Submitted in partial fulfilment of the Lancaster University Doctorate in Clinical Psychology

May 2014

Doctoral Thesis

Caring for Looked After Children from the Perspectives of Foster Carers and Social Workers

Kate Houlihan

Doctorate in Clinical Psychology

Division of Health Research

Lancaster University

Word Count

Section	Main text	References and appendices (including title pages, tables and abstracts)	Total
Thesis abstract	298	N/A	298
Literature review	7,981	8,197	16,178
Empirical paper	7,987	8,051	16,038
Critical appraisal	3,762	539	4,301
Ethics section	3,208	6,102	9,310
Total	23,236	22,889	46,125

Thesis Abstract

This thesis explores the provision of care for looked after children from the perspectives of foster carers and social workers. It comprises of a literature review, a research paper, a critical appraisal of the research, and an ethics section.

The literature review aimed to explore the psychological needs of foster carers and how these needs may be met. A meta-ethnographic method was used to analyse and synthesise 21 qualitative research papers that addressed this topic. Five key themes were identified: the emotional experience of being a foster carer; being a 'parent' without parental rights; attachment and loss; value and frustration: two sides of professional support; and being truly understood: the value of peer support. The findings are discussed in relation to psychological theory and other research in this field. A number of clinical implications are discussed, along with recommendations for further research.

The research paper aimed to explore social workers' experiences of psychological consultation around their work with looked after children. Eight social workers participated in semi-structured interviews, in which they were asked to reflect upon their experiences of psychological consultation. All interviews were transcribed and then analysed using interpretative phenomenological analysis. Four themes were identified: An alternative perspective: Seeking expertise; A dual-purpose: consultation for families and the self; Consultation as a lifeline: The final chance; and Validation and acknowledgement: The psychological experience of consultation. The findings are discussed within the context of psychological theory and national policy around the care of looked after children. A number of clinical implications are highlighted and the role of clinical psychologists in the support of social workers is discussed. Recommendations for further research in this area are outlined.

The critical appraisal provides a reflective discussion of the research project. Issues relating to research design and researcher reflexivity are discussed.

Declaration

This thesis records work undertaken for the Doctorate in Clinical Psychology at the Division of Health Research, Lancaster University, from August 2013 to May 2014.

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 a higher degree elsewhere.

Name: Kate Houlihan

Signature:

Date: 16.09.14

Acknowledgements

I would like to thank all of the participants who gave their time to take part in my research project. I was acutely aware of how little time my participants had to spare and so I am extremely grateful to all of those who took part, the project would not have come together without you. My thanks go to my supervisors, Suzanne and Hazel, for all of your help along the way, from when this project was only an idea to the draft reads and advice you gave during the final stages. To my family, partner and friends; I would not have got through these past three years without you. Thank you all for always sticking with me through the highs and lows, for making me hundreds of cups of tea and for reminding me never to give up. Finally, I would like to thank every member of the 2011 cohort; without you my training and thesis journeys would just not have been the same. Thank you for getting me through with endless motivation, support, laughter and, of course, cake.

Contents

Section One: Literature Review

Section Two: Empirical Paper

Section Three: Critical Appraisal

Section Four: Ethics Section

Section One: Literature Review

The Psychological Needs of Foster Carers: A Systematic Review

Word Count: 7,981

Kate Houlihan

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

All correspondence should be sent to:

Kate Houlihan
Doctorate in Clinical Psychology
Furness College
Lancaster University
Lancaster
LA1 4YT
k.houlihan@lancaster.ac.uk

Prepared for Child and Family Social Work[1]

---

[1] See Appendix 1-B for 'Notes to Contributors'

Abstract

This aim of this paper was to systematically review qualitative research into the psychological needs of foster carers and how these needs may be met. Twenty-one papers met the inclusion criteria and were included in this review. A meta-ethnographic method was used to analyse and synthesise the findings of these research studies. Five key themes were identified in the data: The emotional experience of being a foster carer; Being a 'parent' without parental rights; Attachment and loss; Value and frustration: Two sides of professional support; and Being truly understood: The value of peer support. The findings were represented across all of the studies, though it is noted that the papers varied in the quality of reporting. The findings are discussed in relation to psychological theory, along with other research and professional and government guidelines in this field. A number of clinical implications are discussed, along with recommendations for further research in this subject area.

