting attachment relationships. Despite the significance of this issue, the experiences of CIC are under-represented in research literature. A meta-ethnographic method was used to systematically review and synthesise both CIC and caregivers' experiences of accessing mental health services for CIC. Ten articles were retrieved from database searches. Synthesis of their findings yielded five superordinate themes: 1) Feeling threatened, 2) Uncertainty and mistrust, 3) Neglected and alone, 4) Lifting barriers, and 5) Connecting. Associations were suggested between these patterns of experiencing services and the original traumatisation of CIC. Clinical implications were recommended, including promoting control and agency, a sense of safety and comfort, the normalisation of distress, promotion of stable and lasting relationships, inclusion and support for foster carers and addressing fundamental systemic resource pressures.

Keywords: children in care, foster carers, mental health services, help-seeking

Echoes of distress: A qualitative meta-synthesis of caregiver and children in care experiences of accessing mental health services

The term children in care (CIC) is used in the UK to describe children and young people up to 18 years who live away from the family home due to significant concerns about well-being or safety. For the purposes of this literature review, this definition excludes children who have been adopted. In England, 65% of CIC have been exposed to neglect or abuse, and 15% to family dysfunction, resulting in them becoming looked after (Narey & Owers, 2018). Types of care offered by the state can be temporary or permanent, and include foster care, kinship care, residential care or independent living, depending on need and availability.

CIC can face significant strains on their mental health (MH), given common adverse childhood events (ACEs) contributing to being placed in care (Simkiss, 2019). Internationally, studies have found a much higher prevalence of MH needs in CIC than the general population: around 50%; ~45% in England (Baldwin et al., 2019; Lehmann, Havik, Havik & Heiervang, 2013; NICE, 2013). Consequences of poor MH for CIC can be pervasive across the lifespan, affecting education, employment, increased risks of homelessness and substance misuse (Bazalgette, Rahilly & Trevelan, 2015).

A full account of MH interventions developed for CIC is beyond the scope of this review: for a helpful review of specific interventions, see Hambrick, Oppenheim-Weller, N'zi and Taussig (2016). Interventions that include the network around CIC have been described as the most effective, given the complexity that CIC often present with (Robinson, Luyten & Midgeley, 2017). In the UK, CIC can access psychotherapy and systemic interventions via child and adolescent MH services (CAMHS). A survey of child psychotherapists working with CIC in the UK revealed most therapy work is done directly with the child, followed by indirect work with networks (Robinson, Luyten & Midgeley, 2017). There are great variations in availability and types of services offered by local

CAMHS across the UK. Recently, services have faced significant capacity constraints, generally resulting in higher thresholds of need for support (Bazalgette, Rahilly, & Trevelan, 2015).

Developing lasting attachment relationships has been identified as an important goal for CIC placements (Murray, Tarren-Sweeney & France, 2011). The contribution of placement moves to MH needs has been consistently stressed by researchers in this field (McAuley & Davis, 2009). In one review, strong evidence for an association between CIC MH needs and placement instability was found (Rock, Michelson, Thomson and Day, 2013). It was suggested recently that placement instability can be viewed as both a cause and consequence of MH needs (SCIE, 2017). Given that recent statistics in England show the second most common reason for placement changes was carers asking for the placement to end (Narey & Owers, 2018), carer views of CIC MH needs and gaining support from services bears closer scrutiny.

Foster carers can be described as important stakeholders in the care system, who face a complex role supporting CIC with high levels of need (Murray, Tarren-Sweeney & France, 2011). Given inconsistent requirements for MH needs assessment for children entering care across UK nations (Bazalgette, Rahilly, & Trevelan, 2015), carers shoulder the burden of identifying needs and seeking support. Given these factors and the importance of promoting placement stability highlighted above, carer views are of direct relevance in consideration of the help-seeking process.

It is increasingly recognised that children's perceptions should be sought in evaluating services they receive (NICE, 2013), especially CIC, who are acknowledged as a 'frequently excluded group' (DoH, 2004). CIC are key stakeholders in the systems through which they are supported, whose opinions should shape planning and delivery (Rock, Michelson, Thomson and Day, 2013; Wilson, Sinclair, Taylor, Pithouse & Sellick, 2004). Strong

arguments have been presented that statutory services should go further in collaborating with CIC, reframing traditional narratives of them as passive 'help-receivers', who are 'done to', into help-seekers, who are 'done with' (Unrau, Conrady-Brown, Zosky & Grinnell, 2006). Despite this, the paucity of qualitative research about CIC experiences of accessing MH services has been repeatedly highlighted (Davies & Wright, 2008; Johnson & Menna, 2017).

Despite the importance of professional networks supporting CIC MH (Robinson, Luyten & Midgeley, 2017), a common issue for foster carers is recognised as not feeling included due to complex systems of legal and professional responsibility (SCIE, 2017). Via the present study, exploration of perceptions of inclusion within or exclusion from these networks could be helpful, especially since the foster care environment and relationships are recommended as the main therapeutic intervention for CIC (Luke, Sinclair, Woolgar & Sebba, 2014) and interventions most helpfully include both carers and CIC (Robinson, Luyten & Midgeley, 2017). Ultimately, carers and CIC are parts of one system seeking help; including both perspectives allows for recognition of areas of commonality and difference, hopefully facilitating a deeper understanding of the phenomena introduced above.

As such, the research aim of this review is to synthesise qualitative research literature qualitatively exploring CIC and foster carers' perceptions of accessing MH services in order to acknowledge common issues, how far these views align and consider implications for MH services supporting CIC.

Methodology

Data collection

A literature search was conducted in March 2021 using the following bibliographic databases: APA PsycINFO, Academic Search Ultimate, Child Development & Adolescent Studies, CINAHL. Development of search terms took place within the SPIDER framework (Cooke, Smith & Booth, 2012). Search terms outlined in *Table 1*, below, were used to search

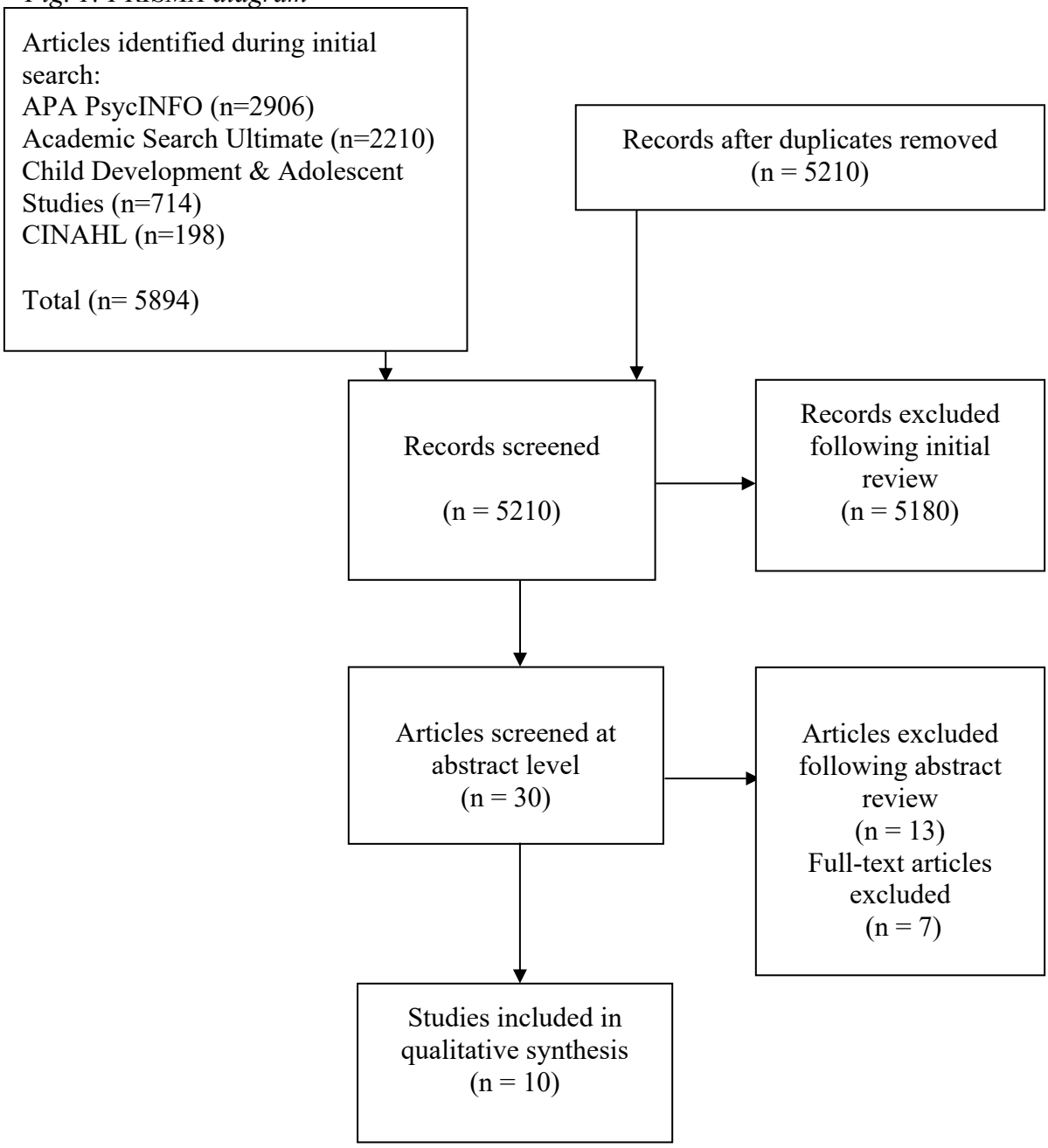
titles and abstracts from the above databases. The search strategy was discussed with an Academic Liaison Librarian from Lancaster University. There were no date restrictions to studies sourced. A record of the literature search is outlined in the PRISMA diagram below (*Figure 1*).

Criterion	**Detail**
Search terms: S (Sample)	(“foster carer*” OR “foster parent*” OR “foster care” OR “foster home care” OR “institutional care of children” OR “residential care” OR “children in care” OR “foster child*” OR “child in care” OR “looked after” OR “care-leaver*” OR “aging out” OR “ageing out” OR “aged out” OR “young people in care” OR “out of home care” OR “out-of-home care” OR “child protection” OR “state care” OR “child welfare services” OR “out of home placement*” OR “out-of-home placement*” OR “non family placement” OR “family placement” OR “kids in care” OR “CYF family home placement” OR “residential placement” OR “**alternative care**” OR “kinship care” OR “children in state care” OR “residential care”)
PI (Phenomenon of interest)	AND ("mental health services" OR “child and adolescent mental health services” OR CAMHS OR “mental health needs” OR “mental illness (attitudes towards)” OR “mental disorders” OR “self-harm*” OR “self-injury” OR “help-seeking” OR “child psychotherapy” OR “child psychiatry” OR “child psychology” OR “mental health treatment” OR “Mental health intervention” OR “help-seeking” OR “emotional needs” OR “emotional well-being”)
DER (Design, evaluation, research type)	AND (interview OR “focus group” OR experience* OR perception* OR view* OR thought* OR opinion* OR qualitative OR mixed methods OR phenomenological)
Databases	APA PsycINFO, Academic Search Ultimate, Child Development & Adolescent Studies, CINAHL
Inclusion criteria	Studies should: • focus on the experiences of CIC and/or caregivers of accessing MH services for help or support for CIC • Qualitative design, or mixed methods (where qualitative components of these studies utilise qualitative analysis and present substantial distinct themes) • Empirical research published in a peer-reviewed journal • Be published in English language
Exclusion criteria	Studies should not be: • Solely quantitative in nature • Classifiable as grey literature or theses

	• Review or opinion articles • Not focusing on experiences of adopted children/adoptive parents

Table 1: Literature search strategy

Fig. 1: PRISMA diagram



An initial search yielded 5894 articles, from this total, 684 duplicates were identified and removed. Articles were screened initially by title and if needed by abstract. To be included in the review, studies should meet the following criteria: qualitative design, or mixed methods (where qualitative components present substantial distinct themes); English language; present CIC/caregiver experiences of accessing MH services on behalf of CIC; peer reviewed empirical research. They should not: be grey literature/theses; focus on experiences/evaluations of specific MH interventions; focus on experiences of adopted children/adoptive parents. A decision was made to exclude studies about adopted children or adoptive parents, because they may have a qualitatively different experience of accessing MH services to young people in care settings, due to permanence in status of their adoptive home, meaning MH services may have different perspectives about their readiness for treatment. There are also a lack of current studies and further research is needed to explore experiences in this area. These inclusion criteria were applied to a sample of the selected papers by an academic supervisor to check for their suitability, and agreement was reached based on these criteria. Thirteen articles were excluded following reading of the abstract, because they either did not pertain to the topic, or were quantitative. Seven articles were excluded following a full text read.

Characteristics of included studies

Ten studies were included in the final analysis (*Table 2*). Of these, six studies focused solely on CIC perspectives, three on carers and one included both. The meta-synthesis included data from 181 participants across included studies, comprised of 91 CIC and 62 carers. Twenty-eight young people with a history of care were included in studies, who reflected on experiences of accessing MH services when in care. Where identified, most participants in studies were female. Of studies with a focus on CIC, age ranges were from eight to 21-years old. Two studies (Fargas-Malet & McSherry, 2018; Stanley, 2007) did not

provide demographic information about CIC interviewed. The majority of studies were carried out in the UK, with one from the Republic of Ireland, two from the USA and one from Canada. Most studies were published relatively recently, with the earliest study published in 2007. Studies utilised a range of methodologies in analysing the data, including IPA, thematic analysis, grounded theory, with one study using 'content analysis' and three referring to nonspecific methods for developing themes from the original data. Methodological issues were considered as part of the critical appraisal process, as detailed below.

Author/year	Research aims	Methodology and analysis	Participants	Nation of study
Davies, Wright, Drake & Bunting (2009)	Primary aims to explore younger children's perceptions of accessing psychological therapy and different methods of collecting views.	Separate SSIs with children and carers simultaneously, triangulation of accounts, Interpretive Phenomenological Analysis	8 children in care aged 8-10 years	UK
Fargas-Malet & McSherry (2018)	To explore practitioners, carers and young people in care's views of MH needs and service provision	Carer phone interviews, social work managers focus groups, CYP face to face interviews. Mixed methods, qual: content analysis	25 focus groups – professionals 33 carers telephone interview 25 CYP interviewed	UK
Jee, Conn, Toth, Szilagyi & Chin (2014)	1) explore youth and foster parent perspectives on MH treatment in foster care. 2) elucidate their preferences for MH delivery. 3) identify opportunities for coordination of care	Interviews, analysed using thematic framework approach	Purposive sampling to represent demographic range of population of CLA – 14 CIC and 4 young adults with exp of foster care, 19 associated foster parents	USA
Johnson & Menna (2017)	1) what types of distress are being experienced by adolescents in care 2) what knowledge of distress and sources of support do they possess? 3) what are their feelings towards MH problems and sources of help? 4) do they feel in control of their MH and related needs? 5) how often are formal or informal sources of help consulted by adolescents in care for MH problems, and who? 6) are there differences in ability or willingness to identify a problem, perceive need, or seek help, what influences this?	SSIs, grounded theory analysis	7 young people (aged 16-20) with experience of foster care	Canada

Miller, Halligan, Meiser-Stedman, Elliott & Rutter-Ely (2020)	Understand the role of foster carers in supporting young people in relation to emotional wellbeing and what they perceive as barriers or opportunities to providing effective support.	Focus groups, thematic analysis	21 foster parents	UK
Root, Unrau & Kyles (2018)	1) how resilient do college students from foster care perceive themselves to be? 2) how likely are students from foster care to seek help when faced with MH stressors 3) how has the foster care experience shaped perceptions that college students from foster care have about MH professionals?	Interviews and focus groups, thematic analysis co-produced by researchers	Convenience sampling of 15 US college students with care background.	USA
Stanley (2007)	Consulting young people in care to explore views of what aspects of care contribute to MH needs and how to best meet those needs.	Four focus groups. Grounded theory analysis	14 young people in care, recruited through local authorities in UK.	UK
Tatlow-Golden & McElvaney (2015)	To explore views of young people with experience of being in care and involved in the youth justice system around their MH, experience of MH support whilst in care and recommendations for improving services	SSIs, thematic analysis within principles of Consensual Qualitative Research	8 young adults (18-24) with experience of being in care	Ireland
Wadman, Armstrong, Clarke, Harroe, Majumder, Sayal, Vostanis & Townsend (2018)	Looking at looked-after young people's perceptions and experiences of factors relating to self-harm, and of interventions and services received, in order to improve future service provision.	SSIs, IPA analysis	24 young people with experience of self-harming in care – foster care, residential care, including care-leavers	UK
York & Jones (2017)	To understand the experiences of foster carers who care for children and young people with MH difficulties and their experience of accessing MH services	SSIs analysed with grounded theory	9 foster carers and 1 kinship carer	UK

Table 2: demographics of included studies

Quality appraisal

The Critical Appraisal Skills Programme (CASP, 2018) tool was applied to the papers included in the synthesis. CASP appraises ten areas, including data collection, methodology and ethical considerations. Papers were scored numerically using items on this tool; one for weak evidence; two for moderate evidence; three for strong evidence (as per Duggleby et al., 2010). The CASP tool was applied to included studies by an academic supervisor and scores compared. Discrepancies between ratings were discussed until agreement was reached about appropriate scores. Studies were not excluded from the study due to CASP ratings, since this

may have resulted in losing data pertinent to the research question. However, it was noted that stronger studies eventually contributed more to the final analysis.

Total scores for included papers ranged from 19 – 28 (*Table 4* for ratings). With a mean of 23.8, the overall quality was quite high. Most papers used well-described and robust qualitative methods. However, some were not as strongly evidenced. Stanley (2007) references Strauss and Corbin (1990) which describes Grounded Theory, although does not elaborate on this process. Root, Unrau and Kyles (2018) described using 'content analysis' as per Taylor-Powell and Renner (2003). They describe developing codes and themes, with increased rigour through consensus-seeking between researchers. Fargas-Malet and McSherry (2017) described thematic development through 'content analysis'. Jee, Conn, Toth, Szilagyi and Chin (2014) employed a deductive 'thematic framework' approach, as described by Pope, ZIebland and Mays (2000), developing a framework of inter-related themes. Davies, Wright, Drake and Bunting (2009) employed IPA with child and carer interviews and described the process of analysing their innovative data using 'recursive analysis' and attempts to improve analytical credibility. Generally, authors very thoughtfully located and considered their findings within the broader theoretical and clinical/practical context within which they emerged. They tended to offer nuanced reflections about the dynamics between CIC, caregivers and services/systems, and the significance of differing perspectives on barriers to help-seeking between them. They also tended to present focused clinical implications, pertaining to the settings within which studies were undertaken. Interestingly, recommendations for future research were not consistently identified, although tended to be present across studies scoring more highly in CASP ratings here.

Epistemological stance

The present meta-synthesis was conducted in the spirit of critical realism (Bhaskar, 1989). A critical realist perspective proposes three levels of reality: empirical, actual and real.

These represent: the human interpretation of events as they are experienced and observed (empirical); the actual playing out of events regardless of human recognition (actual); and the causal mechanisms underlying events (real). Fletcher (2017) suggests that via this apprehension, critical realists can develop recommendations about social phenomena based on discernment of both social tendencies and underlying causal mechanisms. As studies identified for this synthesis employ a range of qualitative methodologies, a critical realist stance allows for translation of data across diverse methodologies.

Data synthesis

Findings from identified studies were analysed within the framework of Noblit & Hare's meta-ethnography approach (1988), using the following process (*Table 3* below for a summary of stages of the analysis). First and second order constructs (any original quotes/ reporting of participants' views and interpretations offered by researchers) from each study were analysed line-by-line and translational codes developed representing key concepts. This stage of the analysis allowed reciprocal translation to develop across studies, as well as noting any significant exceptions. Translations would eventually form a framework around which to develop third order constructs (the researcher's original interpretations). During this stage of the analysis, a sample of translations and third order constructs was discussed and reviewed by an academic supervisor, in an attempt to monitor for bias and improve rigour. At this stage, the data was forming into higher ranking conceptual themes, collating the dominant ideas from third order constructs (*Appendix 1-A* for a table revealing theme development). The analysis could be described as a lines-of-argument synthesis (Noblit & Hare, 1988) since it enabled a new conceptual framework beyond any of the constituent findings alone.

PHASES OF NOBLIT & HARE META-	PHASE DEMONSTRATED IN CURRENT SYNTHESIS

ETHNOGRAPHY (1988)	
PHASE 1	A topic to be reviewed was identified with reference to recent CIC literature.
PHASE 2	A literature search was conducted in May 2021 using the following bibliographic databases: APA PsycINFO, Academic Search Ultimate, Child Development & Adolescent Studies, CINAHL. The search is detailed in *Table 1* and *Figure 1.*
PHASE 3	The main researcher familiarised himself with the identified articles by reading and re-reading them closely.
PHASE 4	1st and 2nd order constructs from the results section of each study were identified. These consisted of qualitatively analysed data focusing on CIC and foster carer experiences of accessing MH services. These were listed in a table, using numerical identifiers for ease of analysis at a later stage (see *Appendix 3*).
PHASE 5	Items on this table were analysed line by line and translated conceptually across the studies using a coding spreadsheet. Using a process of constant comparison across original data of the studies, reciprocal 3rd order constructs were developed. During this process, a sample of 3rd order construct development was discussed and reviewed by an academic supervisor.
PHASE 6	At this stage, concepts identified during the analysis were grouped into themes. Five themes were developed that served to group 3rd order constructs in a lines-of-argument synthesis.
PHASE 7	The findings were expressed through the present report.

Table 3: stages of Noblit & Hare's meta-ethnography (1988)

	Clear statement of aims?	Qualitative method appropriate?	Design appropriate for aims?	Recruitment strategy appropriate?	Data collection addresses research aim?	Relationship between researcher and participants considered?	Ethical issues considered?	Data analysis rigorous?	Clear statement of findings?	How valuable is the research?	/30
Davies, Wright, Drake & Bunting (2009)	1	2	3	2	2	2	2	2	2	3	22
Fargas-Malet & McSherry (2018)	2	2	2	3	1	1	2	1	2	3	19
Jee, Conn, Toth, Szilagyi & Chin (2014)	3	3	2	3	2	1	1	2	2	3	22
Johnson & Menna (2017)	3	3	3	3	2	2	2	3	3	3	27
Miller et al. (2020)	3	3	3	3	2	2	2	3	3	3	27
Root, Unrau & Kyles (2018)	3	3	2	3	2	1	1	2	2	1	20
Stanley (2007)	3	3	3	2	2	2	3	1	2	3	24
Tatlow-Golden & McElvaney (2015)	3	3	3	3	2	2	3	3	3	3	28
Wadman et al. (2018)	2	3	3	3	2	1	2	2	3	3	24
York & Jones (2017)	2	3	2	2	3	3	2	2	3	3	25

Table 4: CASP ratings of included studies

Findings

The analysis yielded five main themes: 1) Feeling threatened, 2) Uncertainty and mistrust, 3) Neglected and alone, 4) Lifting barriers and 5) Connecting. **Feeling threatened, Uncertainty and mistrust** and **Neglected and alone** focus on the sense of threat, fear and isolation resulting from attempted engagement with MH services, which presented barriers to the help-seeking process. The final two themes **Lifting barriers** and **Connecting** present attitudes, relational and therapeutic approaches that were found beneficial in the help-seeking process. These themes stand in contrast to the first three and could be viewed as offsetting the barriers found there.

Feeling threatened

The initial theme comprises the sense gained from CIC and carers of feeling threatened across different levels within the care system. Vulnerability was particularly exposed during the help-seeking process. Subthemes within this theme are: *Coercion and therapy, Opening up, Stigma* and *Pushing people away.* Overall, nine of the included studies contributed to this theme. Six papers were evenly distributed within each subtheme, with largely reciprocal constructs (see *Appendix 1-A*).

Coercion and therapy

Multiple accounts reported CIC feeling coerced into therapy (e.g. Root, Unrau & Kyles, 2018, pg.84/85) – "they tried to force me" (Tatlow-Golden & McElvaney, 2015, pg.4). These impositions could be interpreted as a source of threat, rather than a route to support, leading to defensive responses:

> you've got to sort your problems out, you've got to do this, you've got to do that'. They'll wind me up and I'll get mad and I'll just flip on 'em (Stanley, 2007, pg.261).

CIC also reported feeling pressure from professionals during the course of therapy, for example, disclosing sexual abuse without developing rapport: "'how did that make you

feel?'…before even, like, talking to ya…I didn't like it" (Tatlow-Golden & McElvaney, 2015, pg.4). Ultimately, this approach was seen as harmful for some CIC by carers: "Some kids have been so damaged…if you force them to bring all that out…Not all kids can" (Jee et al., 2014, pg.549). Therapy settings could be experienced as constraining, with CIC feeling additional scrutiny within them, perhaps contributing to a sense of threat: "sitting in a little room where someone's just trying to get everything out of you" (Tatlow-Golden & McElvaney, 2015, pg.4). This coercion seemed part of a pattern of CIC feeling they were being 'done to' rather than collaborating in an inclusive endeavour. This became apparent across studies with decisions and plans made on their behalf: "if I had the choice I never would have went [before]" (Johnson & Menna, 2017, pg.96). As part of this pattern of being 'done to', CIC could reject undergoing therapy: "They don't like it because it's taking away their free time and they don't like talking about their problems to other people" (Jee et al., 2014, pg.549).

Opening up

The process of having to open up about difficult past experiences was potentially threatening for vulnerable CIC. Some CIC reported resentment at having to become emotionally intimate with strangers: "To tell a complete stranger…about my personal life" (Tatlow-Golden & McElvaney, 2015, pg. 4). One study revealed disclosures as potentially re-traumatising: "I get angry and upset all over again" (Jee at al., 2014, pg. 549), as also recognised by a carer: "she went to therapy and started bringing up all this stuff. She freaked out" (Jee et al., 2014, pg. 549). Some described feeling they were under cross-examination, with a sense of being uncontained: "I couldn't talk I was crying so hard…I didn't go again after that" (Tatlow-Golden & McElvaney, 2015, pg. 4). The demand for disclosure could leave CIC with "feelings of exhaustion" (Root, Unrau & Kyles, 2018, pg.85), rather than healing, as well as leading to retaliation: "I wasn't listening; all I thought of was walking out

and hitting them" (Wadman et al., 2018, pg.371). Carers recognised such disclosures could be unsettling for children, noting: "She does come down quite quickly from those sorts of feelings of heightened anxiety or dysregulation. She will come down, but you know you definitely see it there" (Davies, Wright, Drake & Bunting, 2009, pg.27).

Stigma

Stigmatisation contributed strongly to this theme of feeling threatened. For CIC, stigma about being in care was compounded when accessing MH services, serving as a powerful barrier to help-seeking throughout studies: "They see you going in there, they would be like, 'Oh, she crazy!'" (Jee et al., 2014, 2018, pg.548). Feelings of guilt, embarrassment and insecurity about MH needs meant stigma was a significant barrier to seeking help for CIC: "I usually wouldn't tell anyone about mental health issues because it's triggered by a lot of guilt" (Fargas-Malet & McSherry, 2018, pg.585). The most common effect was feeling unable to disclose distress, expecting judgement from peers and adults: "It's like you see these people in school, never had a problem with their parents, never done anything wrong, been perfect" (Root, Unrau & Kyles, 2018, pg.261). Shame from being in care was a concern, compounded by micro-aggressions from teachers. This 'othering' consequently provoked anger: "whenever I mention that I'm in foster care to teachers…they treat it like it's something bad" (Johnson & Menna, 2017, pg. 97). Stigma could be rooted in negative familial MH experiences, almost appearing internalised as a result: "makes me think of my mother – schizophrenia, depression…suicide" (Tatlow-Golden & McElvaney, 2015, pg.4).

Pushing people away

Perhaps unsurprisingly, given common patterns of transition and disrupted attachment, CIC described pushing others away: "I just tell them what they want to hear to get them out of my face" (Jee et al., 2014, pg.549). This was interpreted by carers as

protecting against vulnerability due to emotional damage (Fargas-Malet & McSherry, 2018, pg.585) and a dearth of earlier secure attachments: "I've never had someone in my life I can actually depend on" (Wadman et al., 2018, pg.371). At times, carers also seemed to push help and support away - perhaps mirroring this defensive posture - either due to the implication that seeking help would indicate failure, or else fearing criticism: "I don't need for you to tell me how to manage his behaviour…it's him who needs the counselling" (Miller et al., 2020, pg.7).

Uncertainty and mistrust

This theme focuses on experiences that provoked fear and uncertainty amongst CIC, which served to undermine help-seeking, disclosure of MH needs and also contributed to increasing distress. Subthemes are: *Not knowing, Instability* and *Mistrust.* Overall, all ten of the included studies contributed to this theme. Four, five and seven papers contributed to the development of the subthemes respectively, with largely complementary concepts within each (see *Appendix 1-A*).

Not knowing

Incomprehension at different aspects of the help-seeking process and care system was central to a sense of mistrust amongst CIC, but also hindered development of a shared purpose – towards healing young people's distress. CIC showed lack of awareness about the reason for therapy (Davies, Wright, Drake & Bunting, 2009, pg.20), or why they were referred to a specific type of therapist (Jee et al., 2014, pg.548). Systemically, children could be unsure of the role of fostering agencies, meaning they did not seek out help through this potential route (Johnson & Menna, 2017, pg.96). Children were uncertain what MH services would do or want from them: "What are they going to try and get out of me?" (Fargas-Malet

& McSherry, 2018, pg.587), whilst others were unsure what services were available to support them (Fargas-Malet & McSherry, 2018, pg.586).

Not knowing was also a source of anxiety for carers. In some studies, carers were frustrated about not knowing the content of therapy sessions, leading to uncertainty about how to best support CIC afterwards: "I know it's supposed to be confidential…but sometimes it would be nice for them to give you a little feedback" (Miller et al., 2020, pg.8). Carers also revealed confusion and uncertainty about different aspects of service provision. For example, knowledge of available and appropriate local services (Fargas-Malet & McSherry, 2018, pg.588).

Instability

Instability emerged across studies as a very harmful aspect of CIC's experience in care, denying them the opportunity to build stable relationships and trust in structures that might otherwise offer support. A common barrier to gaining MH support was CIC transitioning between placements. For CIC this rapid change of adults in their lives could be unsettling: "There's so many people in and out of your life" (Tatlow-Golden & McElvaney, 2015, pg.3). Numerous different people being involved in services meant children struggled to engage. According to one carer: "you can lose a teenager by turning them over to someone else…she says she didn't want to relive it" (York & Jones, 2017, pg.149). Staff turnover was seen by carers as contributing to delays in service provision by CAMHS (Fargas-Malet & McSherry, 2018, pg.588). CIC found moving between placements harmful in terms of losing support, but also loss of a sense of control and agency: "I'd moved to a different placement and everything was moving so fast…I just didn't have no control in my life" (Wadman et al., 2018, pg.370). The paradox of needing to be in a stable placement to receive therapy was frustrating for one carer: "They can't go to CAMHS until they're in a stable placement. But you can't say whether they're going to be in a long-term stable placement" (Miller et al.,

2020, pg.7). One carer also poignantly observed that, due to this instability, "children have a tendency to get lost in the system" (Fargas-Malet & McSherry, 2018, pg.589).

Mistrust

CIC routinely expressed mistrust around a number of professionals and services they had previously accessed, including the care system, welfare and MH services. This learned lack of trust in professionals and services generally appeared to impact upon how CIC viewed MH services. This was acknowledged by one CIC: "every single system I ever used let me down…I don't trust services" (Tatlow-Golden & McElvaney, 2015, pg.4). Mistrust was fundamental to some CIC struggling to access MH services and therapy: "I can't stand there and talk to someone…just don't trust anyone" (Wadman et al., 2018, pg.371). Long-term patterns of vigilance and mistrust in adults undermined the likelihood of forming reparative therapeutic relationships for some CIC: "I've never had someone in my life who I know I can actually rely on" (Wadman et al., 2018, pg.371). CIC spoke about the importance of confidentiality in allowing them to feel that they could trust and seek support from adults. Where this confidentiality was not present, this led to feelings of betrayal, for example:

> I said something to my social worker once…then a couple of months later you get like a review report don't you, and it fucking had all of it in, didn't it…what do you think you're playing at, it was like confidential (Stanley, 2007, pg.261).

A strong element of this theme was mistrust from CIC towards the motivations of professionals in this field: "they're in it for the wrong reasons, and they don't fully understand" (Tatlow-Golden & McElvaney, 2015, pg.4). CIC could experience "lack of genuineness by professionals trying to help" (Root, Unrau & Kyles, 2018, pg.84), who were perceived to lack integrity: "I used to always think, they just be in it for the money" (Jee et al., 2014, pg.550). CIC appeared acutely aware of the attitude of carers and therapists yet

could themselves be mistrusted about the sincerity of their expressions of distress: "some staff would think you were pretending" (Tatlow-Golden & McElvaney, 2015, pg.3).

Carers also struggled with mistrust when engaging with supporting agencies. Incomplete information was a hindrance to effective support for carers: "Sometimes you find out about things six months down the line and you think I wish I had known at the beginning, because you would have done things different" (Miller et al., 2020, pg.6). Some carers suspected services would fail their CIC, for example, anticipating long waits, or even that CIC were discriminated against due to their status. One carer noted their daughter "went to CAMHS within three months. Yet we've got children that are in the system that have to wait years" (Miller et al., 2020, pg.7). There was even the perception that social workers hid knowledge of specific services from carers due to limited resources: "if social workers can get away with not doing something for us, they'll not do it" (Fargas-Malet & McSherry, 2018, pg.590).

Neglected and alone

This theme is comprised of the sense of CIC and carers being alone and neglected within the help-seeking system. Subthemes within this theme are: *Alone, Dismissed* and *Neglected.* Overall, eight of the included studies contributed to this theme. Four or five papers contributed to development of each subtheme (see *Appendix 1-A*).

Alone

In some of the studies children appeared alone in their distress, either through choice, circumstance, or as a result of the relational instability they had become used to. Some children chose to deal with distress on their own: "usually I just kind of deal with it myself because it passes" (Fargas-Malet & McSherry, 2018, pg.586). Isolation appeared to be self-

imposed by some CIC as a defence: “there’s no point, I’ll be gone in six months, and anyone I speak to here, I’ll never speak to again” (Tatlow-Golden & McElvaney, 2015, pg.3). Others found it hard to cope alone: “I just don’t know what to do. I try to stop crying and I just try to suck it up” (Johnson & Menna, 2017, pg.99).

Carers also described struggling to cope alone and without support, given their complex role supporting children who were themselves deeply distressed e.g., Miller et al., 2020 (pg.7). At times, this was due to not knowing where to turn: “There’s help available but a lot of us don’t know it’s there” (Fargas-Malet & McSherry, 2018, pg.590). One carer bemoaned a lack of communication amongst all parties in the welfare-MH system: “None of the systems talk to each other” (Miller et al., 2020, pg.6).

Dismissed

Compounding this sense of isolation was a feeling of being dismissed by other parties within the MH support system. CIC could tell when they were being listened to, but not heard: “not many children who are in foster care get listened to. Well, they do, but it goes in one ear and out the other” (Tatlow-Golden & McElvaney, 2015, pg.3). Therapists could assume an expert stance, noted in one study where social inequality was keenly felt: “it was difficult to relate [to the therapist] because they were kinda established in their lives…they’re here because my life isn’t established” (Root, Unrau & Kyles, 2018, pg.85). Such power imbalances mirrored feelings of being unheard within the system as a whole:

> A lot of the times your feelings aren’t really listened to or taken into consideration. Like when you’re in foster care…until a certain age a lot of your decisions are made for you (Root, Unrau & Kyles, 2018, pg.85).

Some CIC felt therapists did not listen to them, prioritising their own expert knowledge and experience above empathic listening: “they assume too much sometimes” (Fargas-Malet & McSherry, 2018, pg.587). Children could feel invalidated by therapists “she twists things I

say…it's like nothing is important to her that I say" (Wadman et al., 2018, pg.372). This feeling also arose when children felt infantilised in therapy: "she was just incredibly patronizing. And it made me feel a bit like a child" (Wadman et al., 2018, pg.372). This invalidation could disempower children, reflected in one study where a participant reflected: "the therapist (was) focusing on problems and not solutions" (Root, Unrau & Kyles, 2018, pg.83), betraying a sense of being problematised. Carers also repeatedly described feeling unheard or dismissed by services. This reinforced their official lack of professional status: "I was telling them there was something wrong. But you know what we get a lot of is…there's nothing wrong with them" (Miller et al., 2020, pg.7).

Neglected

In addition, both CIC and carers felt they were left neglected by MH services at times. According to some carers, MH services displayed a lack of effort at engagement (Fargas-Malet & McSherry, 2018, pg.586) and too few contacts with therapists (Davies, Wright, Drake & Bunting, 2009, pg.29). CIC felt their needs were neglected due to generic interventions, which were problem-focused: "the emotions that young people feel going through the care system. None of that is dealt with" (Tatlow-Golden & McElvaney, 2015, pg.4).

The long wait for therapy due to lack of resources was one of the most common barriers to accessing MH services across many of the studies. CIC recognised that support may not be timely, contributing to a sense of their needs being neglected: "When I needed it most, they weren't there. When I didn't need it, they were throwing it at me" (Tatlow-Golden & McElvaney, 2015, pg.5). This lack of timely support was something that came up repeatedly across accounts: "they have to have a quicker turnaround to be of benefit" (Fargas-Malet & McSherry, 2018, pg.588). During long waits for access to services, carers could feel bereft of support themselves: "it took a year for everything to be diagnosed

properly (ADHD)…the wait can be problematic because there are issues and behaviours that you don't know how to deal with" (York & Jones, 2017, pg.148).

Lifting barriers

This theme explores the positive sense of being helped to feel comfortable and in control and the benefits this brought to the help-seeking process. Subthemes collated here are: *Comfort, Normalising, Empathising* and *Choice and control.* Overall, nine of the included studies contributed to this theme. Between four and six papers contributed to development of each subtheme respectively (see *Appendix 1-A*), appearing to present broadly complementary evidence.

Comfort

Efforts to help CIC feel more comfortable were acknowledged across studies as invaluable in lifting some of the barriers to accessing services highlighted above. One child suggested presenting therapy in a less formal way would increase comfort: "they should just say…'do you want to talk to somebody?'...Not 'do you want to go to counselling'" (Tatlow-Golden & McElvaney, 2015, pg.5). Individual therapists managed to invoke a sense of comfort at times: "she went out of her way to make me feel comfortable, and I never felt like I was talking to a professional" (Wadman et al., 2018, pg.373). Some children revealed they appreciated a range of communicative approaches during therapy, for example recognising the value of non-verbal communication: "We actually do, like, activities, so I can express how I feel sometimes, which I find a bit easier. And there's things I can fiddle with, things I can do while I'm there" (Wadman et al., 2018, pg.373).

CIC and carers consistently highlighted the significance of delivering MH services within an appropriate setting. CIC felt it was better to attend therapy in a setting that made them comfortable (e.g., somewhere they knew well and were familiar with), as highlighted by

one carer who asked for alternatives to clinical settings to be considered: "find a way they could come to the house or…see exactly what you can do without going to a place like that" (Fargas-Malet & McSherry, 2018, pg.589). The location should be easily accessible and convenient: "if we could bring those services into the local area" (Fargas-Malet & McSherry, 2018, pg.589). Issues such as the waiting area, amount of mixing with other children attending therapy, and what was on offer were all noted as important in helping children feel comfortable: "If they put something like a coffee machine or something like that in there…It's all so boring" (Davies, Wright, Drake & Bunting, 2009, pg.29). Some suggested more of a youth club atmosphere rather than clinical environment, with access to leisure activities and punchbags, for example: "beanbags just to chill and relax or do meditation" (Tatlow-Golden & McElvaney, 2015, pg.5).

Normalising

Where steps were taken to normalise experiences of distress and MH needs, this was highly valued, for example knowing a peer was also in therapy, or seeing other children in the therapy setting (Davies, Wright, Drake & Bunting, 2009, pg.29). The value of group therapy was consistently highlighted, as it helped CIC know they were not alone in their distress (e.g., Johnson & Menna, 2017, pg. 96). Ultimately, CIC seemed to yearn for 'normal' experiences and care: "treat them like the way you would your own child, or any child" (Tatlow-Golden & McElvaney, 2015, pg.5). One carer suggested reducing stigma through attending appointments in a primary care setting: "at the doctor's office…it's nobody's business" (Jee et al., 2014, pg. 552). One recommendation was to develop a new term that is not 'mental health', instead naming services "Chat if you want" (Tatlow-Golden & McElvaney, 2015, pg.5).

Empathising

Empathising emerged as an important quality, required to offer sensitive and valuable support to CIC seeking help from services, observed in different forms throughout included studies. Being empathised with by MH professionals was acknowledged as helpful in feeling heard and cared for by CIC. Adults could call on greater empathy had they lived experience of care, according to numerous accounts: "Because both…have been in my shoes…they know what I'm going through" (Johnson & Menna, 2017, pg.96); "people who live in care have more insight into what it's been like in care. I reckon that counts for a lot" (Stanley, 2007, pg.262). Some CIC also showed empathy for therapists and the difficult task they had connecting with impenetrable young people: "they wouldn't really know what's going on in your head 'cause you find it so hard to open up" (Tatlow-Golden & McElvaney, 2015, pg.4).

Choice and control

In contrast to feeling coerced (theme one), some CIC recognised and appreciated being offered opportunities for choice and some control, which helped facilitate safe engagement with MH services. Children gained this from being able to collaborate in agenda-setting during therapy: "you can talk about anything" (Tatlow-Golden & McElvaney, 2015, pg.4). This allowed them to feel therapy was 'done with' rather than 'done to' them. Being offered some control within therapy sessions reduced anxiety from the threat of coerced disclosure and consequent vulnerability: "I understand if there are some days you can just sit here and not say a word, I don't mind" (Wadman et al., 2018, pg.373). This lack of pressure to speak could help facilitate trust and rapport: "when I go to her, I feel that I'm not pressured into saying anything and we just build our way into the conversation" (Stanley, 2007, pg.261). Otherwise, being given choice over timings and location of appointments with therapists was helpful: "it kind of made me feel as if I was in some form of control, and if I didn't want to go that was no problem" (Tatlow-Golden & McElvaney, 2015, pg.4).

Connecting

This theme presents descriptions of building positive relationships and connections through the help-seeking process and in interactions with MH services and the benefits this brought in helping CIC engage in the process of accessing effective support. Subthemes in this theme are: *Listening, hearing, Trust* and *Building attachments.* Overall, seven studies contributed to this theme. Either four or five papers contributed to each subtheme here (see *Appendix 1-A*).

Listening, hearing

CIC in some studies highlighted the importance of feeling attended to and heard during their engagement with MH services. As well as suggestions for best practice, this also encompassed different experiences of the therapeutic relationship; a counterpoint to the sense of disempowerment outlined in theme three. One CIC suggested the best way to understand their feelings was "by listening hard" (Davies, Wright, Drake & Bunting, 2009, pg.28). Care-leavers in one study highlighted the need to prioritise listening over being fixed in therapy: "just be there and listen…cause everything they say is important" (Tatlow-Golden & McElvaney, 2015, pg.5). CIC suggested it was important for professionals to hear their needs and offer person-centred support: "I think they need to try and meet the individual needs of the young people" (Fargas-Malet & McSherry, 2018, pg.587). The importance of non-judgemental listening was also highlighted by carers (Jee et al., 2014, pg.550).

Trust

Where trust was developed in MH services and professionals, this was hugely beneficial to the process of help-seeking. This quality was discernible across studies where CIC and carers reported positive engagement with services. Continuity of care was seen as vital to building trust, as observed by one carer: "they would feel most comfortable discussing things or problems with the counsellor who they are familiar with…because they

develop a bond" (Jee et al., 2014, pg.550). It was important for CIC to feel practitioners were being honest with them. One child appreciated frank honesty that might be painful rather than being misled: "look, your mam isn't here today, because she's more than likely having a drink somewhere" (Tatlow-Golden & McElvaney, 2015, pg.5). For CIC, engagement was helped by perceived integrity: "some of them now, aren't in it for the money… they genuinely love working with kids" (Tatlow-Golden & McElvaney, 2015, pg.4). Carers and therapists with lived experience were seen as particularly credible: "(they) have been in my shoes…they know what I'm going through" (Johnson & Menna, 2017, pg.96). Trust in the system could grow over time: "I realize that they do help you, they do want the best for you, and they don't want you to fail, they want you to succeed" (Johnson & Menna, 2017, pg.96).

Building attachments

The importance of taking time to build meaningful relationships was repeatedly acknowledged across studies. Carers suggested professionals could only effectively help CIC once they had taken the time to get to know them: "you can't just jump in…with both feet, can you?" (Davies, Wright, Drake & Bunting, 2008, pg.28). Several carers suggested building a safe connection with a young person through joint work including the carer: "if you're going to live there…it would be wonderful if we could all talk together and still be friends" (Jee et al., 2014, pg.551). Some CIC expressed how much easier it was to talk about problems with those they had built a connection with, for example family and carers. Here, the need for a key attachment figure was made clear: "That one person who knows you inside and out" (Tatlow-Golden & McElvaney, 2015, pg.5).

Discussion

The present review enables consideration of barriers to accessing MH services from CIC and foster carer perspectives, pointing a way towards meeting the needs of CIC. By

utilising the meta-ethnographic methods outlined by Noblit and Hare (1988), five main themes were developed from included studies. Quality of included studies was mixed, although none were appraised as poor. Most themes included representation from a large majority of studies, whereas the fifth theme was developed from seven of the ten papers. This would suggest that most of the studies presented findings that were conceptually reciprocal on the whole. Although it would be unhelpful to claim generalisability across this population due to the limited amount of included studies, this apparent reciprocity would appear important and lend validity to the findings of the present synthesis.

Recognising the five themes as focusing largely on emotive and relational expressions of CIC whilst seeking help for distress, the potential origin and maintenance of these dynamics will be considered here. It seems pertinent in this regard to draw parallels between the consequences of common traumatic experiences of CIC and broadly negative experiences described in CIC and foster carer interactions with MH services.