Keywords: foster carers; psychological experience; attachment; support needs

Foster-carers provide a family environment for children who are unable to remain living with their biological families (Barratt, 2002; Maluccio et al., 2006; Blythe et al., 2013b). In recent years, the number of children who are looked after by the state in the UK has increased (NSPCC, 2014), resulting in an increased demand for foster care placements (Triseliotis et al., 1998; Blythe et al., 2013b). This trend has also been reported internationally, including in Australia (Gilbertson and Barber, 2003; Riggs et al., 2009), the USA (Lauver, 2010) and Canada (Jones and Morrissette, 1999). However, this need has not been met with an increase in carers (Gilbertson and Barber, 2003; Farmer et al., 2005; Colton et al., 2008; Riggs et al., 2009).

Looked after children (LAC) are frequently removed from the care of their families for reasons such as neglect and abuse, and have often experienced several changes of home and caregiver (Kinsey and Schlosser, 2012). As such, these children can present with complex mental and physical health needs (Callaghan et al., 2004; Hibbert and Frankl, 2011). A shift from accommodating LAC in residential care has increased the demand for foster placements (Colton et al., 2008) and has resulted in children with complex psychological, behavioural, social and health needs being cared for by foster families (Allen and Vostanis, 2005).

Research investigating the impact of foster care has tended to focus on outcomes for LAC (e.g. - Minnis et al., 1999; Gilbertson and Barber, 2003; Farmer et al., 2005; Austerberry et al., 2013), though has begun to focus on the impact on carers. Linked to the mismsatch between supply and demand of placements, some research has investigated factors associated with retention of carers. Gilbertson and Barber (2003) interviewed foster carers to understand what had contributed to their ending a placement. Carers reported feeling unprepared, with a lack of information about their foster children, and finding it difficult to cope due to inconsistent professional support. Participants reported ending placements due to feeling unable to manage children’s behaviour and feeling concerned about their own wellbeing should the placement continue. Farmer et al., (2005) reported similar findings from a UK study investigating the impact of foster carer stress on placement outcome. Participants reported several stressors, including fearing allegations being made against them by children, difficulties managing behaviour and hostility from others, such as from neighbours who did not want to live near to foster children. These difficulties, in addition to self-reported stress prior to beginning placements, were associated with increased placement disruption and breakdown (Farmer et al., 2005).

Further to this, a number of quantitative studies have identified factors associated with foster carer wellbeing. A key factor appears to be social support, with greater support being associated with a reduced risk of depression (Cole and Eamon, 2007), reduced stress (Soliday et al., 1994; Ivanova and Brown, 2010), and greater role satisfaction (Soliday et al., 1994; Rhodes et al., 2003). In a survey of Australian foster carers investigating wellbeing and satisfaction, Whennan et al., (2009) found that carers’ self-reported parenting self-efficacy was associated with greater satisfaction, wellbeing and an intention to continue to provide placements. Additionally, those who reported greater self-efficacy in managing children’s behaviour perceived fewer behavioural difficulties. Considering the association between difficulties in managing behaviour and feeling unable to cope (Gilbertson and Barber, 2003; Farmer et al., 2005), carers’ beliefs in their own abilities appears key to their wellbeing.

Foster children often experience difficulties in forming new relationships due to their previous experiences (Golding, 2003; Kinsey and Schlosser, 2012). Additionally, Kinsey and Schlosser (2012) identified that foster carers may feel trepidation about investing in relationships with foster children due to uncertainty about placement duration. Indeed, Whennan et al., (2009) found a significant, positive association between carers’ relationships with foster children and their self-reported stress and role satisfaction. This suggests that forming relationships with foster children can be a key stressor and is likely to impact upon carers' coping and wellbeing.