Childhood ACEs, such as abuse and neglect, as commonly experienced by CIC (Simkiss, 2019), have been theorised as frequently leading to development of early maladaptive schemas (EMS: Young, 1990, 1999). EMS have been characterised as self-defeating patterns of relating to and understanding the world and others, set down in childhood and repeating across the lifespan (Young, 1990, 1999). For example, Lumley and Harkness (2012) highlighted connections between physical abuse and emotional deprivation, isolation and vulnerability schemas. Jenkins, Meyer and Blissett (2013) linked emotional and sexual abuse to mistrust/abuse and abandonment/instability schemas. In the present review, themes were categorised by perceptions of threat, fear and neglect. The repeated emergence of these responses raises the question as to how far potential EMS are stimulated by - or even reinforced by – attempted engagement with MH services. The analysis also yielded

experiences and ways of relating that served to offset these difficulties. The question arises as to how such exceptions can be recognised and harnessed in attempting to benefit CIC.

The first theme presented examples amongst CIC of feeling attacked within the social care system and by extension, how this provoked resistance to help-seeking. Recognising this sense of threat, MH services could seek to promote a sense of safety through offering control and agency, stable, reliable relationships and normalising experiences in mitigation of stigmatisation (as detailed in the fourth and fifth themes).

A major component of this sense of safety for CIC - who are often disempowered (DoH, 2004) - is a sense of control in engaging with services. Empowerment has been described as both an ethical requirement, but also an unavoidable step in reaching mature development, often not considered by carers and social workers until too late in CIC (Munro, 2001). Children with a sense of positive self-esteem, mastery and control have been shown to manage stressful life events more easily (Rutter, 1990). Munro (2001) emphasises the need for this to be done gradually and sensitively, necessarily by someone who knows the child very well, highlighting the need for strong, lasting relationships. Consistently in the present review, CIC collaboration in agenda setting and planning of services was highlighted as valuable in encouraging engagement. As per Unrau et al. (2006), CIC should be enabled to move from help-receivers to active participants who are ‘done with’.

A recent study of stigma in foster children (Dansey, Shbero & John, 2019) highlighted the importance of positive, supportive relationships in reducing its impact on this population. The authors suggest such relationships can aid in development of a positive sense of identity and self-esteem, which was also highlighted in the present review. Efforts may be required to change perceptions of MH amongst this population, with recognition that stigma can be internalised and contribute to narratives of deficiency or guilt (Dansey, Shbero & John, 2019). Given instances of ignorance of both MH needs and services highlighted here

amongst both CIC and carers, an argument can be made that proactive psychoeducation and awareness about available therapies/services should be offered as part of the care journey.

The second theme focuses on uncertainty. Placement instability for CIC has been consistently regarded as damaging, with children who undergo repeated moves being more likely to experience attachment difficulties (Munro & Hardy, 2006) and have increased MH needs (Rock, Michelson, Thomson and Day, 2013). In the present review, MH services were denied due to the very instability that provokes such damage. Munro (2001) suggests resources should be focused on addressing this problem, meeting the identified wishes of CIC in her study (and also the present review) in aiding development of lasting relationships.

As shown in theme five, there is hope that CIC can develop trust, and experience change, in relationships. Here, explicit communication - denoting high integrity - and ethical values of practitioners, were repeatedly highlighted as important to CIC. Potentially, aversive relational histories and transitions served to provoke hypervigilance, especially within an environment often perceived as hostile (the social care system itself). CIC have been found to choose when and with whom to reveal sensitive information carefully (Stanley, 2007). As such, it may be helpful for practitioners to carefully consider how they present themselves and communicate with CIC. Jobes (2012) suggests therapeutic relationships should be formed with compassion and collaboration in mind.

Clinical and research implications

The need for greater support for carers in promoting placement stability has been recognised by social workers (Norgate, Warhurst, Hayden, Osborne & Traill, 2012). This review has reinforced the value of peer support for carers, as shown in previous research (Worthington et al., 2013). Furthermore, inter-agency/professional communication and strong networks were seen as smoothing process barriers and vital in providing continuity of care for CIC. Given feelings of being dismissed and invalidated, and that carer experience and

knowledge can be a valuable resource, carers could be included in interventions to a greater extent, through either consultation or bridging relationships. Despite involving complex dynamics, often revolving around power, professionalisation and experiential versus theoretical knowledge, this could help them feel a trusted and valuable member of a supportive team around the child (Jennings & Evans, 2020). Further to this, it has been suggested that including parents in therapeutic work with children exposed to high levels of adversity can help the development of mutually rewarding relationships (Anthony, Paine & Shelton, 2019). Due to the current need for carers to identify MH needs and promote access to services, MH training should be mandatory and thorough (Allen & Vostanis, 2005).

Neglect was compounded by a lack of personalised approaches and the serious, pervasive issue of waiting times. In the UK, service transformation agendas in the NHS (DoH, 2015) may meet some of this need, but the effects of such issues for CIC in particular are an urgent priority. The tangible barriers that make up this theme are systemic issues that should be addressed if the needs of CIC are to be met, as indicated via the fourth and fifth themes of building comfort, security, predictable stability and meaningful connection. Fundamentally, many of these issues arise from too great a difference between demands and resources, although as reported here, there are steps MH services and professionals can take to encourage such connections in CIC and carers. This may come about partially through recognising the reactions of CIC potentially arising from EMS and the consequences of childhood ACEs. The formulation skills available to clinical psychologists may play a helpful role in identifying such patterns and consequent systemic dynamics, working towards promoting practices highlighted in this review that were viewed as enabling easier access to and engagement with MH services for CIC.

Further research might explore what qualities or actions make therapists likeable, relatable and trustworthy. Further research including CIC with the aim of developing services

would be valuable. Furthermore, research exploring whether there is a relationship between help-seeking and EMS, or what such a relationship might look like, may prove illuminating.

Limitations

This meta-synthesis has certain limitations. Ultimately, available research literature is limited, unfortunate given the frequency of MH needs in CIC and likelihood of significant lifelong impact. However, the included studies were largely complementary and served to highlight seemingly common occurrences. Given the diversity of studies' country of origin (including UK nations, USA, Canada and Ireland), the broadly complementary nature of findings suggests there could be generalisable elements to the framework of understanding presented here, in explanation of barriers to help-seeking amongst this population. Given the connection suggested here between schema and relational patterns developed as a result of ACEs and engagement with MH services, it logically follows that where such phenomena exist these broad patterns could emerge. Furthermore, they should consequently be recognised and accounted for. However, the limited number of studies included here should prompt caution as to this generalisability and further research is indicated.

Conclusion

The qualitative approach and diverse sample included in the present review has allowed insight into some of the barriers and enablers to CIC accessing MH services. As stated, this may influence how practitioners and carers reflect on the attitudes and behaviour of participants in this system and how to helpfully respond, shown to involve communication, connection, trust and stability. The main question arising from this review is around how far patterns of distress and struggling to trust or connect, so often developed by CIC through difficult childhood experiences, may be triggered or reinforced through common experiences in the help-seeking process. It is hoped that awareness of the potential for unhelpful dynamics outlined here may lay the foundations of considered responses and greater understanding.

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Appendix 1-A: Summary of theme development during synthesis

Theme 1: Feeling threatened			
Article	First order constructs (examples)	Second order constructs	Subthemes & third order constructs
Fargas-Malet, M. & McSherry, D. (2018)	'they don't take enough time and effort to actually see what's wrong'	Barriers are practitioners not taking time to know children, as well as putting pressure on them to engage	***Coercion and therapy*** Therapy, rather than supportive and containing, can feel restrictive and threatening.
Jee, S.H., Conn, A., Toth, S., Szilagyi, M.A. & Chinn, N.P. (2014)	'when you force some kids to talk about things they really, really don't want to, it causes more damage than it does good'	Children resent feeling compelled into therapy and this can be harmful	Pressure from professionals to engage and coerce could feel damaging.
Johnson, E. & Menna, R. (2017)	Children reported no choice in attending therapy or not. Negative experiences reported from talking about problems.	Lack of choice to attend or not was a barrier, trust and awareness are helpful.	MH support was imposed rather than a collaborative process. This leads to CIC often rejecting therapy as a burden on their time and diminishes the chances of it being found helpful.
Root, K.M, Unrau, Y.A. & Kyles, N.S. (2018)	Children had felt 'forced to seek help'	Being forced builds up resistance to engage in help seeking.	
Stanley, N. (2007)	'you've got to talk to this person; you've got to sort your problems out'	Lack of choice and control is unhelpful and a barrier in accessing services	
Tatlow-Golden, M. & McElvaney, R. (2015)	'they tried to force me'. Reports of coercion by professionals and caregivers, professionals setting the agenda, feeling rushed into opening up.	Coercion contributed to an atmosphere of scrutiny and constraint for children accessing services	

Davies, J., Wright, J. & Drake, S. & Bunting, J. (2009)	Talking about mental health and difficulties with therapist can provoke anxiety and leave children sad, angry or otherwise emotionally dysregulated.	These responses could be expected early in therapy. Building trust may help to manage this emotional response	***Opening up*** For CIC, opening up about inner pain and past trauma through therapy could contribute to a sense of vulnerability. When experienced in this way, therapy became upsetting, damaging, and ultimately threatening, which meant CIC tended to disengage or react angrily.
Fargas-Malet, M. & McSherry, D. (2018)	Foster carers described children being reluctant to talk about their feelings and past. Opening up was of benefit, in their opinion, when it happened	Reluctance may have stemmed from a culture of not wanting to talk, not feeling mentally well, and stigma.	
Jee, S.H., Conn, A., Toth, S., Szilagyi, M.A. & Chinn, N.P. (2014)	Engaging in treatment triggered distressing memories. Therapy work stimulated anger and high levels of distress: 'when she went to therapy and started bringing up all this stuff, she started freaking out'	Triggering of distressing memories led to reluctance to engage. Long repressed feelings are hard to manage and could lead to resistance to engage or continue attending.	
Root, K.M, Unrau, Y.A. & Kyles, N.S. (2018)	The process of opening up was exhausting and an effort, especially if multiple times, since MH needs are minimised/not dealt with.	Engaging in talking therapy could be stressful effort without relief from the distress.	
Tatlow-Golden, M. & McElvaney, R. (2015)	Children find it hard to open up and have felt rushed into opening up without trusting the therapist: 'I was like: "I can't do this anymore"'	Having to disclose trauma to multiple professionals could be re-traumatising. The need to open up led to resistance from young people.	
Wadman, R. et al. (2018)	"I find it extremely difficult to talk to people". Disclosures provoked anger and fear. Disclosing difficulties was threatening in various ways, including increased scrutiny and interference in your life.	Not having experience of a consistent, reliable adult figure contributed to reluctance to talk, children felt rejected or abandoned. Professionals should acknowledge the difficulty of opening up for CIC.	

Davies, J., Wright, J. & Drake, S. & Bunting, J. (2009) Fargas-Malet, M. & McSherry, D. (2018) Jee, S.H., Conn, A., Toth, S., Szilagyi, M.A. & Chinn, N.P. (2014) Johnson, E. & Menna, R. (2017) Stanley, N. (2007) Tatlow-Golden, M. & McElvaney, R. (2015)	Children actively avoided telling peers they attended therapy. Children reluctant to talk about distress in terms of MH due to stigma. MH service engagement brings the fear that peers will treat children differently: 'They see you going in there, they would be like: "Oh, she crazy!"'. Foster care is also a label with social bias. Children experienced stigma from being in care and attending therapy: 'I don't like how they'll just treat me differently' 'you're scum' 'Everybody thinks that you're schizo, you're mental, but you're not'. 'I was ashamed, there's such a stigma around it. Kids in care, you're not normal'	Therapy does not take place in a vacuum in terms of social context Stigma is associated with feelings of embarrassment, guilt and fear as a barrier to talking about mental health. Being in care and accessing MH services compound each other as a dual stigma for CIC that acts as a strong barrier to engaging in therapy. Stigma acted as a barrier to engagement with MH services Discriminatory attitudes from being in care affected CIC's ability to confide in friends and seek help. There is a double stigma of being in care and having MH difficulties, which caused shame, affected relationships and openness.	***Stigma*** There was a dual stigma of being in care and receiving MH support. Stigma around receiving support led to not seeking support for MH needs in some cases. Felt stigma arose from the environment around CIC, including history of MH distress within families. This contributed to internalised stigma, presenting a further barrier to engaging with MH services.
Fargas-Malet, M. & McSherry, D. (2018)	Carers claim CIC can refuse professional help and are emotionally damaged.	Implication more should be done to engage CIC due to the emotional damage preventing their engagement, Services being rejecting of CIC	***Pushing people away*** CIC pushing people away may be a result of the sense of threat highlighted in this theme, as well as

Jee, S.H., Conn, A., Toth, S., Szilagyi, M.A. & Chinn, N.P. (2014)	CIC are discharged easily: 'if you miss three appointments, forget about it'	Negative first impressions led to general resistance to engage any further in therapy, leading to suboptimal therapeutic relationships.	attachment histories and schema prevalent in this population. Examples reveal perception of such barriers to connection between parties in this system (i.e., children, carers and MH professionals).
Johnson, E. & Menna, R. (2017)	Carers report CIC do not engage in therapy willingly. 'I just tell them whatever they want to hear to get them off my back'	Connections were observed between not wanting to talk and not enjoying therapy. Not wanting to talk was compounded as a barrier by CIC's lack of problem recognition about their MH or benefit of talking to others.	
Miller, R.M. et al. (2020)	'it's him who needs the counselling'	The barrier to accessing support can be at the carer level – frustration at lack of direct support and systemic interventions.	
Tatlow-Golden, M. & McElvaney, R. (2015)	Some children did not want to talk about their problems in therapy. Problems occurred when not knowing when to ask for support or trying to deal with distress alone: 'I try to stop crying and tell myself to suck it up' 'they wouldn't really know what's going on in your head, because it's so hard to open up'.	CIC recognised they could appear impenetrable, making therapy a difficult task for professionals.	
Wadman, R. et al. (2018)	Pushing away others as CIC can have no experience of reaching out for help. If they do, professionals can seem to not listen or interact: 'they don't really interact with you, they just sit there with their notebook'	Pen and paper is a barrier to empathetic connection from CIC point of view	

Theme 2: **Uncertainty and mistrust**			
Article	First order constructs	Second order constructs	Subthemes & third order constructs
Fargas-Malet, M. & McSherry, D. (2018)	Carers complained that changes in staff members slowed down referrals Children found it difficult having to tell their stories again and again.	Instability was portrayed as a problem with communication amongst health care professionals contributing to lack of consistency and a fractured experience in services.	***Instability*** Instability in the lives of CIC was a consistent and significant barrier to gaining MH support. Changing staff and placements meant children did not have the opportunity to form enduring, trusting relationships with those who might help. Carers recognised the fallacy of this trend within the system that was supposed to help.
Tatlow-Golden, M. & McElvaney, R. (2015)	'There's so many people in and out of your life'	Lack of consistency in people around the CIC and lack of consistency in expectations led to insufficient time for relationships to build up. This was central to many CIC accounts.	
Wadman, R. et al. (2018)	'I'd moved to a different placement and everything was moving so fast, and I just didn't have no control in my life'. Instability served to increase distress and provoked self-harming	Moving placements led to loss of control, independence, and supportive relationships	
York, W. & Jones, J. (2017)	Carers reported times of transition were particularly difficult and increased anxiety for CIC. 'after the initial assessment there was a change in professional – the girl didn't go back…they lost her…you can lose a teenager by turning him or her over to someone else'	Transitions were representative of broader instability for CIC. Further to disengaging, young people can be lost in the sense of not being followed up by the service	

Davies, J., Wright, J. & Drake, S. & Bunting, J. (2009) Fargas-Malet, M. & McSherry, D. (2018) Jee, S.H., Conn, A., Toth, S., Szilagyi, M.A. & Chinn, N.P. (2014) Johnson, E. & Menna, R. (2017) Stanley, N. (2007)	Children were anxious not knowing what to expect from therapy or a new therapist Unsure of process of therapy - what will they want from me? Adults highlighted a lack of information about services. Some CIC were unclear why they were referred to a particular therapist Children unsure of role of fostering agency 'sometimes, it would be nice for them to give you a little feedback'	Children were unsure of the purpose of therapy or what it would be like. Uncertainty added to reluctance to engage Not knowing sat alongside being unwilling to engage Misunderstanding these avenues of support led to not seeking help Carers not knowing what happens for CIC in therapy has implications for their own support	***Not knowing*** Lack of comprehension of the help seeking system, MH services and MG contributed to CIC's mistrust. Carers shared this lack of awareness, which hindered the help-seeking process and undermined carer investment in the MH and care system.
Fargas-Malet, M. & McSherry, D. (2018) Jee, S.H., Conn, A., Toth, S., Szilagyi, M.A. & Chinn, N.P. (2014) Miller, R.M. et al. (2020)	Carers lost trust in MH services – not convinced CIC will make it through waiting lists. Children lose trust by experiencing changing therapists. Social workers might feasibly hide resources from carers and children. CIC perception therapists have poor motives for helping: 'they just be doing it for the money'. Therapists have different life experiences 'I've never felt I can actually trust somebody to reach out, so I don't'.	Carers and adults present barriers due to previous experiences that make them doubt MH provision. Scepticism about reasons for being a therapist contributed to sense of mistrust and not being able to relate to CIC. Mistrust in the system and available support from carers	***Mistrust*** Mistrust in services and the system as a whole by CIC and carers was the result of experiences trying to seek help, and an artefact of past relationships for these children. CIC could be acutely aware of MH professionals' motivations for helping, and their integrity was repeatedly brought into question. Carers were also guarded due to past experiences and their own status in comparison to MH practitioners. Their lack of faith and trust in the system could undermine the

Root, K.M, Unrau, Y.A. & Kyles, N.S. (2018)	'lack of genuineness of by professionals trying to help'	Perceiving lack of genuineness fuels resistance to access MH services, contributing to fears of being judged, rejected, or 'having the help thrown back in their face'	likelihood of CIC accessing services successfully.
Stanley, N. (2007)	'what do you think you're playing at, it was like confidential, talking to you confidentially and you go away, you fucking put it on paper'	Confidentiality was linked to the need to exert some control over the help seeking process	
Tatlow-Golden, M. & McElvaney, R. (2015)	CIC felt mistrusted by carers about legitimacy of their distress. Mistrust of school counsellor training in MH. Some staff lack motivation or empathy. Therapists are being paid to help.	Mistrust of CIC about capacity and ability of adults they encounter to help them or understand properly is a barrier to their seeking help. Questionable motives of MH professionals added to this – mistrusting their intentions or validity.	
Wadman, R. et al. (2018)	'Every single system I used has let me down…I don't trust services' Disclosing self-harm would lead to negative consequences.	CIC feeling let down by services generally, leading to alienation from the system Context and history of support leads to fear of sanction or mistrust in the adults in CIC lives.	
Theme 3: **Neglected and alone**			
Article	First order constructs	Second order constructs	Subthemes & third order constructs
Fargas-Malet, M. & McSherry, D. (2018)	'I just kind of deal with it myself because it passes'; 'Bottle it up for a couple of days and it will go away'	Minimising their distress and understating need for help	***Alone***

	Or not knowing where to get help	Being alone with their distress	CIC routinely felt alone in coping with their mental distress. Carers could also feel they were struggling without support in very challenging, stressful situations and CIC who presented with complex needs.
Johnson, E. & Menna, R. (2017)	Carers stated agency workers are often busy and unavailable for some	At these times, the help isn't available	
Miller, R.M. et al. (2020)	Communication between carers and social workers could be problematic. 'None of the systems talk to each other' Perceived lack of support for carers and young people from outside services, e.g., lacking training for disclosures.	Hindering carers supporting and advocating for CIC A major barrier to carers supporting the needs of CIC, in terms of distress especially.	
Tatlow-Golden, M. & McElvaney, R. (2015)	Connecting with staff and forming relationships becomes pointless due to transitory nature of care.	Context of care discouraging relationship formation in some cases	
Miller, R.M. et al. (2020)	Attachment theory offered as a blanket explanation. CAMHS denying child's difficulties, although carers witness it.	Having your view as a carer dismissed meant important information was lost.	***Dismissed*** For CIC, there was a sense of feeling dismissed by MH 'experts', who enjoyed special social status or adhered to their own theory and knowledge, disconnected from the difficult lives of the children. This resulted in an alienation that undermined therapeutic rapport. This feeling of needs and experience being dismissed and invalidated compounded the overwhelming disempowerment of CIC in their lives. Carers also reported a similar pattern of feeling disenfranchised within MH help-seeking systems at times.
Root, K.M, Unrau, Y.A. & Kyles, N.S. (2018)	'it was difficult to relate to the therapist' 'until a certain age a lot of your decisions are made for you'	Power differentials and class issues could underlie barriers between the CIC and therapist. CIC also feel disempowered, as part of the care system, but also as a result of the expert, saviour stance of MH professionals.	
Tatlow-Golden, M. & McElvaney, R. (2015)	'not many children in foster care get listened to' Some staff thought self-harm was pretend distress	Professionals need to go beyond listening to children and actually hear them	

Wadman et al. (2018)	'she was nice, but she was just incredibly patronizing'	Therapist could be patronising and infantilising, as well as failing to listen well.	
York, W. & Jones, J. (2017)	Carers felt not listened to by professionals	Lived experience of carers dismissed by 'experts', meaning they feel devalued	
Davies, J., Wright, J. & Drake, S. & Bunting, J. (2009)	More contact with therapists would be helpful according to CIC and carers.	It takes time to build a relationship	***Neglected*** The sense of neglect from MH services towards CIC arose throughout findings. This emerged through reports of disengagement/reluctance to engage or maintain contact. Inflexibility and unsuitability of generic interventions or hypothesising contributed to this sense of not being attended to in terms of individual needs. Also, in reports of lengthy waits for therapy or consultation.
Fargas-Malet, M. & McSherry, D. (2018)	Carers stated services displayed a lack of effort in engaging CIC, including in terms of relationships and waiting times.	Significant barriers are located within health services themselves, rather than CIC reluctance.	
Miller, R.M. et al. (2020)	'What we get a lot of is…there's nothing wrong with them' Long delays getting support for carers and CIC	CIC with significant needs could be failed by the system because they were not referred or accepted at referral.	
Tatlow-Golden, M. & McElvaney, R. (2015)	'When I needed it most they weren't there' 'the emotions that young people experience going through care. None of that is dealt with'	Services should be targeted at levels of need appropriately, without having to wait. Some CIC were let down by services	
York, W. & Jones, J. (2017)	Long waits for carers to get support from MH services.	Barriers seemed to be not at the referral stage, but when already accepted into MH services.	

Theme 4: **Lifting barriers**			
Article	First order constructs	Second order constructs	Subthemes & third order constructs
Davies, J., Wright, J. & Drake, S. & Bunting, J. (2009) Fargas-Malet, M. & McSherry, D. (2018) Jee, S.H., Conn, A., Toth, S., Szilagyi, M.A. & Chinn, N.P. (2014) Johnson, E. & Menna, R. (2017) Tatlow-Golden, M. & McElvaney, R. (2015) Wadman et al. (2018)	Physical environment and comfort matter. More fun activities would be good. Accessibility is important and services could be local or home visits. MH services should be delivered in a primary care setting. Youth feel comfortable in a setting they know. Make therapy more 'natural' Recommendations from young people of being flexible with labelling and describing the service – not 'MH'. Changing the setting to feel more relaxed and inviting. 'she went out of her way to make me feel comfortable'. Activities can be helpful to detract from difficult talk.	The environment and context mattered and were linked to the therapist and therapy inextricably Removing barriers of physical location The familiar primary care setting might feel safer. Also, widely available geographically Improving natural feel would encourage children to engage with MH services Informal service settings would encourage engagement with young people, make them more inviting and suggest control Individual therapists can help children feel comfortable and at ease in sessions through their manner and content.	***Comfort*** Being made to feel comfortable either through demeanour, altering the image of therapy, or adapting the physical environment could work to weaken some of the defences of CIC highlighted above.
Davies, J., Wright, J. & Drake, S. & Bunting, J. (2009)	Knowing a peer in therapy helps	Ambiguous between keeping therapy private or telling others, but knowing others in therapy is definitely a benefit for these children	***Normalising*** CIC particularly valued efforts to normalise their experience of mental distress. This worked in direct

Jee, S.H., Conn, A., Toth, S., Szilagyi, M.A. & Chinn, N.P. (2014) Johnson, E. & Menna, R. (2017) Tatlow-Golden, M. & McElvaney, R. (2015)	Presenting therapy as just another doctor's appointment might feel more acceptable to children. Group therapy with others in care would reduce stigma. Group therapy could be enjoyable because others had similar experiences. Therapists should treat CIC in therapy as they would all other children. Use 'Chat if you want' not 'Mental health'	Suggestions to reduce stigma of attending a routine setting and joint experiences with peers to normalise therapy. Suggestion to encourage help seeking by making it appear more acceptable. Improving equity to reduce stigma, feelings of difference. Reducing formalness	contrast to the powerful forces of stigmatisation around MH and being in care.
Jee, S.H., Conn, A., Toth, S., Szilagyi, M.A. & Chinn, N.P. (2014) Johnson, E. & Menna, R. (2017) Miller, R.M. et al. (2020) Stanley, N. (2007) Tatlow-Golden, M. & McElvaney, R. (2015)	Carers recognise child need more time to process information in therapy and long repressed feelings can be hard to manage. CIC would prefer to seek help from someone who could understand their situation past and present. 'you feel everything they do' – carers empathising with CIC disclosures. People who lived in care know what it's like, relevant experience means you know how to respond. 'they wouldn't really know what's going on in your head' Some therapists give you time and space Children really need to feel understood.	CIC struggles in therapy are to be expected in some ways. It's very important that young people have trusted people in their networks who can empathise with them. Secondary trauma can result from close working with traumatised young people. It is important to provide positive role models of survivors of care, with expert, lived experience. Therapists working with CIC are at an inherent disadvantage due to them being closed off.	***Empathising*** The ability to empathise was implicitly connected in the mind of some CIC to the validity of practitioners, e.g., whether they had lived experience, or their level of experience. This seems related to issues of trust and hypervigilance around strangers for CIC.

Davies, J., Wright, J. & Drake, S. & Bunting, J. (2009)	Children's control of sessions, such as the agenda.	Interpreted by carers as need to maintain control to avoid upsetting feelings, but recognised by one child as helpful, although recognising containing authority of therapist.	***Choice and control*** The feeling of being offered choice and control facilitated a safer engagement with services. CIC with a sense of control felt 'done with' rather than 'done to', easing anxiety about disclosure and leading to greater trust in the practitioner and process of letting others in to help.
Stanley, N. (2007)	'I'm not pressured into saying anything'	Choice and control were important for CIC, facilitated through an unpressurized approach.	
Tatlow-Golden, M. & McElvaney, R. (2015)	Some therapists offer choice, control, which is a contrast to others. Setting the agenda and flexible timings help.	Ways to help CIC feel more in control to help them feel comfortable in therapy.	
Wadman et al. (2018)	'some days you can sit here and just not say a word'	Having this control is part of a positive relationship where the CIC feels at ease.	
Theme 5: Connecting			
Article	First order constructs	Second order constructs	Subthemes & third order constructs
Fargas-Malet, M. & McSherry, D. (2018)	CIC need to open up to somebody they feel 'comfortable' with. It's easier for them to talk to family and carers usually.	When feeling comfortable, embarrassment, insecurity or guilt were not barriers, as otherwise.	***Trust*** Trust was reported across studies where CIC and carers reported positive experiences of accessing MH services, and this could be described as fundamental to its success.
Jee, S.H., Conn, A., Toth, S., Szilagyi, M.A. & Chinn, N.P. (2014)	CIC feel more comfortable talking with someone they are familiar with. continuity of care with the same therapist is central to this. CIC feel better opening up to families and carers.	Mistrust is often a barrier to engaging with MH services, these are exceptions where trust was formed. Stability of practitioner is very important.	

Johnson, E. & Menna, R. (2017)	Practitioners with lived experience could be trusted 'they've been in my shoes'. 'I realize that they do help you'	Importance of having trusted individuals in support networks of CIC. Also, changing perception of the system over time, gaining trust where previously when younger, they felt misunderstood.	
Tatlow-Golden, M. & McElvaney, R. (2015)	Some professionals are genuine and lovely. 'aren't in it for the money'. CIC appreciated being told the truth. Building trust takes time.	Integrity of practitioners is important – not misleading. CIC were sensitive to motivations and intentions of therapists.	
Wadman et al. (2018)	Calling a friend is a last resort – not services.	Some children turn to those they can trust for help.	
Davies, J., Wright, J. & Drake, S. & Bunting, J. (2009)	Therapists understand your feelings 'by listening hard', and pacing is important.	Children appreciated their feelings being understood by the therapist	***Listening, hearing*** Being heard and having needs recognised within MH services and the wider care system was acknowledged via some accounts in the literature. This was a noteworthy sign of helpful and positive experiences gaining MH support, standing in contrast to disenfranchisement elsewhere.
Fargas-Malet, M. & McSherry, D. (2018)	'they need to try and meet the individual needs of the young people'	Importance of not assuming about young people and taking time to know them.	
Jee, S.H., Conn, A., Toth, S., Szilagyi, M.A. & Chinn, N.P. (2014)	Non-judgemental listening important according to carers	Central aspect of learning to trust adults.	
Tatlow-Golden, M. & McElvaney, R. (2015)	'just be there and listen…'cause everything they say is important'; 'just sit down and listen to what they have to say'	CIC want to be listened to in therapy and understood, including to their reasons for being in care and struggling.	
Davies, J., Wright, J. & Drake, S. & Bunting, J. (2009)	The relationship with the therapist makes me happy. One child did not want separation from the therapist.	Positive relationships can form with the therapist and children can become attached. Carers think the connection is vital to therapy	***Building attachments*** Accounts of CIC building lasting, trusting relationships with people who knew them really well and they

	The therapy only starts once rapport has been developed, which takes time.		could learn to rely on for support stood out amongst studies. It felt safer to disclose and share private experiences where this connection had been made.
Fargas-Malet, M. & McSherry, D. (2018)	Carers felt children need a long-lasting professional relationship.	Young people will be able to invest in the relationship	
Jee, S.H., Conn, A., Toth, S., Szilagyi, M.A. & Chinn, N.P. (2014)	'it would be wonderful if we could all talk together'.	Working alongside carer and CIC could help promote a safe therapeutic relationship and bring the family together as allies in problem-solving, prior to one-to-one counselling.	
Miller, R.M. et al. (2020)	Some CIC and carers had positive relationships with social worker	In these cases, social worker acknowledged as central to their support	
Tatlow-Golden, M. & McElvaney, R. (2015)	Children need 'that one person'	Ideally, CIC wanted services, staff and professionals who would listen, understand, and care, that they could count on.	

Appendix 1-B: Author guidelines

Adoption & Fostering Author Guidelines

Journal Description

Edited by Roger Bullock (Fellow, Centre for Social Policy, The Social Research Unit at Dartington, UK) and managed by Miranda Davies, *Adoption & Fostering* is a quarterly peer reviewed journal which has been at the cutting edge of debate on childcare issues for over 50 years. It is the only UK journal dedicated to adoption and fostering issues, providing an international forum for a wide range of professionals: academics and practitioners in social work, psychology, law, medicine, education, training and caring for children and young people.

As the official journal of the CoramBAAF Adoption & Fostering Academy, the UK's leading adoption and fostering charity, the journal supports CoramBAAF's aims of promoting the highest standards of practice in adoption, fostering and childcare services, to increase public understanding of the issues and to provide an independent voice for children and families, disseminating new research and practice developments, informing and influencing policy-makers, all those responsible for children and young people, and public opinion at large.

In addition to informative and thought provoking articles from around the world, *Adoption & Fostering*offers regular legal notes and health notes prepared by dedicated practitioners and professionals concerned with the welfare of looked after children and young people in the UK.

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Each issue of the journal features around 12 pages of legal notes prepared by experts in England & Wales, Northern Ireland and Scotland. These include commentary on specific cases and for Scotland, recent developments and updates in the law.

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"*Adoption & Fostering* Journal is essential reading for all those involved in adoption and fostering, and is read and valued right around the world."

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"As a practitioner, *Adoption & Fostering* is always the journal I turn to first. Virtually all the content has immediate relevance. Also, back copies spanning some 40 years provide an invaluable record of how research and practice have developed in the UK and overseas."

David Pitcher, Family Court Adviser and Children's Guardian, Child and Family Court Advisory and Support Service (Cafcass)

Chapter 1 Aims and Scope

Adoption & Fostering is the only quarterly UK peer reviewed journal dedicated to adoption and fostering issues. Edited by Roger Bullock (Fellow, Centre for Social Policy, The Social Research Unit at Dartington), it also focuses on wider developments in childcare practice and research, providing an international, inter-disciplinary forum for academics and practitioners in social work, psychology, law, medicine, education, training and caring.

This journal is a member of the Committee on Publication Ethics (COPE).

Manuscript Submission Guidelines:

This Journal is a member of the Committee on Publication Ethics

Only manuscripts of sufficient quality that meet the aims and scope of *Adoption & Fostering* will be reviewed.

There are no fees payable to submit or publish in this journal.

As part of the submission process you will be required to warrant that you are submitting your original work, that you have the rights in the work, that you are submitting the work for first publication in the Journal and that it is not being considered for publication elsewhere and has not already been published elsewhere, and that you have obtained and can supply all necessary permissions for the reproduction of any copyright works not owned by you.

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Chapter 2: Research paper

Team formulation for foster carers: a qualitative analysis

Thomas Speight

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

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All correspondence should be addressed to:

Thomas Speight

Doctorate in Clinical Psychology

Division of Health Research, Furness College

Lancaster University

Lancaster

LA1 4YF

Tel: 01524 595970

Email: tspeight1@lancaster.ac.uk

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Abstract

Foster care has been described as a highly challenging role, with carers facing multiple stressors. One aspect of this is managing emotional and behavioural challenges presented by children in care (CIC). As such, research has focused on interventions seeking to provide support and training to carers, as well as improve understanding of the emotional needs of CIC through reflective function; the ability to understand others' thoughts and feelings. One approach implemented recently in the UK has been team formulation (TF). Despite being described as an effective support tool across health and social care settings, this approach has not been studied in a foster care context. This research aimed to explore foster carers' experiences of using TF in support of placements and the impact on their understanding, relationships and coping. Interpretative Phenomenological Analysis was employed to examine semi-structured interview data gathered from four foster carers who had taken part in TF. This yielded four superordinate themes: 1) Firefighting, 2) Everyone's in my corner, 3) It's another world for me, 4) It's not set in stone. Foster carers expressed that TF served to meet many of their previously unmet needs, including providing a source of validation, professional respect, a route to effective learning and growth, and highly adaptable utility. Based on this, clinical implications are recommended.

Keywords: children in care, foster carers, team formulation, IPA

Team formulation for foster carers: a qualitative analysis

Recent statistics around foster care in the UK suggest an increasingly difficult field in which to work, with increasing demand annually. In recent years, numbers of placements increased at a slower rate than demand, according to latest figures from the UK (Ofsted, 2019). Children in care (CIC) often have a history of neglect or abuse, which has been shown to contribute not only to poor outcomes in several life domains, but neurobiological effects that impact across the lifespan (McCrory, De Brito & Viding, 2011). The National Institute for Health and Care Excellence (NICE) suggest that 45% of children in foster care may fit the criteria for a mental health (MH) diagnosis (NICE, 2013). The benefits of stable foster placements, of providing CIC with stable attachment relationships and consequently benefitting children's MH and long-term outcomes in life, have been widely acknowledged (Social Care Institute for Excellence, 2017). Conversely, placement instability denies CIC an opportunity to develop such reparative, healing relationships.

Foster care has been described as a challenging, multi-faceted occupation, requiring patience, resilience and compassion alongside specialised training and knowledge of policy and legislation (Narey & Owers, 2018). Research has shown the potential for high levels of stress amongst carers (Harding, Murray, Shakespeare-Finch, & Frey, 2018). With research connecting placement breakdowns to the emotional and behavioural challenges of CIC (Rubin et al., 2007), interventions are often aimed at foster carers' ability to understand and consequently meet children's emotional needs (Wotherspoon, O-Neill-Laberge & Pirie, 2008). This can lead to development of attachment relationships, with CIC wellbeing associated with carers acting as a secure base (Schofield & Beek, 2005). As such, foster carers require training and support towards understanding the impact on children of neglect and trauma over time (Murray, Tarren-Sweeney, & France, 2011). Reflective practice has

been used to meet this need, as well as facilitating discussion of the impact of the role on carers themselves, reducing their stress burden (Onions, 2018).

Recently, research has focused on interventions promoting reflective function (RF); parental understanding of children's thought processes and motivations for behaviour (Redfearn et al., 2018). Carers' ability to utilise RF through mentalising can facilitate growth within an attuned, dependable relationship. Research has shown that attachment, behaviours of concern and foster placement breakdowns are connected to carers' capacity to mentalise (Cooper & Redfearn, 2016). Further research has shown lower mind-mindedness (an associated relational construct pertaining to caregivers' language in relation to children: Meins, Fernyhough, Fradley & Tuckey, 2001) in foster carers than biological parents (Fishburn et al., 2017). This suggests mind-mindedness in birth parents is more easily expressed, highlighting the scale of the challenge facing foster carers. Furthermore, during moments of high arousal and stress, caregivers' mentalising ability can also be massively reduced (Onions, 2018; Redfearn et al., 2018).

Given the significance of such factors for CIC, a number of recent interventions have targeted promotion of parental mentalising ability. For example, Mentalization Based Treatment for Children and Families (MBT-CF) (for a review, see Byrne, Murphy & Connon, 2020). Studies have shown evidence of MBT-CF resulting in reduced psychological distress, with benefits for parents' RF, sensitivity and attunement to children in 14 of 34 studies included in the review (Byrne, Murphy & Connon, 2020). Adolescent Mentalization Based Integrative Treatment (Bevington, Fuggle & Fonagy, 2015) is an approach that promotes mentalising within teams, aiming to promote secure attachments with 'hard-to-reach' adolescents through developing the therapeutic milieu around them.

Further interventions combine these concepts, recognising the significance of attachment, with behavioural, context- and person-specific team-based approaches.

Dozier's Attachment and Biobehavioural Catchup intervention (Dozier, Lindheim & Ackerman, 2005) is a parenting intervention recognising the impact of disrupted early attachment relationships on stress response behaviour, particularly relevant in populations of CIC. Through these programmes, parents are guided to support children's emotion-regulation, understand distress signals and respond effectively (Dozier, Lindheim & Ackerman, 2005). The approach is founded in and evaluated via empirical methods and has been shown to result in more typical cortisol production amongst CIC (a stress indicator) (Dozier et al., 2006), more secure attachments and improved emotional regulation, behavioural inhibition and impulse control (Dozier, Roben, Caron, Hoye & Bernard, 2018).

In order to address the multiple needs highlighted above, some services have recently adopted a team formulation (TF) approach involving carers and a multi-disciplinary team. Formulation is an important tool in clinical psychology practice, aimed at co-creating hypotheses and leading to discrete planning based on this shared understanding (Johnstone, 2018). TF engages a staff team collectively, allowing cohesion through interdisciplinary working (Kelly, Rhodes, Macdonald & Mikes-Liu, 2018). Research literature has highlighted benefits of TF for staff involved. For example, TF was acknowledged as helping staff from an inpatient MH service maintain positivity and empathy in the face of adversity (Dallimore, Christie, & Loades, 2016). TF helped inpatient MH staff normalise the challenges presented by young people, consider individual complexities and anticipated difficulties, as well as areas of strength and need (Price, Knowles, Greasley, & Dunn, 2016). TF has been shown to improve insight, communication, generate ideas, reduce negative reactions, reduce blame, manage risk and maintain morale (Dallimore, Christie, & Loades, 2016; Johnstone, 2018; Whitton, Small, Lyon, Barker, & Akiboh, 2016). These reported benefits may be invaluable for foster carers using this approach in better understanding and responding to the needs of CIC and reducing the stress burden.

TF has been described as helping move staff perception of young people away from narrow labels and towards seeing them as individuals (Price, Knowles, Greasley, & Dunn, 2016). Such processes may promote adoption of an empathic stance in response to children's behaviour of concern, in contrast to narratives of irreparably damaged, troubled children who are beyond help (Mannay et al., 2017). Given the challenges for foster carers employing RF highlighted above, and its relative importance in promotion of healthy attachment relationships, one aim of TF as explored in the present study was to cultivate mentalising skills and practice mind-minded talk in relation to specific CIC.

TF has been criticised as lacking evidence towards beneficial outcomes, due to heterogeneity in approaches preventing comparison (Geach, Maghaddam & De Boos, 2018). However, this flexibility has also been described as a strength of the approach. Indeed, Johnstone (2018) argues it would be an error to attempt standardised practice, due to TF's focus on exploring meaning and experience, suggesting qualitative exploration may be appropriate in examining this process.

Despite research exploring the impact of interventions promoting RF and mentalising highlighted above, no research to date has examined use of TF in this context and with these aims. Given this, as well as recognition of the need for further research into TF in action (Johnstone, 2014; Price, Knowles, Greasley & Dunn, 2016), the present study aims to explore experiences of foster carers who have engaged in TF, with comparison to previous experience and practice. Importantly, it is hoped this will facilitate exploration of levels of support, security and containment, mind-mindedness and changes to RF. Does engagement with TF help foster carers feel differently about the children they support, affect relationships, and lead to greater consideration of helpful responses to behaviour? It is hoped this study will contribute to wider research literature around support for carers of CIC and the

use of TF. Given these aims, the main research question is: 'how have foster carers experienced TF and how do they perceive the impact of engaging with TF on their fostering?'

Method

Design

A qualitative approach was determined appropriate to explore participants' experiences and meet the research aims. Interpretative Phenomenological Analysis (IPA; Smith, Flowers & Larkin, 2009) was chosen to examine experiences of foster carers who had participated in TF. IPA engages principles of idiography, phenomenology and hermeneutics, meaning it focuses on individuals' subjective experience and sense-making of their experiences. The researcher engages with this data actively, interpreting what participants are thinking and feeling given wider theoretical awareness, a process known as applying the 'double-hermeneutic' (Smith, Flowers & Larkin, 2009).

Data were collected via semi-structured interviews, which enabled the researcher to maintain openness, allowing participants to focus on areas of particular relevance to them, their experience of TF and its impact on their fostering experience. An interview topic guide (*Appendix 4-E*) was developed with reference to current issues in formulation and fostering, following consultation with representatives of fostering agencies who had been involved in TF. The interview guide focused on areas of foster care history and experiences, process of TF, and the impact of TF on relationships and fostering practice.

Participants

Four foster carers with experience of utilising TF were recruited to the study. Participants were recruited from fostering agencies that offered TF in support of placements. IPA allows for smaller sample sizes due to its focus on the idiographic (Smith & Osborn,

2004), with a strong reliance on the richness of data and depth of exploration within the dataset, which can be facilitated through smaller sample sizes (Robinson, 2013). The study included a broadly homogenous sample, with participants of a similar age, the same ethnicity and all female. Participants did have different levels of experience, from three to twelve years. A participant table provides more detail and brief biographical sketches of the participants (see *Table 1*). Homogeneity can be important within IPA to add credence to the theoretical generalisability of findings (Smith & Osborn, 2004). In the final report, participants were given pseudonyms to maintain anonymity.

Participant name	Margaret	Claire	Joanna	Vicky
Amount of experience	6 years' experience	7 years' experience	3 years' experience	12 years' experience
Age	50 years old	50 years old	56 years old	Not reported
Gender	Female	Female	Female	Female
Characteristics of fostered children	8 children fostered, 11 to 18 years of age, male and female, both short-term and long-term placements offered.	10 children fostered, 9-18 years age, male and female, short, long-term and respite offered.	2 children fostered, 9 and 11 years old, male and female, long-term placements	Multiple short and long-term placements, (no. not reported) 7-14 years old
Biographical information	Margaret began fostering for a career change. Margaret felt motivated to foster due to the difficult circumstances of her own childhood. This led to her offering empathy and a non-judgemental approach to children. She	Claire chose to pursue fostering with her partner following viewing a documentary about foster children. They felt it would be very rewarding to help transform children's lives and provide some stability. They were provided with a	Joanna had experience of adopting a child previously and began fostering when she left her old career. She was motivated by the opportunity to provide a nurturing home for a child. Joanna reported the two days training she received prior to	Vicky had a great deal of experience working with children in schools prior to fostering. Fostering was a long-term ambition. Vicky reflected on the standardisation of training in childcare and development since she started fostering, when

	felt unprepared for early placements and unsupported, which led to reported burnout.	significant amount of training prior to fostering by their agency but felt it did not fully prepare them for the reality of the task.	fostering could not prepare her for her first placement.	it was notably minimal.

Table 1: participant demographics and biographical sketch

Ethics

Ethical approval for the study was sought and gained from Lancaster University Faculty of Health and Medicine Research Ethics Committee in January 2020 (see Chapter 4).

Procedure

Following dissemination of marketing materials, potential participants were approached by staff from their agencies. Candidates were sent recruitment emails and the opportunity to approach the researcher for further information or to register interest. Originally, the plan was to employ a physical and electronic marketing campaign. However, prior to recruitment, nation-wide lockdown due to the COVID-19 pandemic began. Since carers were no longer in direct weekly contact with their agencies, this reduced opportunities to stimulate interest in the study via advertising and face-to-face discussion. Recruitment materials are included in *Appendix 4.* Interviews took place via Zoom virtual conferencing or telephone. Consent was obtained verbally at the opening of interviews.

Data analysis

Interviews were recorded on a digital audio recorder and transcribed by the principal researcher. Data were analysed using IPA as outlined by Smith, Flowers and Larkin (2009). Interview transcripts were read and re-read by the principal researcher to familiarise himself with the data. Exploratory comments were applied, denoting experiential descriptions of the participants, linguistic analysis and conceptual interpretation from the researcher (see

Appendix 2-A for an example of theme development). These were then developed into emergent themes across individual accounts at a more interpretative level, reflecting meaning derived from exploratory comments across the whole account and attempting to get as close to the participant's world as possible (Smith, Flowers & Larkin, 2009). Emergent themes were collated into superordinate themes for each transcript, seeking to provide a framework of understanding for the meaning and impact of TF on participants.

Each interview was analysed individually in this way and efforts were made to put the findings from one transcript aside prior to analysing the next with the aim of maintaining idiographic integrity prior to the final analysis (Smith, Flowers & Larkin, 2009). Once all four interviews had been analysed in this way, superordinate themes were compared across the interviews, noting points of similarity and divergence. These were organised into over-arching themes that formed a narrative around the most pertinent dimensions of the process and context for these individuals.