Guidelines suggest that foster carers should be provided with initial training, support in forming relationships with LAC and training updates (The Fostering Network, 2004; Department for Education, 2011). Research has reported that foster carer wellbeing is associated with accessing initial and ongoing training (Whennan et al, 2009; Ivanova and Brown, 2010). However, training appears to vary and research suggests that dissatisfaction with training can contribute to carers' decisions to discontinue placements (Festinger and Baker, 2013). Recent reviews of research into carer training have reported a lack of research in this area (Rork and McNeil, 2011; Kinsey and Schlosser, 2012; Festinger and Baker, 2013). The reviews have highlighted several methodological flaws such as a lack of reported information about the types of placements provided and on the prior knowledge and experiences of carers (Rork and McNeil, 2011; Festinger and Baker, 2013). These flaws mean it is difficult to distinguish the effects of training from other factors, such as foster carer knowledge (Rork and McNeil, 2011).

Although quantitative research has identified factors associated with foster carer wellbeing and willingness to continue to provide placements, the findings do not provide a detailed understanding of how carers manage their role. However, qualitative research has begun to emerge, shifting away from the correlative nature of the quantitative studies to provide an understanding of foster care from carers' perspectives.

The aim of this review was to synthesise qualitative research in order to understand the psychological impact of providing foster care on carers. This meta-synthesis is timely, as, although the qualitative research base in this area has grown, to date, this literature has not been reviewed. The method of meta-ethnography, involving the systematic comparison of the findings of qualitative research (Noblit and Hare, 1988), was chosen for this meta-synthesis. It has been suggested that this approach allows for the synthesis of studies conducted within the same topic area but across different disciplines (Sandelowski et al., 1997). This seemed particularly important given the nature of multidisciplinary working around LAC (Department for Education, 2003; Department of Health, 2004).

Method

Research Questions

As outlined, providing foster care can involve significant stress and so it seems important to understand the psychological impact that providing foster placements can have upon carers. As such, the main research questions are what psychological effects do foster carers experience as a result of providing care and how are their psychological needs met?

Inclusion Criteria

To be included in this meta-synthesis, papers were required to meet six essential inclusion criteria: (i) the paper was published in the English language; (ii) the paper was published in a peer-reviewed journal; (iii) the study used qualitative methods of data collection and analysis; (iv) the sample consisted of adults providing foster care to LAC; (v) if several groups of participants were included, the results for each group were reported separately; (vi) the papers focused on the psychological needs and outcomes for foster carers.

Search Strategy

An exhaustive systematic literature search was conducted between November 2013 and January 2014 to identify relevant research papers thesis. The databases searched were PsycINFO, PsycArticles, CINAHL, and Web of Science. The thesaurus function for each database was used to ensure that the search terms captured the relevant topic areas. Initially, a broad search strategy was employed to include all literature surrounding LAC care, including foster care, kinship care, whereby children are placed with family members, and adoption.

Searches were conducted using the following terms: (Foster care* OR foster parent* OR foster mother* OR foster father* OR foster famil* OR adoptive parent* OR adoptive mother* OR adoptive father* OR adoptive famil* OR kinship care* OR out of home care OR foster child*) AND (training OR educati* OR support* OR professional training OR psychological training OR psychoeducation OR professional support OR social support* OR parenting OR parent* training OR parent* support) AND (qualitative OR interview* OR focus group* OR theme* OR thematic analysis OR lived experience* OR grounded theory OR interpretative OR phenomenol* OR narrative OR content analysis).