Validity and credibility

Due to the inherently interpretative nature of IPA, different researchers may develop alternative analyses of the data, which is accepted as inevitable (Smith, Flowers & Larkin, 2009). However, to increase credibility of the analysis, thematic findings were shared and discussed with the academic supervisor, with the aim of reducing researcher bias. The principal researcher kept a reflexive journal throughout the process, with the aim of maintaining neutrality during data collection and analysis (Smith, Flowers & Larkin, 2009). This meant acknowledging the researcher's role as a trainee clinical psychologist, a parent, with a history of supporting CIC and using TF in a professional context. This journal was a reflexive aid, helping to identify the researcher's experiences and knowledge of theory, and consequently to attempt to suspend his own beliefs and any biases in interviews and when analysing participants' data. For example, aspects of the delivery of TF and the researcher's

experience of TF as a valuable multi-functional tool were put aside during data collection and analysis. Further, the researcher's perceptions about an historical lack of resources in social care held the potential to fuel assumptions about participants' experiences and relationships with statutory services, so it was important to acknowledge this and maintain neutrality as far as possible. This was prominent during the data collection phase as the researcher attempted to maintain a stance of naïve, open curiosity during interviews (aided by a lack of familiarity with TF applied in this context). Skills developed in the researcher's role as a trainee clinical psychologist aided this, e.g., through employing active listening in maintaining open curiosity. The researcher was unfamiliar with use of IPA prior to this study, although prior experience of close linguistic analysis and use of other qualitative methodologies was of benefit. Given this, the researcher maintained regular contact with his academic supervisor during analysis, with the aim of faithfully pursuing the guiding principles of IPA and faithfully representing the accounts of participants.

Findings

Four superordinate themes were generated and are as follows: (1) Firefighting, (2) Everyone's in my corner, (3) It's another world for me, (4) It's not set in stone. The themes serve to represent participants' accounts of their experiences with TF and its impact on their lives as foster carers.

Theme one: Firefighting

All participants began their accounts of fostering with descriptions of facing extraordinary challenges. Faced with this difficult context, participants felt part of a system that was **Firefighting**.

Participants all had anecdotes about feeling an intolerable stress burden associated with attempting to support children:

> My first child that was placed with me, that was a complete and utter nightmare. He had special needs, very complex special needs and he should never have been placed with me. That was quite a traumatic experience. (Joanna)

There was a sense across accounts that this challenge was compounded by lack of support, creating a sense of feeling overwhelmed:

> I can only refer to my first placement as like a tornado coming through my door, because I wasn't prepared, I didn't know anything about her. I just got told that this was 'the ideal foster child; she's a darling'. 'Dream foster child' is the words that came back to haunt one of the social workers. There is no 'dream foster child' they haven't gone through a dream, have they? (Margaret)

The consequent disarray only served to undermine self-confidence: "because of what happened I felt very unsure of myself very down and 'can I do this?'" (Joanna). This sense of disarray and feeling uncontained also seemed to affect children, mirroring and compounding their own inner turmoil: "There's all these people for that one little person and that's frustrating...you have to deal with the questions, the behaviours that come from being in this whirlwind" (Claire).

The system surrounding foster carers was portrayed as over-stretched, with overwhelmed practitioners and insufficient resources: "Not that they don't want to do anything, but they are just overwhelmed with work…they are firefighting" (Joanna). In this system, carers and children could appear lost or neglected within impersonal bureaucracies, as described by Claire:

> So we were going on holiday once and they'd actually forgotten to arrange a respite carer for her so it was done all last minute, this was the night before we

> were going to fly and they phoned us up saying "Right we've found somewhere" I think it was something like 3 hours away from where we live....And they said, "Stick her in a taxi and send her to the respite carers"…But yes, it wasn't a social worker that worked with our agency or the local authority that she was from...Their advice was to stick this young girl in a taxi who was a huge absconder. She used to run away all the time.

This apparent lack of concern, given the help requested by carers amidst specific risk concerns, highlights absence of support contributing to placement endings: "that placement broke down because we asked for help for a year and we didn't get it until it was too late" (Vicky).

Aspects of the system provided the greatest aggravation to Claire: "Frustration is huge, and that's not directed at the children. Sometimes most of that is directed at, we call it like 'the red tape'". Part of this resulted from feeling unheard, as above, and consequently disempowered:

> you're always either on the phone ringing the social worker up or sending emails saying "look, this has happened, it happened after this, we don't think this is working, can we try this?". And then sometimes you get a 'no', just 'no', so you're like "ok then, erm, what do we do then?" (Claire)

This was representative of an impersonal system that carers sometimes felt compelled to rebel against: "I didn't realise that you have to battle with the powers that be. It's the battle, isn't it?" (Margaret). In this battle, participants presented themselves as disempowered below detached professionals: "you're still not treated as a professional…you have to attend all these meetings and give your professional view but you're not" (Vicky). In this way, participants appeared positioned ambiguously between their daily challenge, parenting CIC, and the system that held authority over them. This status was reinforced through narratives

that positioned participants as values-driven, in contrast to this wider system, which was seen as corrupted: “it’s just all about the money and what’s available isn’t it. When really we should just be focusing on what the child needs” (Margaret).

In summary, this theme presented the impact of multi-level systemic stressors on participants. Participants described the difficult task of fostering, which at times felt destabilising and chaotic. In facing this challenge, participants portrayed a sense of feeling unsupported, ill-prepared and disempowered. In the face of such adversity, carers positioned themselves as fighting for children (whose needs only they could understand), reinforcing a sense of otherness from wider systems that did not share the same single-minded goal.

Theme two: Everyone’s in my corner

In this theme, participants highlighted the benefits of collective working towards coping, positive relationships and feelings of confidence and efficacy. During the disarray sometimes surrounding placements, regular access to TF provided a sanctuary from the storm, through which carers could unburden themselves: “quite often we go in and say, we’ve had a really bad week” (Joanna). There was a cathartic element to having others witness their struggle, meaning they were not carrying the burden alone:

> the whole room would talk about it, so you kind of thought ‘actually I know they are not here in the house with us but it’s good to know that they know what it is actually like at home’ (Claire).

In this way, TF offered relief from the build-up of stress between meetings:

> I’d go in to the meeting thinking “Phwoar I think I’m going to have a bit of a break down today or I’m going to say you’re going to have to… you know she’s going to have to go as I don’t think I can do it any more” Sometimes I felt like

> that but then I'd come out of the meeting feeling slightly more refreshed so it was good for that. (Claire)

Participants recounted a sense of containment and safety resulting from the team structure that helped them feel more in control when facing the challenges brought by children they fostered:

> I have found them exceedingly helpful and they are good. Never mind just helping [*child*], they help me. They sort of, you know, they make me feel calmer and more in control and they have been brilliant. (Joanna)

TF presented a space where comfort was offered, as described by Vicky, even though she found the focus away from the child onto parent's distress frustrating:

> we had to touch on difficult areas and issues for the parent to hear so she was, you know, getting up and crying and leaving the room and we all had to comfort her.

TF also provided a potentially diverse forum of professionals, where needed:

> it was great to get the psychological, you've got the educational and then you've got the social worker and obviously (*former carer*) was involved as well. (Margaret)

Meetings were consistently described as enabling inter-disciplinary relationships: "I've built up a really good rapport with [the teaching assistant]" (Joanna), forged in the realisation of genuine shared aims:

> it was just nice to know that the people in these meetings weren't there just because that is how it is, well it's just my job, I need to be here because this child needs this formulation meeting. It never ever felt like that. It just felt like everybody was fighting for her and we were just trying so hard to keep her here. (Claire)

In contrast to earlier experiences of being alienated from the wider network around the child, through TF, carers could perceive that others had a stake in the child's best interests and

welfare: “I think because [school representative] does turn up to most of these meetings, she’s interested” (Joanna). This sense of collective care was evident in descriptions of shared emotional connections: “she kind of touched everyone and you could see that in the meetings” (Claire).

This TF community offered some positivity for foster carers: “you have got a big, massive friendly team behind you” (Joanna), opening the door for recognition and praise, which impacted on participants’ confidence: “the gratitude and the praise was a little bit like a tonic” (Claire). This praise boosted feelings of competence, as with Claire, who was informed: “You’re amazing how you deal with it”. Participants also appreciated that qualities and achievements of children could be celebrated:

> she never said anything positive about herself, she was so negative and had nothing nice to say about herself, but it was nice to hear, I don’t know, for example, just something that she’d done in the school environment that day. (Claire)

Carers felt able to express themselves safely and there was a sense of equity in voices across the TF group, evident in multiple accounts: “Everyone has their say on thoughts of what we can do” (Joanna). Importantly, this also included the foster carer, as Margaret pointed out, when consulted despite her perceived lack of experience: “they put it through to me about my thoughts and yes, it was wonderful” (Margaret). Open communication meant that attendees felt safe disagreeing: “everybody had kind of agreed, I think there was one or two people that said: ‘I’m not happy about that’” (Claire). Despite these benefits of TF, issues highlighted by one participant resulted from the inclusion of a birth parent, diverting the focus from the child’s needs to her distress and guilt.

> well legally I think she has to be there or has to be given the right to be there and a lot of the core group meetings, legally she has to be invited and you just feel that

> it would be a lot better if she just wasn't there… there were some things that needed to be said that we didn't want mum present for. (Vicky)

Vicky acknowledged resentment towards this parent due to past events, but there was also a sense that the focus on the child was derailed due to her presence. This was one of the few times during participants' accounts that the composition of the TF served to frustrate its purpose.

In summary, this theme presents the impact of working as part of a group on participants. TF was a route to validation; cathartic in managing weekly stressors of fostering, which helped sustain placements. The meetings created a sense of containment for participants. They were a stage for recognition of shared values and goals, and sharing praise, which increased confidence across and within the network, so notably absent in previous experiences of fostering (as highlighted in theme one). Importantly, most participants tended to feel a sense of equity and openness to communicate within the group.

Theme three: It's another world for me

Through TF, participants reported a novel space for reflection. Importantly, this facilitated effective mapping of theory onto practice, often for the first time. Learning could take place for everyone, resulting in greater understanding of the child's experience for all involved.

TF was a platform where attendees learned to think and act in different ways. Margaret described the effect: "you know it's another world for me, it's another level of intelligence, but it was fascinating". There was a sense of access to expertise that might otherwise seem inaccessible:

> the information of understanding of how his brain works, that was fantastic; I could listen to that all day – especially the science part of it, because I'm very

> scientific. To listen to the professionals who know what they're on about, talk about how his brain's developed, that was really informative for me, it was brilliant (Margaret).

Claire recalled a journey of finding explanations for behaviour that had been previously mystifying, with a sense of accomplishment and reward:

> it quite often gave me a eureka moment 'cause I'd be like "Oh I get it now, that's why she does that". So, it kind of took away a little bit of the wondering for me of like: "I don't get why she does that. I understand this, but I really don't get what that is all about". And then you know a couple of times it would come up and literally a light bulb would go off and I'd go "Woo, okay [laughs] I now know why that is presenting itself" I found that really useful. (Claire)

This process of developing shared understanding through a combination of practical experience and theoretical knowledge was an important function of TF for participants: "So that was resolved in the fact that we sort of agreed on the reason for her behaviour" (Vicky). Margaret reflected how TF led to opportunities for reflection and mentalising around the young person she supported:

> The formulation meeting was informative. Just to go back and reflect, put myself in his shoes with what he's gone through. Although he's quite vocal and he talks quite freely about what's happened to him with his parents, going back to the minutes of the formulation meeting, I have asked [*support worker*] if I can have a copy of them when they're done. Just so every now and then I can go back and re-read them, so I can remember what [*child*]'s gone through. (Margaret)

Behaviour that was potentially very distressing could be normalised through TF: "the self-harm was never to try and kill herself, it was never about that, it was about her trying to deal with her emotions and that's how she did it" (Claire). This understanding consequently

facilitated thinking and acting in new ways: “I understand where it’s coming from and I understand what I need to do, the ongoing meetings have really opened me up to thinking out of the box” (Joanna). Taking a step back and rationalising, precipitated within the group, enabled a different relationship with the child over time: “I think we deal with things differently now. I think in the beginning we took everything personally” (Claire). Carers felt like they could get to know the children in a new way, with added depth and richness from such insight: “I feel I really know [child] now” (Margaret).

It was apparent that TF facilitated learning and growth for all involved, not just the foster carers:

> I think we had discussed some of the stuff that maybe myself or [*partner*] had done in the meeting. Say like to defuse a situation or whatever and everybody in the room was like “oh wow that sounds brilliant”. I think they learned from it as well not just us: “God we wouldn’t have thought that would have worked but it did”. We both learned loads from these meetings. (Claire)

Again, this stood in contrast to participants disempowered and unheard role within the network around the child, as expressed in the first theme. Carers appreciated closer access to the multi-disciplinary team around the child, meaning flesh could be added to the skeletal histories they were aware of: “the formulation meeting gave me the nooks and crannies” (Margaret). This included more accurate representations to the team of events than were previously available (e.g., through written accounts): “God that doesn’t look anything like what you’ve written here, so it’s good that you’ve described it because that’s just really intense” (Claire). Similarly, there was a sense of a fuller picture coming together by attendees representing the different faces children showed them, again facilitating deeper insight through the formulation:

> one person would say "Well she quite often does this or says that" and we're like "she doesn't do that here". Or CAMHS would say "She's like this or she comes across like that" And we're like "no she doesn't, she doesn't do that here". So yeah, it was good to see all these different bits of her personality coming out in different areas, which we wouldn't have known about if we hadn't have talked about it (Claire).

In this way, attendees came to challenge their beliefs or assumptions about the child through TF, coming to know them in a fuller way.

TF also allowed discussion of sensitive details of children's history, for example, horrific abuse: "that's not on his referral. So, to learn about that, that made me prepare myself even more" (Margaret). Again, this deeper understanding led to the possibility of more appropriate responses to children:

> once it's all out in the open and you can all talk then realising there was things that came out that I wasn't aware of that had happened in her childhood, it helps you understand the behaviours more. (Vicky)

Sharing earlier placement history allowed planning for success with different approaches: "I got all the background about why the placement's broken down as well" (Margaret).

In summary, this theme presented how participants experienced learning via TF. Participants expressed positive and rewarding learning experiences, through the marriage of their practical experiences and professionals' expertise. In this way, through formulation, understandable explanations were developed for children's behaviour, which led participants to suggest they could empathise with CIC more readily. TF was an opportunity for learning for everyone involved, and served to create a richer, more accurate picture of the complexities and experiences of children being supported, and the challenges of the fostering task.

Theme four: It's not set in stone

Participants encountered TF whilst facing different challenges, at different points in placements and their own careers. Given this, participants appeared to appreciate the helpfully adaptable processes TF enabled, which are highlighted in this theme.

Participants found TF useful preparation for new placements: "we'd got the groundwork there, we'd started to think about what behaviours might happen, what might I see, what may be behind some of the behaviours" (Joanna). This preparation stimulated a different frame of mind; carers could realistically anticipate the challenges that lay ahead: "so it helped to sort of get me ready, in the right frame of mind" (Joanna).

Carers also appreciated TF as an ongoing reference and source of support during placements, meaning they could learn in difficult circumstances, and again, feel contained: "We've been having ongoing support from [agency] and the team ever since then anyway sort of like weekly sessions regarding her behaviours" (Vicky). Again, this stood in contrast to previous absence of meaningful support. Similarly, TF could facilitate a process of longitudinal evaluation, meaning gains and successes could be recognised by carers: "we've shown basically as the months went on that these [behaviours] have reduced as she's got used to the house, used to our routine" (Joanna).

For two of the participants, TF had been suggested by their agency in response to challenges arising, meaning support was available promptly and as needed. This adaptability led to a sense of safety and something they could count on:

> I think the agency would like us to meet with the psychologist at least once every three months but at the moment it's me saying no I want monthly ones still. I want monthly sessions. But I do feel that if I ask "I need to see [*psychologist*]" they would… I can request an emergency session on a Wednesday, so it's not set in

> stone, it's very much led by how I feel and again with how they feel as well. (Joanna)

Similarly, waiting time for an urgent meeting was "very quick, which I've never experienced from any local authority" (Vicky). In this way, the importance of carers and placement integrity itself to professionals around the child was emphasised. Following a disagreement Claire had with CAMHS "a meeting was called kind of quite quickly", through which reconciliation between members could be sought. Again, TF served to reinforce the importance of placement integrity, refocusing participants on the best interests of the child.

The flexibility of TF led to carers helping to shape the agenda and consequently a feeling of having a voice: "the meetings are very much led on what I want to discuss. Or if my supervisor has picked up with something, she'll bring up that and we'll discuss that for a bit, then we go to the formulation" (Joanna). Meetings were described as malleable and focused on the needs of not only the child, but also the carer, serving to act as a containing space, if needed: "sometimes the meetings went on for ages, they were only slotted in for a certain time but there was just so much to get out, it was like 'gotta get it out'" (Claire). Despite this flexibility, a number of carers acknowledged the helpful structure of having a chairperson to direct the meetings, meaning the focus on the child's best interests and overall planning was not lost, and helping impose a sense of containment: "they dealt with mum and chaired the meeting back and brought everyone back together" (Vicky); "[chairperson] she directs it, she's chairing it, it goes the way [chairperson] sees things to go" (Joanna).

Given the functional relevance and availability of TF, it was recognised by most of the carers as a valuable experience. Margaret was effusive in her evaluation of TF:

> My initial thing I thought: "this is professional, it's organised, yeah!" I haven't done enough to know or pick up on any things that could be better. For me it was fantastic, so I can't say anything negative about it. (Margaret)

TF here stood in contrast to an earlier experience, where she felt unprepared by the local authority for a placement:

> I just felt that the process happened quite quickly, and I got put through the process, I was put to the board really quickly. But talking about it and having a child through your front door, with the intense mental health needs that this child needed, it was a bit 'oh god' you know 'I don't know if I'm doing the right thing'. (Margaret)

Most participants suggested TF should become more widespread for foster care networks: "it would be a lot better and then in the long run, there wouldn't be as many placement breakdowns" (Claire); "I stated that I wish that could happen for every child that was being placed, if it was possible" (Margaret). This consistent praise for TF speaks to its impact on participants.

In summary, this theme demonstrates the practical flexibility participants enjoyed about TF as they encountered it, which helped the process to meet some of their unique needs and stood in contrast to their previous experiences of fostering support. TF was available rapidly and flexibly, as needed. It was appreciated as preparation for new placements, or as a form of ongoing support. Participants spoke very positively of their experience of TF on the whole.

Discussion

The main aim of the study was to explore experiences of foster carers who have engaged with TF in support of their foster placements. All four participants were able to reflect on their experiences of TF meetings, sharing perceptions of the structure and running of meetings, perceived benefits and difficulties, the effects of TF on their professional relationships and with children placed with them, and comparisons to historical experiences of fostering. Four superordinate themes were generated from participants' accounts: (1)

Firefighting; (2) Everyone's in my corner (3) It's another world for me; (4) It's not set in stone.

The findings, as expressed in the first theme, presented the challenges faced by foster carers, especially prior to TF, where they often felt unsupported. Associated placement breakdowns reflected the acute stress reported in previous fostering studies (e.g., Harding, Murray, Shakespeare-Finch & Frey, 2018). There was a sense from carers of great frustration with the systemic deficits that undermined their best efforts, encapsulated in Margaret and Claire's struggles with 'red tape'. This created a sense of disconnection between frontline carers, who took direct responsibility for the wellbeing of CIC, and those with legal responsibility. Carers felt devalued and even disrespected, affecting their confidence and feelings of competence. Within this atmosphere, CIC with unexpectedly high levels of need and behaviours of concern were overwhelming, which could lead to disappointment at struggling to meet their original aim of making a difference to the lives of CIC, as suggested by Onions (2018). Disenchanted carers appear unlikely to maintain their career, only contributing to the increasing schism between demands and resources (Ofsted, 2018).

Similar functions were expressed here to those summarised in a systematic review of TF (Short et al., 2018): increased knowledge and understanding, improved interactions, space for reflection, improved practical efficacy and team working. Furthermore, the positive outcomes of TF as described by foster carers showed some clear similarities to those of other therapeutic interventions (e.g., MBT-CF (Byrne, Murphy & Connon, 2020) and Attachment and Biobehavioural Catchup (Dozier, Lindheim & Ackerman, 2005)), such as gaining a deeper understanding of their child, learning more about what might be underlying their child's behaviour, and recognising the challenges that they may face in parenting. However, in addition to this, a further benefit was in changing carers' perceptions of themselves within the professional network around the child, allowing them to feel heard and validated,

engaging with meetings and planning of interventions with greater agency and input, thus redressing perceived power imbalances and facilitating recognition of shared goals and values. Thus, TF presented benefits on multiple levels, allowing for development of new perspectives and skills, but also promoting evolution of the system around the child, and the roles of those involved in it. In this way, TF appeared to provide a forum with similar benefits to the Psychological Consultation Service described by Kim Golding (2004), with carers able to discuss the experience of being with the child, feeling listened to, valued and understood. The service also provided a foundation for new professional networks to develop, reducing delays to support and advice.

Theme two described the impact of TF group dynamics on foster carers. Foster carers valued being part of an integrated team. Involvement in decision-making and extra support was found to improve competence in supporting CIC in a previous study (Munford & Sanders, 2016). Here, carers' equitable status, feelings of reassurance and belonging inspired confidence and provided motivation for the fostering task, similar to previous studies (e.g., Schofield, Lee & Merrick, 2013). Being involved appeared powerful for carers, perhaps pertaining to feelings of being in control and thus more contained.

Theme three drew together responses to learning through TF. A significant part of this was the focus on developing carers' RF and their mentalising capacity. Learning opportunities contrasted to earlier experiences when contextualised through ongoing practice. It can be helpful for lessons to be generalized in the unique context of each fostering relationship (Luke et al., 2014: pg. 126). Such person-centred learning laid the groundwork for growing mind-mindedness in carers towards the children they supported. Increased mind-mindedness has been shown to promote better parent-child interactions (Palacios, Roman, Merino, Leon & Penarrubia, 2014). Further, it has been argued that mothers who are mind-minded are less likely to become irritated by children's behaviour, beneficial in reducing

stress on parents (McMahon & Meins, 2012). Mentalising, a skill shown by carers in the present study and developed via TF, has been shown to aid development of healthy attachments (Onions, 2018). However, it is difficult to engage during moments of high arousal, for example during behaviour that challenges (Onions, 2018; Redfearn et al., 2018). The reflective milieu held by the TF group in the present study was helpful in allowing carers to pause and rationalise, engaging mentalising when this may otherwise have proven difficult.

Theme four focused on the flexible utility of TF for carers. Part of this was coming to feel well-prepared, learning about what to expect and how to manage effectively. Knowledge of the expectations and requirements of the carer role have been shown as important elements of managing the stress of parenting (McKeough et al., 2017). Uncertainty was shown to exacerbate feelings of powerlessness and lack of control in carers (Moyer & Goldberg, 2017; Viana & Welsh, 2010). Emphasis on approaching one issue at a time may have increased confidence and feelings of control. The rapid availability of TF to participants here also stood in contrast to earlier experiences, described as a safety net which provided reassurance.

Findings from the study focus heavily on aspects of TF that reduced foster carer stress. In understanding parental stress, Louie, Cromer and Berry (2017) highlight the bi-directional interplay between stress and parenting satisfaction. As such, it is worth acknowledging the importance of positivity and praise in the present study. This optimism and positivity extended to perceptions of CIC, with appreciation that TF enabled development of positive narratives, in contrast to ‘damaged’, ‘challenging’, or even ‘looked-after’ labels. Such labels can affect children in multiple domains of life, diminishing educational expectations and engagement (Mannay et al., 2017) and affecting relational development (Tobbell & Lawthom, 2005).