The initial searches resulted in 4415 citations and the titles were scanned to remove duplicate citations and articles that were not relevant to the review. The inclusion criteria were then applied by reading the abstracts of the remaining articles. This resulted in 64 citations, for which the full articles were retrieved. At this stage, 33 articles were excluded, with 31 meeting the inclusion criteria. However, it became clear that the reported psychological needs varied significantly between the groups of carers. For example, issues reported for adoptive parents included difficulties associated with not having their own children and stigma in adoption (Daniluk and Hurtig-Mitchell, 2003; Forbes and Dziegielewski, 2003; Atkinson and Gonet, 2007; McKay and Ross, 2010). However, key issues for kinship carers included managing conflict with the children's parents, pressure around caring for family, and fears about the potential for children to be moved into non-family care (Burke and Schmidt, 2009; King et al., 2009; Backhouse and Graham, 2013).

As the aim of qualitative meta-synthesis is to collate research reporting on the same experiences (Sandelowski et al., 1997), it was decided to limit the review to focus on just one group. The 31 papers were sorted and it was found that the majority focused on foster care, with only six papers on adoption and four on kinship care, leaving 21 papers to be reviewed. Three of the final papers report different findings from the same study (Blythe et al., 2012;

Blythe et al., 2013a; Blythe et al., 2013b). Finally, the reference lists of the included papers were searched, though this did not yield any further articles. A flowchart outlining this search strategy can be found in Figure 1.

Insert Figure 1

Quality Assessment

The Critical Appraisal Skills Programme (CASP; Public Health Resource Unit, 2006) was used to assess the quality of the papers across 10 areas considered relevant for qualitative research. For example, issues around the appropriateness of the research design and data analysis are considered. Two screening questions are used to assess the appropriateness of qualitative methods and whether papers clearly state the aims and relevance of the research. All papers met these criteria. The CASP was used alongside a scoring system (Duggleby et al., 2010), whereby scores out of three were given for eight areas following the screening questions, resulting in each paper being given a total score out of 24 (Table 1). Scores were allocated depending upon whether a study was considered to provide a weak (1), moderate (2), or strong (3) explanation. Scores were allocated based on whether papers reported details relevant for each criterion, and notes were kept to evidence the presence or absence of these details (Appendix 1-A). The researcher acknowledges that quality criteria are subjective and could be interpreted differently by different researchers. In order to increase the reliability of the quality assessment, a selection of the papers were independently scored by three other trainee clinical psychologists. These scores were compared and it was found that they were similar for all raters. Any differences were discussed and a consensus score reached.

The quality scores ranged from 11-21 and the themes presented are supported by studies from across this range. The subjective and interpretative nature of qualitative research means that there is a lack of consensus on how to appraise quality (Walsh and

Downe, 2006). Additionally, studies are often reported in line with publication-specific templates (Sandelowski & Barroso, 2003; Walsh and Downe, 2006). For example, the CASP (Public Health Resource Unit, 2006) assesses the reporting of researcher reflexivity. However, details on the researchers' position are often removed from publications due to word restrictions (Walsh and Downe, 2006). As such, it has been suggested that papers are not excluded on the basis of quality (Sandelowski et al., 1997; Sandelowski et al., 2003). Therefore, although the quality scores were considered during analysis, the scores were treated with caution due to acknowledgement that they were based only on how the studies were reported.

Insert Table 1

Study Characteristics

The papers report on sample sizes ranging between five and 54 foster carers. Seven studies were conducted in the UK, seven in the USA, two each in Canada and Australia, and one in New Zealand. Five studies used semi-structured interviews, two used structured interviews and two used unstructured interviews. Three papers do not specify the interview approach. One study collected data through focus groups and individual interviews, and one combined structured interviews with questionnaires. Finally, one study used a technique called 'photovoice' (Pickin et al., 2011), whereby participants were asked to take photographs to represent their experiences, which were subsequently used as interview prompts. Similarly, the selected studies used a range of data analysis methods. Five used thematic analysis, five used phenomenological analysis, three used grounded theory, one used analysis based upon 'consensual qualitative research', one used 'domain analysis', one used content analysis and the method of analysis was not named in three studies. The characteristics of all papers can be found in Table 2.