The need to maintain openness in communication appears highly important to maintaining feelings of equity for carers in the TF process. Barth, Crea, John, Thoburn and Quinton (2005) suggested that focusing too much on attributions from attachment theory was a common trap for CIC multi-disciplinary teams, limiting alternative perspectives and attributions. Here, the practical experiences of carers were valued and sought, contributing to the understanding held by all members of the TF, which reveals how primacy was not given to theoretical explanations over practical experience. There is also a risk, within an over-burdened system, of splitting and projection of distress within the systemic dynamics of such groups (Golding, 2010). In the present study TF was a route to new connections or reconciliation between parties. Connections have been drawn between the benefits of TF and systemic family therapy to improve communication, clarify assumptions, and make personal positions explicit (Johnstone & Davos, 2014: pg.220).

Clinical implications

In the present study, carers compared their previous experiences to the support offered via TF. Functions of TF appear to make it particularly useful in this context, serving to address systemic issues in the foster care system as reflected in participants' experiences here, for example, in carers' feelings of inclusion, validation and containment. New opportunities were facilitated; in the narratives around CIC, the witnessing of shared values and belief this brings in the system, and the validation of carers' struggles. The impact of these factors is difficult to measure, although, taken as a whole, they appear potentially transformative for carers, and ultimately possibly for the children they support. Although only a small-scale study, the suggestion from findings presented here is that TF may offer long-term benefits for CIC due to reductions in carer stress and ability to cope. Given the well-recognised importance of healthy attachments and stability for these children, TF would

appear a possible route to encouraging such environments. Given the scale of the present study, further research would appear warranted.

Future research

A primary consideration for potential research is around the cost-benefit implications of using TF in this context. Longitudinal studies across a range of variables would be a logical next step. One idea may be to observe mind-mindedness pre- and post-TF. Also, longitudinally, burnout, stress and quality of life measures could be employed to measure the impact of TF on carers. It could be helpful to explore how far TF changes expectations about placements and attitudes towards CIC and new placements over time. In addition, research focusing on the vicarious impact of TF support for carers on CIC themselves, their experience of placements and relationships with carers, would be valuable.

Limitations

The question of whether the study could be defined as a small-scale service evaluation was considered during design of the study. The study serves to explore the TF approach used by the organisations involved in supporting fostering agencies and local authorities with foster carers. Due to its innovative use in this context, it could be argued that there is an impetus to understand it better in discerning the value of greater dissemination with this client group. Also, this initial exploration may allow for comparison with other approaches, as described here, in future research. As it stands, this initial study has started to explore some of the experiences of foster carers of TF in support of their placements and its impact on them in the systems within which they operate. Further research is needed to build upon these initial results, since generalisability cannot be implied from a small-scale study such as this.

In terms of recruitment, following the global pandemic, recruitment became a difficult task and certainly impacted, limiting face-to-face marketing of the project, resulting in a

smaller number of participants recruited than initially hoped for (ca. 10-15 participants). This reduced the diversity of narratives available for analysis. Participants were recruited from two areas of the UK geographically distant from each other that could be described as socio-economically diverse, although sharing the same ethnicity and broadly of a similar age. Although helpful in terms of the chosen methodology potentially limiting recognition of wider experiences within the fostering system. Foster carers may have chosen to participate in the study due to positive experiences of TF, creating a positive bias. Others who did not experience TF as positive may have been reluctant to invest time discussing the process. The dataset could have been strengthened through undertaking more interviews and incorporating greater diversity in the sample. Another approach would have been to triangulate data with accounts of foster children or agency staff/social workers, although this would have precluded the use of IPA.

Conclusion

In summary, this study identified four themes relating to foster carers' experiences of TF. Themes related to struggles within the foster care system, then ways that TF helped address some of these problems. Carers portrayed the experience of an inclusive and supportive collective, entering into a new world of learning and growth, and encountering a containing, flexible process they found rewarding and beneficial. Carers learned about the children they supported, leading to new approaches, and found a greater sense of equity and professional appreciation, which increased their confidence. TF provided witnesses to their distress and struggle, helping maintain resilience, whilst providing a platform to share positive narratives about CIC that may otherwise have gone unrecognised. Ultimately, TF enabled carers to grow in confidence and competence, with obvious benefits for the children placed with them. This research highlights the need for more research into the experiences

and outcomes of TF for foster carers and contributes to the argument for promotion of TF in support of foster carers.

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Appendix 2-A: Example of theme development

Participant	Step 1: Exploratory comments	Step 2: Developing emergent themes	Step 3: Connections across participants	Step 4: Final superordinate theme
Claire: "there's a shortage of foster carers, there's a shortage of social workers"	High demands – fewer resources acknowledged	Demands-resource imbalance	Over-stretched system around foster care CIC and carers neglected and waiting too long	Theme 1: Firefighting
"they'd actually forgotten to arrange a respite carer for her, so it was done all last minute"	Neglectful social workers, *'forgotten'* is uncaring, highlights her lack of importance to them *Last minute* implies poorly executed, far from ideal	Unimportant CIC neglected by s/ws	Fighting bureaucracy and impersonal system Question values base of foster care/social service system	
"Frustration is huge, and that's not directed at the children. Sometimes most of that is directed at, we call it like 'the red tape'"	Struggling to cope with red tape – as a foster carer, elements of the role that are not about supporting child directly are the most challenging	Struggling through red tape	Foster carers disconnected and disempowered in this system Highly challenging placements unsupported	
"it was a nightmare"	Strength of feeling here over how difficult the placement had been	Placement can be a living nightmare	CIC turmoil permeates system Hard to apply lessons in turmoil	
"There's all these people for that one little person and that's frustrating...you have to deal with the questions, the behaviours	*Use of 'one little person'* – child as helpless, disempowered in the face of all these events and this machinery of state	Helpless child in the machine	Vulnerable children amongst storm Cycles of distress	

that come from being in this whirlwind" "These poor kids must think "oh here we go, I'm off again" I don't know how they cope with it to be honest"	Sense of inevitability and resignation to having a bad time in life for CIC Children are the ones who pay the price – describes the plight of their reality	Children pay the price for a broken system		
Vicky: "that placement broke down because we asked for help for a year and we didn't get it until it was too late" "you're still not treated as a professional…you have to attend all these meetings and give your professional view but you're not" "they will completely diss your point of view"	Experience of help-seeking is that it was sometimes futile; a long slog with no helpful outcome Demands made do not match the status and respect afforded to the role – a mismatch Feeling dismissed and disrespected provokes resentment	The long, futile slog of help-seeking in the past Professional role but not professional respect Dismissed resentful carers go unheard Strata of disconnected professionals sit above us		
Joanna: "Not that they don't want to do anything, but they are just overwhelmed with work…they are firefighting" "my first child…was a complete and utter nightmare"	Social services barely keeping up – firefighting	Social services reacting not proacting Fostering can be… a living nightmare		

"I couldn't get my head round it at all… doing it as a theoretical exercise before you got a child…it doesn't make sense" "because of what happened I felt very unsure of myself very down and 'can I do this?'"	The hope that turns into a nightmare – living a nightmare Training divorced from experience can seem abstract and irrelevant Had been psyched up and then an illusion was shattered – am I up to the task?	Abstract training – theory in a vacuum Poor preparation undermines self-confidence with poor performance		
Margaret: "I didn't realise that you have to battle with the powers that be. It's the battle isn't it?" "I just got told that this was 'the ideal foster child; she's a darling'… There is no 'dream foster child' they haven't gone through a dream, have they? They've gone through absolute chaos, hell, neglect, abuse…" "It all goes back to money and from what I've learned fostering is a business, it's just all about the money"	The tiring part is fighting the 'powers that be' – sense of struggle with authorities Being kept in the dark by social services Sense of resentment at deception Focus on money is at starkly odds with the emotional investment highlighted directly above. Fostering is a business – morally corrupt?	Fighting the powers that be is the real challenge Kept in the dark – who are you kidding? Morally bankrupt – a business or a saviour's mission?		

“I can only refer to my first placement as like a tornado coming through my door, because I wasn’t prepared”	Placement was a surprise storm	The storm bursting in		

Chapter 3: Critical Appraisal

Thomas Speight

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

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All correspondence should be addressed to:

Thomas Speight

Doctorate in Clinical Psychology

Division of Health Research, Furness College

Lancaster University

Lancaster

LA1 4YF

Tel: 01524 595970

Email: tspeight1@lancaster.ac.uk

Critical Appraisal

Through the critical appraisal I will offer a range of reflections about the project, providing a summary of the research findings, reflections about my relationship to the topic and development of interest in the subject area, and the anticipated impact on my own clinical practice. I attempt through this critical appraisal to address methodological concerns relating to each part of the study. I found this engagement with methodology one of the most interesting aspects of the project personally and I feel changes to methodology and my own personal relationship to qualitative research should allow for some helpful and interesting reflections about the project.

Summary of findings

The study used qualitative methods to explore the experiences of children in foster care and foster carers. The literature review analysed literature focusing on access to MH services from both foster carer and CIC perspectives. Ten studies were examined using a meta-ethnographic approach. This led to identification five themes: 1) Feeling threatened, 2) Uncertainty and mistrust, 3) Neglected and alone, 4) Lifting barriers, and 5) Connecting. Recommendations from this study focused on the type of relationships CIC may benefit from, having the stability to form them, offering control and a voice, leading to a sense of being 'done with' in their engagement with MH services. Furthermore, psychoeducation about MH should be offered in combination with a clearer picture of services and support available. The value of peer relationships and normalising of their distress were highlighted as key issues. Another major issue was around the lack of timeliness of intervention, a significant consequence of limited resources in this sector. This was seen as highly detrimental and contributing to worsening of distress, as well as reinforcing lack of self-

worth and disenfranchisement from a system which, for too many young people, was perceived as their enemy.

The empirical paper explored experiences of four foster carers who had used team formulation in support of their placements. Data from semi-structured interviews with participants was analysed using IPA (Smith, Flowers & Larkin, 2009). From this, four themes were developed: 1) Firefighting, 2) Everyone's in my corner, 3) It's another world for me, 4) It's not set in stone. These themes revealed how team formulation had served to meet a range of needs highlighted in the first theme (a collation of previous fostering experience prior to team formulation). This ranged from the benefits of having a respectful and engaged group with a shared purpose, to the revelation of learning via a new format (and the doorways to new perception this opened for all involved), to the efficacious flexibility and utilitarian nature of team formulation. All of these findings contrasted strongly with the isolation and struggle most participants had experienced prior to this. Findings also revealed a difference in carers' ability to mentalise, confidence and resilience resulting from the containing, supportive function of the group which helped mitigate for this highly stressful role.

Both the SLR and empirical paper serve to reinforce the perception of an imbalance between resources and demands in the current UK social care system, leading to a range of issues for people trying to work in this field. Following from this, the literature review served to raise the question of how far such perceived deficiencies reinforce some of the difficult emotions commonly experienced by CIC and following childhood ACEs (Simkiss, 2019), posing the question of whether MH services should consider such phenomena in consideration of access to and designing of services. Helpfully, the findings also point to positive practice and systems that act in mitigation of such effects, so recognising and reinforcing or replicating them as far a possible may prove beneficial. Similarly, the empirical paper offered solutions to this difficult context, specifically through team

formulation and the opportunities offered to foster carers, and other professionals, via this process. Team formulation in particular provided a powerful containing environment for foster carers, offering multiple functions, as highlighted in previous research (Dallimore, Christie, & Loades, 2016; Johnstone, 2018; Whitton, Small, Lyon, Barker, & Akiboh, 2016). It also provided functions recognised in similar interventions (the Reflective Fostering Programme and a Psychological Consultation Service associated with a residential/school setting), such as promoting mentalisation, access to specialist advice, improving confidence and validation for the difficult task of fostering (Golding, 2008; Redfearn et al., 2018). A logical conclusion is for team formulation to be promoted more widely, particularly since it may help to bridge some of the disconnection and separation from MH clinicians noted by carers via the literature review. The impact of networks, being connected and active respect for the carers' role were all part of a clear movement across both studies of aiming for greater stability across placements; creating a more robust container for CIC, often struggling, having been hurt and let down in the past.

Relationship to the topic

I took a long route to settle on this topic through various different concepts across a year of my studies. My initial aim was to explore a topic around attachment theory and particularly how these ideas are discussed with parents. This was something I was drawn to from previous experiences working in the field of CIC and special educational needs. Through this work, I recognised the value of mentalising and reflecting on the reasons for children's behaviour with parents in order to promote helpful responses to difficult situations. I found several issues with this concept making it impractical in the time and context of the doctoral studies I was undertaking at the time. As such, I encountered the present concept and felt it aligned well with both aspects of my original desire to explore the context around

children in care and the support they receive, as well as the use of team formulation in developing systems of support, which I had also recently been engaging with through my clinical practice. These interesting aspects of the project helped to sustain my motivation for the work during what has proven to be a very challenging year in so many ways.

Like others, I have found team formulation a valid and well-conceived method of approaching greater openness in communication across teams, as well as a route to more harmonious practices, offering participants a way to express their practical knowledge and experience, vent their distress or struggles and finding ways to organise their knowledge away from the direct work they are engaged in (Dallimore, Christie, & Loades, 2016; Kelly, Rhodes, Macdonald & Mikes-Liu, 2018). Primarily, I was very interested to explore how foster carers experience the learning that may influence their practice as part of this process. As it turned out, the passion I encountered from participants towards team formulation was unexpected, and in the final analysis I attributed this to the ways team formulation flexibly met so many of their needs, which had otherwise been neglected within the foster care system for so long. This was an unexpected result, but retrospectively makes a great deal of sense.

A comment on recruitment

Recruitment uptake was disappointing as I had hoped for approximately ten participants. I did feel that the Covid-19 lockdown heavily impacted on the search for participants through limiting opportunities for advertising and being unable to attend agencies in person. Rather, I relied on word-of-mouth and approaches to potential participants from agencies involved. I was also unable to include as many practitioners as possible in this selective recruitment due to the remote nature of the planning (via email and telephone). Further to this, it is possible people were impacted by the general atmosphere of anxiety and high stress arising from COVID and policy and societal responses to it. Foster carers were coping at that time with

their CIC being at home and not accessing usual services; routines were changed and thus carers were managing not only their own stress and uncertainty, but also that of the young people they supported. Alongside direct threats to physical health and safety, these young people may have been struggling to cope with uncertainty and loss of social and physical activity. Some carers reported to me that they had struggled to find time and available space to speak to me privately, with confidentiality an important factor for foster carers who may be concerned about disclosing sensitive information with children necessarily at home away from school. It is understandable given these factors that some foster carers were reluctant to become involved. However, I did question what this meant for those who did and did not attend. The possibility of positive bias towards team formulation was something I tried to maintain awareness of and during interviews I did try to elicit honest and frank appraisals of the process of team formulation and how it impacted on support, including how it could be improved, as well as whether there were negative aspects. However, I was aware that those who did not find team formulation helpful, or who were facing particularly emotive or difficult situations may have been reluctant to come forward and share their views.

It is worth noting at this point that since interviews were mostly conducted virtually via Skype rather than face-to-face, this may have changed participants' interactions. Sullivan (2012) suggests remote interviews can be as authentic as face-to-face interactions. It has also been suggested this format can increase presentation of self and authenticity due to the relative anonymity it presents (Ellison, Heino & Gibbs, 2006)

Methodological considerations

I shall outline here methodological considerations I observed during development of my analysis at various stages. Noting the crucial role of reflexivity to qualitative research in helping to maintain awareness of the researcher's position in relation to the subject of enquiry

(Berger, 2015), I maintained a journal throughout to keep track of my reactions and relationship to the research as it progressed. I have acknowledged my interest in the use of team formulation and also experiences in working alongside children in care above, which led to attempting to maintain a neutral and curious stance throughout interviews, aware of my own positive bias. However, a further outcome of this journal was recognition of my relationship with the methodological approach I employed in both the literature review and empirical paper. I will attempt to portray some of these journeys into methodology below.

In terms of the empirical paper, a quandary was around whether the research question may be too narrow, perhaps better suited to a service evaluation potentially, since focusing on the practice of a narrow range of fostering services. However, in consultation with my field and research supervisors, it was felt that due to the relative novelty of this approach (not appearing in research literature to date), and by concentrating on foster carer experience and the impact, for instance, on relationships, this could make for a valid thesis project. This became a further reason to attempt IPA of people's narratives, aiming to facilitate more than simply 'was it good, did it work?'

During the analysis I did feel trepidation about employing what was a new methodology for me. Starting with a feeling of 'is there too little with only four interviews?' Also, a fear that there might not be adequate data, or deep enough insights offered to draw out the kinds of interpretations central to IPA. However, four interviews have been considered sufficient for professional doctorate samples (Noon, 2018), where homogeneity of the sample is identified and participants are familiar enough with the subject to provide rich and in-depth accounts of their experiences, which I found during this project.

Since this was my first exposure to it, I was really interested in the IPA approach recommended by Smith, Flowers and Larkin (2009) and attempted to immerse myself in the ethos shaping the many different approaches researchers have taken to it. I considered the

initial stages of making exploratory comments as potentially facilitating a very rich examination of experiences of participants. Through amalgamation of experiential, linguistic and conceptual observations, the analysis could step beyond the phenomenological, and incorporate wider influences from my own understanding of developmental or trauma theory, and also from the wider picture of foster care and the welfare system. Particularly interesting for me was the linguistic aspect, given my own experiences in another discipline. This progressed as I worked through my analysis – I found myself applying close textual analytic skills developed during my first degree in English language and literature. One of the most enjoyable and engaging aspects of that course was learning about critical analysis of poetry and literature – being able to take apart text line by line and examine choice of words. This patient focus on language and its function – why one word was chosen and not another, how words were used in combination to imply meaning beyond the text at a superficial reading – influenced my analysis here. I was aware that in IPA, linguistic analysis is only one aspect of the overall process, providing an opportunity for making sense of the participant's world, as they try to make sense of it themselves; the double hermeneutic (Smith & Osborn, 2004). For me this provided an opportunity to help bridge between the phenomenological and interpretive, allowing consideration not just of what was said, but how it was said (Noon, 2018).

As I was reviewing the data initially, I was concerned that much of the content appeared superficial and concerned with practical description of the process of fostering and team formulation. Close analysis did reveal a greater amount via the exploratory commentary than I anticipated, it felt like nuance was revealed. Points that had been lost or overlooked in the conversational flow of interviews became evident, as I recognised that participants spoke about certain phenomena using specific language or phrases, and how they would sometimes

present a concept repeatedly across their account, which may have been missed without this level of analysis.

Following the development of separate superordinate themes for each separate interview, I was concerned about the apparent difference between themes emerging from each. However, it turned out they complemented each other well in some ways, and the reappraisal into different themes was less complex than anticipated. It transpired that most themes turned out to be compatible across interviews, some were split between them. Overall, having these different concepts to rely on in developing eventual superordinate themes proved an interesting and valuable resource, deepening the final findings, and leading to a comprehensive/thorough accounting for the experience of participants.

The literature review was also an interesting journey, which I will try to convey some of here. Developing the concept was a trial initially. I was obliged to find something relevant to the area of interest with enough studies that were sufficiently contemporaneous. Eventually, following a long search through many different ideas, I found that access to MH services, with both carer and CIC views was a viable concept. Given the numbers of qualitative studies available on this topic, I had to decide about viability of including both perspectives, and whether this could be justified. I think eventually upon consideration, including both was helpful, since both key stakeholders and carers often act as gatekeepers or seekers of MH services for their CIC, where they may need to undertake informal assessments of the MH of CIC and thus flag their need to services (Villagrana, 2010). Foster carer and CIC views were largely complementary and painted the same picture of MH services for foster children.

In terms of the analysis used for the literature review, I employed meta-ethnographic synthesis, as outlined by Noblit and Hare (1988). At this stage, I must acknowledge my inexperience in terms of meta-synthesis, which led to reading around examples of the application of this methodology, through which I observed it has been interpreted and applied

in a number of ways (as discussed by France et al., 2019). As such, I endeavoured to pursue the spirit, guiding principles and structure as described by Noblit and Hare (1988), whilst practicably engaging with the data I sought to synthesise. I employed a coding technique to help structure my analysis and the translations between studies. This brought codes that briefly described the first and second order constructs into comparison with each other, allowing for identification of reciprocity or refutation in translation between the studies. As such, I was able to go beyond the findings of any single study and provide an over-arching theoretical proposition, whilst still maintaining the integrity of those initial findings. This was helped by lessons I had learned in previous research projects, where this link between eventual findings and original data had been hard to track. I achieved this through maintenance of a fastidious and detailed spreadsheet, allowing linking between construct development and precise points in the included studies, as well as relying on impressions collated via my reflective journal. This was very helpful in maintaining the integrity of the findings and enabling retrieval of relevant quotes and points from those constituent studies.

I was concerned at times that the schema-based/relational dimension of the third order constructs and final super-ordinate themes could have been misplaced. It appeared to come together so fully and naturally; a large proportion of the translations developed could be read as relational and were forming into a clear pattern. However, I had undertaken a rigorous analysis and coded very thoroughly; I felt it was an exhaustive process (largely due to my awareness of my inexperience). When I cross-checked with my academic supervisor, she agreed that the analysis appeared appropriate, which gave me confidence. Further to this, significant development took place between original formation of themes to later re-working. It was apparent there was crossover between themes, although through refinement, the five themes finally developed - with two apparently more positive than the three that included negative experiences and barriers – appearing to represent separate aspects of this

phenomenon. It was apparent that in some ways the positive themes appeared to emerge almost in response to many of the problems drawn out in the negative themes.

In development of these themes, a minimal number of data points from the original studies were excluded, although with care to include the major barriers to accessing MH services and not to diminish representation of the first and second order constructs analysed. Such trimming of data to maintain integrity of over-arching themes is expected in qualitative analysis, since we are aiming for a composite portrayal of experience, rather than comprehensive (Denovan & Macaskill, 2012).

During this redrafting of themes and cutting down content the most obvious change was that I cut a sub theme 'critical'. This focused on where people were critical of others within the feeling attacked theme. The rationale for developing this was that I encountered studies replete with critical narratives, intending to reflect a sense of feeling attacked leading to attacking others. Although I felt theoretically this was robust, when I reflected after my initial write-up, I lost confidence in its integrity. The reason was that logically, if you ask people's opinions of a system they think is letting them down, or with the inherent pressures identified across literature, you would anticipate a high level of criticism. You are essentially asking them for a critique. This does not ultimately reflect the kind of relational pattern of feeling attacked – learning to attack that I initially felt was present. Reflecting on this, I decided to remove this section. The criticism of the system was still represented via the deficiencies made apparent throughout the rest of the themes. In order not to lose anything I felt was important to convey, I considered where some of the individual points may fit into other themes and feel I managed to include them still, on the whole.

At this stage, I should perhaps acknowledge the influence of my own therapeutic practice and learning on the development of these themes. Interest in Cognitive Analytic Therapy (Ryle & Kerr, 2002), through which an individual's problematic relational patterns are

explored, certainly had an influence on the formation of this theory about the potential transference of CIC struggles, such as resentment, anxiety, and loneliness across the system surrounding them. It is important to express that this was not initially anticipated and only emerged during the analysis. Once the synthesis was underway it became increasingly evident and convincing, with further translations and subsequent third order constructs only serving to reinforce the developing narrative. Undertaking the analysis took a lot of effort and was highly time-consuming due to the comprehensive framework employed and since I attempted a physical sorting method, rather than using a computer database. This helped me feel closer to the data and also enabled greater flexibility in development of the themes, reappraising at times as the picture grew and emphasis was changed, or the overall meaning of a theme subtly altered.

In the final framework, the focus was towards how potentially common patterns of feeling experienced by children who have lived through highly distressing events in childhood may be mirrored in and compounded in accessing MH services. This conclusion directly informed the clinical implications of the study. Recognising that experiences of CIC in seeking help for MH needs may exacerbate many of the unwanted patterns of feeling and relating resulting from ACEs and developmental trauma, this should provoke profound questions for practitioners in this field. The upshot of this is that CIC needs should be considered carefully and become more prominent in the design of services.

Impact on clinical practice

As stated above, I held an interest in team formulation with reference to my clinical practice. Team formulation is something that I hope to incorporate into my work with teams and clients in the future. This study has, amongst the recognition of numerous helpful

benefits and ways that it could improve highlighted here, served to convince me of its efficacy as a tool with great diversity and adaptability.

I am aware that across MH services the issue of encouraging service users to have a greater voice in design and delivery has become much more prominent (NHS, 2019). The present study has encouraged me to think about the experiences of people encountering MH services, their possible alienation and disempowerment, the barriers that arise and difficult emotions potentially stimulated in attempting to interact with such institutions (particularly the literature review).

This has become particularly relevant with reference to my current situation, as I begin a role as part of a team setting up a new MH service. Thinking about people's engagement with MH services and retention has become a key issue and will certainly be influenced for me by my work on the present study. I am compelled now to ask questions such as 'How can they be made to feel more comfortable and at ease? How can their agency and control be promoted?' The issue of what individuals bring to services in term of their own trauma histories leads to contemplation of trauma-informed care, also increasingly prominent in local services currently. Trauma-informed care encourages services to acknowledge the impact of trauma on service-users, but also recognises the need to incorporate this awareness across multiple levels of MH services (Reeves, 2015).

Conclusion

At times this study has posed a significant challenge, not only given the breadth of the work, but also given the extraordinary wider context within which it has taken place. I have been sustained and motivated during this time in part by what I feel is the importance of retaining integrity of the participants' accounts and the importance of portraying their stories effectively. The foster care role was really important to them, all had embarked on this career

due to their strong values and desire to try and meet the needs of the young people they were seeking to help. Both studies served to represent some aspect of this very important subject – which engaged with issues around CIC and ways that support for them might be improved. This provided strong motivation to do justice to the topic and data explored in the study. I do feel that the findings from the studies are significant and do meet this aim ultimately.

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Chapter 4: Ethics Section

Ethics application research paper:

Team formulation for foster carers: a qualitative analysis

Thomas Speight

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

Word count: 3,623 (Excluding references and appendices)

All correspondence should be addressed to:

Thomas Speight

Doctorate in Clinical Psychology

Division of Health Research, Furness College

Lancaster University

Lancaster

LA1 4YF

Tel: 01524 595970

Email: tspeight1@lancaster.ac.uk

FHMREC Application form

Faculty of Health and Medicine Research Ethics Committee (FHMREC)
Lancaster University

Application for Ethical Approval for Research

Guidance on completing this form is also available as a word document

Title of Project: Team formulation for foster carers: a qualitative analysis

Name of applicant/researcher: Thomas Speight

ACP ID number (if applicable)*: n/a **Funding source (if applicable)** n/a

Grant code (if applicable): n/a

***If your project has *not* been costed on ACP, you will also need to complete the Governance Checklist [link].**

Type of study

☐ Involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants. **Complete sections one, *two* and four of this form**

☒ Includes *direct* involvement by human subjects. **Complete sections one, *three* and four of this form**

SECTION ONE

1. Appointment/position held by applicant and Division within FHM Trainee Clinical Psychologist

2. Contact information for applicant:
E-mail: t.speight1@lancaster.ac.uk **Telephone**: [redacted] (please give a number on which you can be contacted at short notice)

Address: [redacted]

3. **Names and appointments of all members of the research team (including degree where applicable)**

3. If this is a student project, please indicate what type of project by marking the relevant box/deleting as appropriate: (please note that UG and taught masters projects should complete **FHMREC form UG-tPG**, following the procedures set out on the FHMREC website

PG Diploma ☐ Masters by research ☐ PhD Thesis ☐ PhD Pall. Care ☐

PhD Pub. Health ☐ PhD Org. Health & Well Being ☐ PhD Mental Health ☐ MD ☐

DClinPsy SRP ☐ [if SRP Service Evaluation, please also indicate here: ☐] DClinPsy Thesis ☒

4. Project supervisor(s), if different from applicant: Suzanne Hodge

5. **Appointment held by supervisor(s) and institution(s) where based (if applicable)**: Lecturer, FHM, Lancaster University

SECTION TWO
Complete this section if your project involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants

1. Anticipated project dates (month and year)
Start date: End date:

2. Please state the aims and objectives of the project (no more than 150 words, in lay-person's language):

Data Management
For additional guidance on data management, please go to Research Data Management *webpage, or email the RDM support email:* rdm@lancaster.ac.uk
3. Please describe briefly the data or records to be studied, or the evaluation to be undertaken.

4a. How will any data or records be obtained?

4b. Will you be gathering data from websites, discussion forums and on-line 'chat-rooms' n o
4c. If yes, where relevant has permission / agreement been secured from the website moderator? n o
4d. If you are only using those sites that are open access and do not require registration, have you made your intentions clear to other site users? n o

4e. If no, please give your reasons

5. What plans are in place for the storage, back-up, security and documentation of data (electronic, digital, paper, etc)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with General Data Protection Regulation (GDPR) and the (UK) Data Protection Act 2018.

6a. Is the secondary data you will be using in the public domain? n o
6b. If NO, please indicate the original purpose for which the data was collected, and comment on whether consent was gathered for additional later use of the data.

Please answer the following question *only* if you have not completed a Data Management Plan for an external funder
7a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE?

7b. Are there any restrictions on sharing your data?

8. Confidentiality and Anonymity

a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications?
yes

b. How will the confidentiality and anonymity of participants who provided the original data be maintained?

9. What are the plans for dissemination of findings from the research?

10. What other ethical considerations (if any), not previously noted on this application, do you think there are in the proposed study? How will these issues be addressed?

SECTION THREE

Complete this section if your project includes *direct* involvement by human subjects

1. Summary of research protocol in lay terms (indicative maximum length 150 words):

In recent times, fostering services in the UK have tended to meet support needs of their carers via supervision and training courses. Some fostering services have begun to use meetings known as team formulation in support of their foster carers, with the aim of discussing specific children and possible responses to them. Such meetings may help carers to better understand the child's state of mind and reasons for their behaviour, with the aim of improving relationships.
The present study will aim to recruit 10-16 carers involved in this process for interviews. Interviews will focus on their experiences of team formulation, alongside issues such as how it may have changed their caring practices, understanding of the child and care-giving relationship. Information from interviews will be analysed and organised into themes representing the experiences and opinions of these carers about team formulation.

2. **Anticipated project dates (month and year only**)

Start date: Jan 2020 End date: July 2020

Data Collection and Management

For additional guidance on data management, please go to Research Data Management *webpage, or email the RDM support email:* rdm@lancaster.ac.uk

3. Please describe the sample of participants to be studied (including maximum & minimum number, age, gender):

The study will be open to all foster carers who have engaged in team formulation processes in support of a child they foster, who are employed by one of the fostering services approached to take part in this study. Participation will not be limited by gender, although demographic details such as gender and number of years-experience in fostering will be recorded during interviews, to be included in the final report. Participants should have fluent English, due to time and resource limitations in this study in relation to translation services. We aim to recruit a minimum of ten and maximum of 16 participants from these sources, which should allow for data saturation with a view to the proposed thematic analysis.

4. How will participants be recruited and from where? Be as specific as possible. Ensure that you provide the *full versions* of all recruitment materials you intend to use with this application (eg adverts, flyers, posters).

Fostering services to be targeted for recruitment have been identified as having utilised the team formulation approach recently. They are: [redacted]. It is felt, following initial consultation with managers of the services who have agreed to take part, that recruitment targets can be met.

The study will be advertised in the fostering services via posters. Further to this, flyers will detail the same information and will be made available to carers by staff in the service. Participants will be directed to contact the main researcher via email with queries for further information, or recognition of interest. Following this advertising, potential participants can be identified via the services involved using an opt-in form offered to all carers who have used team formulation. Those who agree to this can then be approached by the researcher via email if appropriate. If the maximum limit of participants is reached, carers will be advised they are not to be included initially and may be requested to act as reserve in case of withdrawal of other participants.

5. Briefly describe your data collection and analysis methods, and the rationale for their use.

Semi-structured interviews will be undertaken as the primary means of data collection. Interviews will be guided by an interview schedule and will consist of open-ended questions, designed to elicit participants' opinions and perceptions of their experiences of team formulation in fostering and the consequences of this for their care work. Participants will be offered face-to-face interviews at a mutually agreed location (presumed in the first instance to take place in the offices of fostering services if available), although the option of video call interviews will be offered.
Interview data will be transcribed and then analysed using thematic analysis, as outlined by Braun and Clarke (2006). Data will be transcribed, which will then be inductively analysed from within a critical realist epistemological stance. This initial process will allow for identification of codes, with a view to developing superordinate themes that represent the experience of the participants around team formulation.

6. What plan is in place for the storage, back-up, security and documentation of data (electronic, digital, paper, etc.)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with General Data Protection Regulation (GDPR) and the (UK) Data Protection Act 2018.

Recorded interviews will be stored on a password-protected, encrypted digital storage, once gathered. This will then be transferred directly onto password-protected file space on the Lancaster University server. Once the project has been assessed this audio data will be deleted by the primary researcher. Electronic copies of consent forms, transcripts of interview data and the subsequent analysis (i.e. coded data) will be stored long term (for a period of ten years). This will be securely transferred to the Research Coordinator of the DClinPsy admin team for storage in password-protected secure file space on the university server. It is important to note that during analysis and storage-process data will be accessible only by the main researcher and not the field supervisor, a caveat designed to reduce conflict of interest, given the field supervisor's working involvement with the above-named services.

7. Will audio or video recording take place? ☐ no ☒ audio ☐ video
a. Please confirm that portable devices (laptop, USB drive etc) will be encrypted where they are used for identifiable data. If it is not possible to encrypt your portable devices, please comment on the steps you will take to protect the data.

Data will be transferred onto encrypted USB via laptop, from digital audio recorder, a soon as possible following the interview. Once transferred, data will be deleted from the audio recorder immediately.

b What arrangements have been made for audio/video data storage? At what point in the research will tapes/digital recordings/files be destroyed?

Where videocall interviews are undertaken, these will be audio-recorded, as with other interviews.
Audio data will be stored securely, initially using password-protected, encrypted USB, then transferred to password-protected file space on the Lancaster University server. Digital audio recordings will be destroyed once the project has been assessed.

Please answer the following questions *only* if you have not completed a Data Management Plan for an external funder
8a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE?

Transcribed interview data, analysed data and consent forms will be stored electronically through the DClinPsy admin team on secure university servers. Access to this data will be restricted by password.

8b. Are there any restrictions on sharing your data ?

Due to the small sample size, even after full anonymization there is a small risk that participants can be identified. This will be made apparent to researchers via the participant information sheet and consent form, alongside recognition that anonymized data may be shared in the future for re-analysis or inclusion in further projects.

9. Consent
a. Will you take all necessary steps to obtain the voluntary and informed consent of the prospective participant(s) or, in the case of individual(s) not capable of giving informed consent, the permission of a legally authorised representative in accordance with applicable law? yes

b. Detail the procedure you will use for obtaining consent?

Written informed consent will be gained by the primary researcher at the start of the interview. Consent will be deemed as informed based on acknowledgement of provision of information about the study. Namely that: information about the study be provided, the opportunity to ask questions is made explicit, data will be anonymised and participation will remain confidential, participation is voluntary and participants may withdraw up to two weeks following the interview. In the case of video call interviews, consent will be requested at the opening of the recording verbally. This will comprise of the interviewer reading through the Participant Information Sheet and consent form, then requesting acknowledgment of understanding and consent from the participant.

10. What discomfort (including psychological eg distressing or sensitive topics), inconvenience or danger could be caused by participation in the project? Please indicate plans to address these potential risks. State the timescales within which participants may withdraw from the study, noting your reasons.

Potential distress may arise for participants discussing emotive issues, relationships or events relating to their care experiences. The main researcher will remain sensitive to potential for distress during interviews. In such cases, participants will be offered the opportunity to pause or stop the interview. Depending on contingent factors, such as level of distress and the environmental context of the interview, participants may be offered the opportunity to continue with interviews when desired, delay interviews for another time, or to withdraw from the interview. In the case of evident ongoing distress, it may be appropriate to refer onto independent support and counselling agencies, e.g. Mind, or to the participant's GP for further support. Support may also be available for foster carers via their fostering services.
Participants will be advised they are welcome to withdraw from the study at any time before and during the interview and up to two weeks following the interview.

11. What potential risks may exist for the researcher(s)? Please indicate plans to address such risks (for example, noting the support available to you; counselling considerations arising from the sensitive or distressing nature of the research/topic; details of the lone worker plan you will follow, and the steps you will take).

Risks to the main researcher appear minimal. Support will be available from the research and field supervisors.

12. Whilst we do not generally expect direct benefits to participants as a result of this research, please state here any that result from completion of the study.

There are no direct benefits to taking part in the study. Benefits may include the opportunity to promote or explore a reportedly helpful process and talk through their experiences. Further to this, participants may feel benefit from being involved in the process of refining these practices, if applicable.

13. Details of any incentives/payments (including out-of-pocket expenses) made to participants:
None planned.

14. Confidentiality and Anonymity
a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications?
yes
b. Please include details of how the confidentiality and anonymity of participants will be ensured, and the limits to confidentiality.
Since interviews may take place in fostering services, confidentiality of participation cannot be guaranteed. However, data collected from interviews will be anonymised and this data will be held privately by the main researcher in the first instance. This data will not be shared with the field supervisor, who has working relationships with the services to be targeted by the study. Also, the researcher will take into consideration further requests promoting maintenance of confidentiality where reasonable.
Interview data collected will be anonymised as far as possible during transcription, in an attempt to maintain confidentiality of participants. Detailed accounts of incidents involving young people will be transcribed omitting any identifying information and will be referred to only in general terms in the final report. Since the focus of enquiry for this study is towards learning about the team formulation process, highly specific details of incidents may well not contribute directly to development of themes meeting this aim and could be removed. However, during transcription it may also be necessary to maintain the tone and phrasing used by participants in describing such incidents in some instances. Analysis of such anecdotes may be valuable, for example, in revealing attitudes towards young people, or where employed by participants with the intention of illustrating a wider point about team formulation or foster care. A reflective appraisal of the study will be included as part of the final thesis, which will offer a space for reflection on decisions made throughout the research process. Considerations about the decision process around the level of incident-detail to be analysed will be expressed as part of this section of the document.
It will be important to explain the limits of confidentiality to participants at the start of interviews, i.e. that confidentiality can be attempted within the parameters set out above, however, where harm to self or others or the risk of this is identified this may be shared, initially with the research supervisor and consequently line managers in the case of unprofessional or harmful behaviour.

15. If relevant, describe the involvement of your target participant group in the *design and conduct* of your research.

In development of the interview schedule, staff members from one of the services involved in team formulation were consulted about the process and helpful topics to focus on. It was felt the staff members would have helpful input into development of the interview guide due to their experience in the field of foster care and introduction and use of team formulation.

16. What are the plans for dissemination of findings from the research? If you are a student, include here your thesis.

The report will be submitted as a thesis as part of a doctorate in Clinical Psychology qualification pursued by the main researcher.
A summary of the report will be shared with services involved. Upon request, the final report will be made available to these services also. This includes [redacted] the company employing field supervisor Sue Knowles, which has been instrumental in promoting and guiding the use of team formulation with the services involved.
Following marking, the report may be amended (as required) and submitted for publication in an academic/professional journal. Participants will also be offered a feedback sheet summarising the main findings of the study, distributed once the report is complete.

17. What particular ethical considerations, not previously noted on this application, do you think there are in the proposed study? Are there any matters about which you wish to seek guidance from the FHMREC?

An issue has been highlighted during review of the initial thesis proposal, which required consideration of the extent to which field supervisor Sue Knowles is to be included in data analysis elements of the study. Sue has offered oversight to clinicians within her organisation towards development of team formulation practices in the services listed above. Sue will not be involved in analysis and will not have access to the data. Her role is anticipated to include linking up the researcher with services, offering advice about the research field and literature, offering draft reads in support of written elements of the project, including the current ethics application. It is felt that alongside clear benefits to [redacted] in terms of exploration of the team formulation practices under scrutiny, the findings will be relevant in the arena of foster care and looked-after-children more generally. For example, in terms of the use of team formulation in development of care-giving relationships via promotion of mentalising and empathy, reflective practices and the consequences of such processes on responses to aversive behaviour.
A further issue pertains to disclosures of unprofessional behaviour or potential safeguarding issues due to the planned discussion of caring practices during interviews. Contingencies for such an event have been discussed with each of the services involved as part of gaining written consent for the study, in line with local procedure.

SECTION FOUR: signature

Applicant electronic signature: T Speight Date 12.11.19

Student applicants: please tick to confirm that your supervisor has reviewed your application, and that they are happy for the application to proceed to ethical review ☒

Project Supervisor name (if applicable): Suzanne Hodge Date application discussed 12.11.19

Submission Guidance

1. **Submit your FHMREC application by email to Becky Case (**fhmresearchsupport@lancaster.ac.uk) as two separate documents:
    i. **FHMREC application form.**
    Before submitting, ensure all guidance comments are hidden by going into 'Review' in the menu above then choosing *show markup>balloons>show all revisions in line.*
    ii. **Supporting materials.**
    Collate the **following materials for your study, if relevant, into a single word document:**
        a. **Your full research proposal (background, literature review, methodology/methods, ethical considerations).**
        b. Advertising materials (posters, e-mails)
        c. Letters/emails of invitation to participate
        d. Participant information sheets
        e. Consent forms
        f. Questionnaires, surveys, demographic sheets
        g. Interview schedules, interview question guides, focus group scripts
        h. Debriefing sheets, resource lists

    Please note that you DO NOT need to submit pre-existing measures or handbooks which support your work, but which cannot be amended following ethical review. These should simply be referred to in your application form.
2. Submission deadlines:
    i. Projects including direct involvement of human subjects **[section 3 of the form was completed]**. The *electronic* version of your application should be submitted to Becky Case **by the committee deadline date.** Committee meeting dates and application submission dates are listed on the FHMREC website. Prior to the FHMREC meeting you may be contacted by the lead reviewer for further clarification of your application. Please ensure you are available to attend the committee meeting (either in person or via telephone) on the day that your application is considered, if required to do so.
    ii. The following projects will normally be dealt with via chair's action, and may be submitted at any time. **[Section 3 of the form has *not* been completed, and is not required].** Those involving:
        a. existing documents/data only;
        b. the evaluation of an existing project with no direct contact with human participants;
        c. service evaluations.

Appendix 4-A: Research paper protocol

Team formulation for foster carers: a qualitative analysis

Main researcher: Thomas Speight

Research supervisor: Dr Suzanne Hodge

Field supervisor: Dr Sue Knowles

Rationale

Recent statistics around foster care in the UK suggest an increasingly difficult field in which to work, with a growing schism between demand and resources. Numbers of children in foster care are increasing (53,000 in 2018), whereas available foster care placements are reducing in number (Ofsted, 2018). Additionally, the number of unplanned endings for placements has increased. A contributory factor in placement breakdowns is often cited as children's behaviours of concern and consequent impact on relationships with caregivers. Children in foster care often have a history of neglect or abuse, which can impact significantly on emotional wellbeing and development. The National Institute for Health and Care Excellence (NICE) guidelines suggest that 45% of children in foster care may fit the criteria for a diagnosable mental health condition (NICE, 2013), which may be connected to such adverse histories. Conversely, the benefits of a stable placement on children's attachment relationships and mental health have been officially acknowledged (Social Care Institute for Excellence, 2017).

Foster care has been described as a challenging, multi-faceted occupation, requiring patience, resilience and compassion alongside specialised training and knowledge of policy and legislation (Narey & Owers, 2018). Research has shown the potential for high levels of stress amongst carers (Harding, Murray, Shakespeare-Finch, & Frey, 2018). Consequently, foster carers should be offered

training and support towards understanding the impact on children of neglect and trauma over time (Murray, Tarren-Sweeney, & France, 2011). Such support should also be personalised to the child and carers themselves (Harding, Murray, Shakespeare-Finch, & Frey, 2018).

Specialist foster care services traditionally offer a limited range of support to foster carers, including training and supervision. In order to better meet the above described need, some services have recently adopted a team formulation (TF) approach involving carers and a multi-disciplinary team, including psychologists and social workers. Formulation is an important tool in Clinical Psychology practice, aimed at co-creating hypotheses about what is happening for someone, and how they understand this, leading to planning based on this shared understanding (Johnstone, 2018). Due to the focus on developing understanding for all parties involved, formulation can be part of a wider process, or be utilised as a discrete intervention itself. TF engages a staff team collectively. It is seen as a unifying practice, allowing cohesion through interdisciplinary working (Kelly, Rhodes, Macdonald & Mikes-Liu, 2018). In this case, TF is a multi-functional process, designed to consider anticipated challenges, coping and resources available to carers.

Research literature focusing on TF has highlighted benefits of this approach for staff involved, which may also be evident for foster carers and the services that support them. For example, TF was acknowledged as helping staff from an inpatient multi-disciplinary mental health service maintain positivity and empathy in the face of adversity (Dallimore, Christie, & Loades, 2016). TF helped staff employed in an inpatient mental health service for adolescents normalise the challenges presented by young people, consider individual complexities and anticipated difficulties, as well as identify areas of strength and need (Price, Knowles, Greasley, & Dunn, 2016). The benefits of TF are consistently identified in improving insight, communication, generating ideas, reducing negative reactions, reducing blame, managing risk and maintaining morale and hope (Dallimore, Christie, & Loades, 2016; Johnstone, 2018; Whitton, Small, Lyon, Barker, & Akiboh, 2016).

TF has been described as helping move staff perception of young people away from narrow labels and towards seeing them as individuals (Price, Knowles, Greasley, & Dunn, 2016). Such processes may promote adoption of an empathic stance in response to children's behaviour of concern

(as described below), in contrast to potential narrower narratives of irreparably damaged, troubled children who are beyond help. Such shifts of understanding are a significant topic to be explored with carers via the present study.

In cases to be included in the present study, an important aim of TF was to develop carers' skills of mentalising; the ability to consider the mental states of self and others. Kim Golding (2008) explains that abuse by birth parents can lead to children internalising rejecting, persecutory relational patterns; frameworks that are projected in relationships across the lifespan. Thus, for children in care, promotion of reparative, empathic relationships with caregivers can be vital and increase the likelihood of beneficial outcomes in adulthood. Carers' ability to mentalise and utilise reflective function acts as a model for the child, facilitating growth within an attuned, dependable relationship. Research has shown attachment, challenging behaviour and foster placement breakdowns are connected to carers' capacity to mentalise (Cooper & Redfearn, 2016).