Insert Table 2

The synthesis of studies reporting different research methods has been questioned within the literature. For example, concern has been raised about whether the differing theoretical and epistemological underpinnings of qualitative methods mean that they are not comparable (Atkins et al., 2008). However, others have suggested that the subjectivity of all qualitative research means that researchers may approach a study in different ways but report the same method (Sandelowski et al., 1997). This suggests that, providing that this subjectivity is acknowledged, studies reporting differing approaches can be compared (Sandelowski et al., 1997). It was decided that excluding studies for this reason would mean that the review was not a true and comprehensive representation of the literature. As such, papers reporting a range of methodological approaches were included.

Analysis and Synthesis

The analysis and synthesis of the studies was guided by the method of meta-ethnography (Noblit and Hare, 1988). All papers were read several times to allow the reviewer to become familiar with the research. The studies varied in focus and aims, which increased the complexity of identifying the relevant findings. To manage this, Atkins et al., (2008) suggest constantly referring back to the review aims and research questions. This process was followed for all papers, ensuring that only data relevant to the synthesis were extracted and compared. This comparison involved identifying commonalities and points of difference across the papers. The lists of key concepts were then compared to develop an understanding of the relationships between the studies.

The next stage involved translating the studies into each other (Noblit and Hare, 1988); grouping the key findings based on the similarities and differences between the papers (Atkins et al., 2008; Thomas and Harden, 2008). Atkins et al., (2008) suggest that the order in which studies are compared may influence the synthesis, though acknowledge that there is little consensus as to how to approach this. They outlined a chronological approach to comparison, due to changes in policy over time potentially influencing the findings in the studies they were reviewing. However, this was not applicable to this review due to the inclusion of international studies making it difficult to compare policies or guidelines on foster carer support. Thus the studies were compared by listing each key finding from each study on separate pieces of paper, then grouping them thematically. This was done several times to test different ways of representing the relationships between studies. The aim was to merge the studies but ensure that the individual studies were still represented.

Noblit and Hare (1988) argue that these translations should be based on the interpretations made by the authors of the studies. Additionally, Atkins et al., (2008) suggest basing translations on participant views alone is not sufficient, as authors have selected any reported data, therefore perhaps not fully representing participant views. However, a number of papers included in this review were descriptive, offering little interpretation, and so a comparison based solely on author interpretations was not possible. Thus, the translations were based on author interpretations and the descriptively reported participant data.

The aim of meta-synthesis is to provide a deeper level of understanding or insight than could be gained from the individual studies (Atkins et al., 2008; Noblit and Hare, 1988; Thomas and Harden, 2008). As such, the final stage of analysis was to synthesise the findings. This involved bringing together the participant data and author interpretations to create a new understanding of the key concepts. These have been described as "third-order interpretations" (Britten et al., 2002; p. 211) and are the final concepts discussed in the results section below. Noblit and Hare (1988) argue that any synthesis should be viewed as interpretative, but, rather than detracting from the validity of a synthesis, suggest that it is this interpretation that makes the process useful.

Results

Five key concepts were identified and each will be discussed, alongside quotes from participants in the individual studies.

The Emotional Experience of Being a Foster Carer

Foster carers described a range of emotions in relation to their role, including strong feelings of self-doubt, under-confidence (Allen and Vostanis, 2005; Maclay et al., 2006; Lauver, 2008; Blythe et al., 2013b) and self-blame about children's difficulties (Rosenwald and Bronstein, 2008). Many participants described these emotions as changeable (Lauver, 2008; Rosenwald and Bronstein, 2008; Pickin et al., 2011): "A lot of times you feel like you're on an emotional rollercoaster all the time and it's not stopping" (Rosenwald & Bronstein, 2008; p. 292). This rollercoaster metaphor suggests a level of unpredictability, which makes it more difficult to cope with the emotional nature of the role.