TF has been criticised as lacking evidence towards beneficial outcomes, due to heterogeneity in approaches preventing comparison (Geach, Maghaddam & De Boos, 2018). However, this flexibility has also been described as a strength of the approach. Indeed, Lucy Johnstone (2018) explains it would be an error to attempt standardisation, due to TF's focus on exploring meaning and experience (Johnstone, 2018), suggesting qualitative exploration may be more appropriate in examining this process.

Given recognition of the need for further research into TF in action (Johnstone, 2014; Price, Knowles, Greasley & Dunn, 2016) as well as the relative novelty of using TF in this way with foster carers, the present study aims to explore experiences of foster carers who have engaged in this process. This may focus on the process of TF and comparison to previous experience and practice. Importantly, it will facilitate exploration of foster carers' feelings of support, security and containment, their mind-mindedness and changes to reflective function. Has engagement with TF helped foster carers feel differently about the children they support, has it changed the nature and quality of relationships with their foster children, and led to greater consideration of helpful responses to behaviour? It is hoped this study will contribute to wider research literature about the value and promotion of reflective

functioning and mentalising in foster care and the field of children in care, and in particular, the use of TF in pursuit of these aims. Given these aims, the main research question is: 'what do foster carers see as the impact of engaging with team formulation on their fostering, including understanding of the fostered child, impact on child's behaviours of concern and the quality of their relationship?'

Method

Participants.

Participants will be paid foster carers from fostering services in the North West and Midlands of the UK: [redacted], [redacted] and [redacted]. The study will be open to all foster carers who have engaged in team formulation processes in support of a child they foster, who are employed by one of the fostering services approached to take part in this study. Participation will not be limited by gender, although demographic details such as gender and number of years-experience in fostering will be recorded during interviews, to be included in the final report. Participants should have fluent English, due to time and resource limitations in this study in relation to translation services. We aim to recruit a minimum of ten and maximum of 16 participants from these sources, which should allow for data saturation with a view to the proposed thematic analysis.

Design.

The study will employ a qualitative phenomenological methodology in exploring the experience of foster carers. Qualitative methods have been described as well suited to understanding process and experience (Thompson & Harper, 2012). The study will employ thematic analysis of semi-structured interview data, as described by Braun and Clarke (2006). This approach will allow representation of the experience of carers who have engaged in team formulation; of the process and consequences of engaging in this practice for their work caring for fostered children. These results will be reflected upon and, if appropriate, interpreted with respect to relevant literature pertaining to foster care,

attachment, behaviour management and team formulation. Thematic analysis is valued for its flexibility, in that it allows scope for description of similarities and differences across a data set, recognition of unanticipated insights and allows for a phenomenological interpretation of participants' accounts of their experience (Braun & Clarke 2006). During analysis, development of superordinate themes relating to data collected should provide an overview of how these formulation meetings are experienced, as well as allowing for pertinent issues relating to the process and its consequences to be raised. Themes will be presented in the final report with a clear rationale and evidence of their development from the initial data collected.

As described above, Johnstone (2018) suggests that since team formulation is a process exploring individual meaning and experience within a specific context, qualitative exploration would be more suitable than quantitative approaches in any research in this field. The present study will take place within a critical realist paradigm (Bhaskar, 1997). As such, the accounts of participants will be valued as providing insight into the mechanisms of TF within this context and the changes that come about as a result. It will be important for the main researcher to offer a statement of position and intent as part of the final report in order to provide the reader with contextual information within which to frame the analysis and findings of the study.

Materials.

A semi-structured interview will be employed to gather data from participants. The interview will be informed by an interview topic guide (appendix 5). The guide has been prepared in reference to recent research literature around team formulation, foster care and phenomena under-scrutiny, such as reflective functioning ability and mind-mindedness. Questions are designed to elicit free recall of experiences and participants will be encouraged to offer richly detailed descriptions of the process and of consequences in their understanding of and resulting work with young people. In an attempt to include relevant stakeholders in the design of the study, the guide has been developed in consultation with foster services staff who have been involved in team formulation as part of their practice. It is hoped their input has provided further insight into the process of team formulation in this context.

Procedure.

Fostering services to be targeted for recruitment have utilised the team formulation approach recently. They are: [redacted], [redacted] and [redacted]. It is felt, following initial consultation with managers of the services who have agreed to take part, that recruitment targets can be met.

The study will be advertised in the fostering services via posters (appendix 4). Further to this, flyers will detail the same information and will be made available to carers by staff in the services. Terminology for 'team formulation' used in posters, flyers, opt-in forms, information sheets and the interview guide will be appropriately amended to match that familiar to foster carers in each service. For example, in [redacted], it is known as 'case formulation meetings'. Participants will be directed to contact the main researcher via email with queries for further information, or an initial recognition of interest. Following this advertising, potential participants can be identified via the services involved using an opt-in form (appendix 3) offered to appropriate carers who have used team formulation via their fostering services. Those who agree to this can then be approached by the researcher via email if appropriate. If the maximum limit of participants is reached, additional applicants will be advised they are not to be included initially and may be requested to act as reserve in case of withdrawal of other participants.

Written informed consent (appendix 2) will be gained by the primary researcher at the start of the interview. Consent will be deemed as informed based on acknowledgement of information provided about the study (appendix 1). Namely that: information about the study was provided, the opportunity to ask questions was made explicit, data will be anonymized and participation will remain confidential, participation is voluntary and participants may withdraw up to two weeks following the interview. In the case of video call interviews, consent will be requested at the opening of the recording verbally. This will comprise of the interviewer reading through the Participant Information Sheet and consent form, then requesting acknowledgment of understanding and consent from the participant.

Participants will be offered face-to-face interviews at a mutually agreed location (presumed in the first instance to take place in the offices of fostering agencies if available), although the option of video call interviews will be offered. Where video call interviews take place, these will also be audio recorded. Interviews will be guided by an interview schedule and will consist of open-ended questions, designed to elicit participants' opinions and perceptions of their experiences of team formulation in fostering and the consequences of this for their care work. Once the report is complete, participants will be offered a feedback sheet outlining the main findings of the study.

Interview data will be transcribed and then analysed using thematic analysis, as outlined by Braun and Clarke (2006). Data will be transcribed, which will then be inductively analysed from within a critical realist epistemological stance. This initial process will allow for identification of codes, with a view to developing superordinate themes that represent the experience of the participants around team formulation.

Proposed analysis

Thematic analysis (Braun & Clarke, 2006) will be employed in analysing interview data. The researcher will familiarise himself with the data prior to analysis. Transcribed data will then be analysed line by line and given initial codes. Initially, the data will be analysed from a phenomenological standpoint (Braun & Clarke, 2006). This coded data will then be organised within appropriate super-ordinate themes. Once named, the interview data can be re-examined with consideration of these themes and their validity assessed. At this stage, sub-themes may be developed, enabling fuller representation of the data set. Interpretation of the research findings and the significance of this in terms of research literature pertaining to team formulation and foster care will be considered. This will hopefully lead to insight into the perceived value of team formulation in this context, allowing for recognition of experience of the process and consequences for those interviewed, with potential for recommendations about the process itself and viability for further use in this setting.

Practical issues

Participants will be offered face-to-face interviews at a mutually agreed location (presumed in the first instance to take place in the offices of fostering agencies if available), although the option of video call interviews will be offered. It is probable that the majority of interviews will take place in offices associated with the fostering agencies taking part in the project. Where possible, this should be organised by the main researcher in order to attempt to maintain anonymity of the participants as far as possible.

Recorded interviews will be transferred directly onto password-protected, encrypted digital storage via laptop, as soon as possible following the interview. This data will then be transferred directly onto password-protected file space on the Lancaster University server. Once the project has been assessed this audio data will be deleted by the primary researcher. Electronic copies of consent forms, transcripts of interview data and the subsequent analysis (i.e. coded data) will be stored long-term (for a period of ten years). This data will be securely transferred to the Research Coordinator of the DClinPsy admin team for storage in password-protected secure file space on the university server. Physical copies of these documents will be destroyed via confidential shredding once the report has been submitted for assessment. It is important to note that during analysis and the storage process data will be accessible only to the main researcher and not the field supervisor, a caveat designed to reduce conflict of interest, given the field supervisor's working association with the above-named agencies.

No supplementary costs are anticipated as part of this study.

Ethical concerns

Written approval of the managers of services to be included in the study has been sought and granted.

Interview data collected will be anonymised as far as possible during transcription, in an attempt to maintain confidentiality of participants. This will include anonymisation of information pertaining to fostered children, including use of pseudonyms. Where specific incidents are related this may not be possible, since staff members in services may be aware of specific incidents or people

discussed. This may become an issue where direct quotes are used in reporting of the analysis, i.e. as descriptors of themes derived from the data. This will be made clear at the start of interviews.

It will be important to explain the limits of confidentiality to participants at the start of interviews, i.e. that confidentiality can be attempted within the parameters set out above, however, where harm to self or others, or the risk of this, is identified this may be shared, initially with research supervisors and consequently line managers, if required, in the case of unprofessional or harmful behaviour. This should be in accordance with the local policies of those agencies involved.

Potential distress may arise for participants discussing emotive issues, relationships or events relating to their care experiences. The main researcher will remain sensitive to potential for distress during interviews. In such cases, participants will be offered the opportunity to pause or stop the interview. Depending on contingent factors, such as level of distress and the environmental context of the interview, participants may be offered the opportunity to continue with interviews when desired, delay interviews for another time, or to withdraw from the interview. In the case of evident ongoing distress, it may be appropriate to direct participants to seek support from independent support and counselling agencies, e.g. Mind, or to the participant's GP for further support. Support may also be available for foster carers via their fostering services. Participants will be advised they are welcome to withdraw from the study at any time before and during the interview and up to two weeks following the interview.

An issue has been highlighted during review of the initial thesis proposal, which required consideration of the extent to which field supervisor Sue Knowles will be included in data analysis elements of the study. Sue provides oversight to clinicians within her organisation ([redacted]) in development of team formulation practices in consultation with the agencies listed above. Given her involvement with the services involved in the study, it would not be appropriate for Sue to have access to participant data. Therefore, Sue will not be involved in the process of data analysis. Her role is anticipated to include linking up the researcher with services, offering advice about the research field and literature, offering draft reads in support of written elements of the project, including the current ethics application. It is felt that alongside clear benefits to [redacted] in terms of

exploration of the team formulation practices under scrutiny, the findings will be relevant in the arena of foster care and children in care more generally. For example, in terms of the use of team formulation in development of care-giving relationships via promotion of mentalising and empathising, reflective practices and the consequences of such processes on carers' responses to aversive behaviour.

Timescale

- Ethical review – Jan 2020
- Data collection –Feb 2020
- Data analysis – end March 2020
- Writing report and draft reads – April 2020
- Revision and finalising report – May 2020
- Submission - June/July 2020

Appendices

1) Participant Information Sheet
2) Consent form
3) Opt-out form
4) Poster/flyer
5) Interview question schedule
6) Letter of consent from services

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Appendix 4-B: Interview topic guide

Thesis project: Team formulation with foster carers: a qualitative analysis
Interview question guide

Foster care work

How did you come into foster care work?

Prompt: What first led to you choose fostering?

Could you tell me about the role of being a foster carer?

Prompt: what are the main tasks and responsibilities of being a foster carer?

Can you tell me about any particularly positive or negative experiences you've had through foster care? Challenges particularly leading to TF? That you think others may face that TF could help with?

Prompt: what has been good or hard about fostering?

Foster services & support

Whilst you've done this role, has anything changed about foster care work in your experience?

Prompt: How have things changed over time in foster care work?

Has the level or amount of challenges from YP you face changed during your time in this work?

Prompt: Have you noticed any differences in the children you work with?

How much training and preparation for coming into this type of work did you receive?

Prompt: What type of support did you receive starting work as a foster carer?

Experiences of doing TF – process

How would you describe TF to someone who hasn't heard of it?

Prompt: what is involved in TF? process

How many TF meetings and/or consultations have you taken part in?

Prompt: How long have you been part of the TF process in your service?

Can you give an example of using TF and what happened?

Prompt: Can you tell me about a time you took part in TF around one of the YP you have fostered?

Effects of team formulation

In what ways would you say TF influenced your understanding of the YP?

Prompt: How did being able to discuss the YP with other professionals help you think about them in different ways?

Can you tell me about any changes to your feelings about the YP during or after TF?

Prompt: how far would you say your relationship with the YP has been affected since TF?

In what ways did TF help you think about ways to respond to YP's behaviour?

Prompt: Are there ways TF could help you support a YP who is showing behaviour that challenges?

In what ways do you think your support for the YP might have been different without TF?

Prompt: would the outcome with that YP have been different without taking part in TF?

Are there any ways being involved in TF has led to you thinking about your own reactions to the YP?

Prompt: do you think that TF allowed you space to talk and think about how the YP's behaviour made you feel?

Has being involved in TF changed your relationship with the service in any way?

Prompt: how is TF a different way of working with the service than before?

How have discussions with other professionals in TF helped you to focus on your own self care?

Prompt: is there anything you do differently to help look after yourself following TF?

Changes to TF

How do you feel about being able to meet with other types of professionals in TF meetings?

Prompt: Did you think there was the right number and types of professionals in the TF meetings?

In what ways could TF be improved?

Prompt: is there anything about TF you would change in supporting you to care for children who are fostered?

Do you think you would recommend TF to someone who hasn't tried it, and if so why?

Prompt: How would you persuade someone to try TF meetings about YP?

Appendix 4-C: Participant Information Sheet

Participant Information Sheet

Team formulation for foster carers: A qualitative analysis

My name is Tom Speight and I am conducting this research as a student in the DClin Psychology programme at Lancaster University, Lancaster, United Kingdom.

What is the study about?

The purpose of this study is to find out how foster carers experience team formulation meetings within their fostering service. We are hoping to talk to people about the meetings, how it was to take part, whether anything could be done differently and what was useful about them. Given that foster care is recognised as a really challenging occupation, we are interested in how far these meetings were helpful in easing some of this burden, how far they helped to influence the relationship carers have with a young person and anything foster carers noticed changing as a result of these meetings.

Why have I been approached?

You have been approached because the study requires information from people who are foster carers that have used team formulation meetings to talk about the young person they support, or are going to support. If you have taken part in this type of meeting, we are hoping to talk to you about what it was like.

Do I have to take part?

No. It's completely up to you to decide whether or not you take part, although there is an upper limit to the amount of people who will be interviewed, so everyone might not have the chance to sign up.

What will I be asked to do if I take part?

If you decide you would like to take part, you would be asked to sign consent that you understood what is involved, before undertaking an interview with myself, which will be audio-recorded. Interviews will usually be between 30 minutes to an hour. We can try to arrange this at a time and place to suit you. We can also arrange to do interviews using video-call if that is helpful.

Will my data be Identifiable?

The information you provide is confidential. Any quotes taken from your interview that are used to back up the conclusions being made will be anonymised. It might be the case that descriptions given about shared experiences may be recognised by others. The data collected for this study will be stored securely:

- Audio recordings will be destroyed and/or deleted once the project has been submitted for publication/examined.
- The files on the computer will be encrypted (that is no-one other than the researcher will be able to access them) and the computer itself password protected.
- The typed version of your interview will be made anonymous by removing any identifying information including your name. Anonymised direct quotations from your interview may be used in the reports or publications from the study, so your name will not be attached to them.
- All your personal data will be confidential and will be kept separately from your interview responses.
- Anonymised data may be shared for re-analysis or further projects in the future.

There are some limits to confidentiality: if what is said in the interview makes me think that you, or someone else, is at significant risk of harm, I will have to break confidentiality and speak to a member of staff about this. If possible, I will tell you if I have to do this.

What will happen to the results?

The results will be summarised and reported, which will be shared with the team and with people who have taken part. The report will be submitted for assessment towards my qualification in Clinical Psychology. It is possible that the report will be published in an academic journal.

Are there any risks?

There are no risks anticipated with participating in this study. However, if you experience any distress following participation you are encouraged to inform the researcher and contact the resources provided at the end of this sheet.

Are there any benefits to taking part?

Although you may find participating interesting, there are no direct benefits in taking part.

Who has reviewed the project?

This study has been reviewed and approved by the Faculty of Health and Medicine Research Ethics Committee at Lancaster University.

Where can I obtain further information about the study if I need it?

If you have any questions about the study, please contact the main researcher, or research supervisor:

Tom Speight (primary researcher)
t.speight1@lancaster.ac.uk
Tel: tbc

Suzanne Hodge (research supervisor)
s.hodge@lancaster.ac.uk

Sue Knowles (field supervisor)
[redacted]

Complaints

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

Bill Sellwood
Tel: (01524) 593 998
Professor of Psychology
Email: b.sellwood@lancaster.ac.uk
Faculty of Health and Medicine
Lancaster University
Lancaster
LA1 4YG

If you wish to speak to someone outside of the [name of] Doctorate Programme, you may also contact:

Professor Roger Pickup Tel: +44 (0)1524 593746
Associate Dean for Research Email: r.pickup@lancaster.ac.uk
Faculty of Health and Medicine
(Division of Biomedical and Life Sciences)
Lancaster University
Lancaster
LA1 4YG

Thank you for taking the time to read this information sheet.

Resources in the event of distress

Should you feel distressed either as a result of taking part, or in the future, the following resources may be of assistance. .....

Mind Charity
www.mind.org.uk
0300 123 3393

Samaritans
www.samaritans.org
116 123

Your General Practitioner

Appendix 4-D: Consent form

Consent Form

Team formulation for foster carers: A qualitative analysis

We are asking if you would like to take part in a research project looking into how foster carers experience team formulation meetings within their fostering agency. We are hoping to talk to people about the meetings, how it was to take part, whether anything could be done differently and what was useful about them.

Before you consent to participating in the study, we ask that you read the participant information sheet and mark each box below with your initials if you agree. If you have any questions or queries before signing the consent form please speak to the principal investigator, Tom Speight.

	Please initial each statement
1. I confirm that I have read the information sheet and fully understand what is expected of me within this study	☐
2. I confirm that I have had the opportunity to ask any questions and to have them answered.	☐
3. I understand that my interview will be audio recorded and then made into an anonymised written transcript.	☐
4. I understand that audio recordings will be kept until the research project has been examined.	☐
5. I understand that my participation is voluntary and that I am free to withdraw up to 2 weeks following the interview without giving any reason.	☐
6. I understand that once my data have been anonymised and incorporated into themes it might not be possible for it to be withdrawn, though every attempt will be made to extract my data, up to the point of publication.	☐
7. I understand that the information from my interview will be pooled with other participants' responses, anonymised and may be published.	☐
8. I understand that my anonymised interview data may be shared in the future for re-analysis or use in further projects.	☐
9. I consent to information and quotations from my interview being used in reports, conferences and training events.	☐
10. I understand that the researcher will discuss data with their supervisor as needed.	☐
11. I understand that any information I give will remain confidential and anonymous unless it is thought that there is a risk of harm to myself or others, in which case the principal investigator may need to share this information with their research supervisor.	☐
12. I consent to Lancaster University keeping written transcriptions of the interview for 10 years after the study has finished.	☐
13. I consent to take part in the above study.	☐

Name of Participant_____ Signature_____ Date _____

Name of Researcher _____Signature _____Date _____

By agreeing to be interviewed you confirm that:

- You have read the information sheet and understand what is expected of you within this study
- You confirm that you understand that any responses/information you give will remain anonymous
- Your participation is voluntary
- You consent for the information you provide to be discussed with my supervisor at Lancaster University
- You consent to Lancaster University keeping the anonymised data for a period of 10 years after the study has finished

Appendix 4-E: Participant opt-in form

Study Opt-in form

Health & Medicine | Lancaster University

Dear sir/madam

This letter is to let you know about some research that is taking place with your fostering service. The research study is about how foster carers have experienced team formulation sessions. What was it like and has it affected their support for young people? Do they have anything to tell us about how they found team formulation, is there anything to change and what was helpful about the meetings? I am planning to approach foster carers who have undertaken team formulation, with a request to take part in an interview at their convenience about how they found it. This will be anonymous and confidential, as far as possible.

We have sent through this form to everyone who has taken part in these sessions, along with an information sheet with more information and contact details for the researchers. If you have any interest in helping with this study by talking to us, please could you return the form below, at which point we will contact you.

Team formulation for foster carers: A qualitative analysis

I understand that this study is taking place with the fostering service. I would like to be invited to take part in this study.

Signed: _____

Print name: _____

Please return this form as soon as possible if you want to take part in the study

Appendix 4-F: Study marketing poster/flyer

Foster Carers

WE NEED YOUR HELP

LANCASTER UNIVERSITY
RESEARCH PROJECT

EXPERIENCES OF USING TEAM FORMULATION

WOULD YOU LIKE TO TAKE PART IN SOME RESEARCH?

- have you used team formulation to talk about a young person?
- would you like to take part in some research about these meetings and whether they should be used more widely in fostering?

IF SO, WE WOULD LIKE TO HEAR FROM YOU!

WHAT WOULD BE INVOLVED?

- taking part in an interview for 30 mins to an hour.
- discussing your experiences of team formulation, how it could be changed, what was helpful and the consequences for you.
- interviews to take place at your convenience, which can be by video call or face-to-face.
- we aim to be confidential with information provided in interviews as far as possible.

If you would like to participate in the study and to find out more please contact the researcher by email:
Tom Speight: t.speight1@lancaster.ac.uk
Alternatively for more information about the research please contact:
Dr Suzanne Hodge: s.hodge@lancaster.ac.uk

Appendix 4-G: FHMREC ethics approval letter

Applicant: Thomas Speight
Supervisor: Suzanne Hodge
Department: Health Research
FHMREC Reference: FHMREC19094

07 May 2020

Dear Thomas

Re: Team formulation for foster carers: a qualitative analysis

Thank you for submitting your research ethics amendment application for the above project for review by the **Faculty of Health and Medicine Research Ethics Committee (FHMREC)**. The application was recommended for approval by FHMREC, and on behalf of the Chair of the Committee, I can confirm that approval has been granted for the amendment to this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact me if you have any queries or require further information.

Tel:- 01542 593987
Email:- fhmresearchsupport@lancaster.ac.uk

Yours sincerely,

R.E. Case

Becky Case
Research Ethics Officer, Secretary to FHMREC.

Appendix 4-H: IPA method amendment FHMREC approval confirmation

RE: thesis ethics approval query

FHM Research Ethics <fhmresearchsupport@lancaster.ac.uk>
Tue 08/09/2020 15:22
To:

- Speight, Thomas (Student) <t.speight1@lancaster.ac.uk>

Cc:

- FHM Research Ethics <fhmresearchsupport@lancaster.ac.uk>

Dear Tom,

Thank you for the information.

You can analyse your data from the study FHM 19029 'Team formulation for foster carers: a qualitative analysis'
amended to FHM19096 using the IPA analysis method.

This has been approved by the Chair of FHM REC.

Best regards

Elisabeth

Dr Elisabeth Suri-Payer | Business Gateway Officer and Interim Research Ethics Officer

Chat with me in Teams
E-Mail: e.suri-payer@lancaster.ac.uk
FHM Ethics: fhmresearchsupport@lancaster.ac.uk
FST Ethics: fst-ethics@lancaster.ac.uk
Mobile: 07539 474603
www.lancaster.ac.uk