Three studies (Allen and Vostanis, 2005; Maclay et al., 2006; Lauver, 2010) highlighted concepts of feeling unprepared and overwhelmed by the task of caring: "…I really didn't expect any of that…there have been times in the early years when I thought, 'Oh no - I really can't cope with it'" (Maclay et al., 2006, p. 33). Participants in the study by Lauver (2010) were carers for children with complex medical needs and described feeling unprepared by their training: "They taught me the skills...what I really need to know was what would work best. I finally got that when I was takin' care of him" (Lauver, 2010, p. 293). For this carer, training had given her practical skills but had not prepared her for the emotional complexity of foster care.

Similarly, carers in three studies (McDonald et al., 2003; Broady et al., 2010; Blythe et al., 2013a) reported that the roles did not meet their expectations: "I didn't realize at the time when I took it on how difficult it was going to be" (Broady et al, 2010; p. 565). Some linked this mismatch between expectations and reality with unfulfilled promises of support:

“They tell you that there is help and support and everything out there. But once you’re thrown in, it’s not out there at all” (Blythe et al., 2013a; p.92). This participant felt let down and unsupported in this complex and emotional role. Furthermore, many participants reported feeling unique in their difficulties, which appeared to contribute to feelings of isolation and loneliness (Wells and D'Angelo, 1994; Allen and Vostanis, 2005; Lauver, 2010; Pickin et al., 2011).

Many described having to defend their role and demonstrate that they were meeting expected standards (Daniel, 2011; Blythe et al., 2013a). For example, participants described feeling constantly scrutinised by professionals: “they [the system] want the child to be brought up and accepted in the family, normally, as one of your children, but then they don’t allow you to do it” (Blythe et al., 2013a; p. 91). This participant seems to feel powerless, being responsible for children’s care but also experiencing constant external scrutiny. Others described feeling judged and having to defend their position to wider society: “always feeling like you have to justify your role because people think that it’s the foster parents that took the kids away from their biological parents” (Daniel, 2011; p. 914).

For some, these feelings of powerlessness, isolation and under-confidence changed over time. In two studies (Maclay et al., 2006; Lauver, 2008), carers reported increased confidence and felt able to ask for support as they became more experienced: “Sometimes it was hard for me to ask questions because I didn’t want them to think I didn’t know…That’s not the case anymore. Now if I have something to say, well…let’s just say, I say it” (Lauver, 2008; p. 84). This suggests the emotional experience of providing foster care not only varies day-to-day, as in the rollercoaster metaphor, but also over time.

Being a ‘Parent’ Without Parental Rights

Ten papers discussed the psychological impact of foster carers not having parental rights (Wells and D'Angelo, 1994; Triseliotis et al., 1998; MacGregor et al., 2006; Rosenwald and Bronstein, 2008; Broady et al., 2010; Lauver, 2010; Daniel, 2011; Oke et al., 2011; Pickin et al., 2011; Blythe et al., 2012; Blythe et al., 2013a). Linked to the feelings of being judged from the first theme, participants described a conflict between being responsible for children's care while simultaneously being unable to make decisions without professional input: "We can't be a parent because you [the system] won't let us. You keep taking the authority out of our hands" (Blythe et al., 2013a; p.91). Many participants described feeling powerless and excluded from the care system: "You have all this responsibility but when it comes to make the decision for them…you're nothing…you're powerless" (Rosenwald & Bronstein, 2008; p. 294). This participant appears to have felt worthless, as though not valued as a key part of the care team. Carers reported feeling pressured by high expectations but then being disempowered by the system, potentially reinforcing any lack of confidence and negatively impacting their wellbeing. This was exemplified by one participant, who described wanting to be treated as equal:

> They're hesitant to accept what I have to tell them, they don't seem to get it, understand that I know what she needs. I'm the one who takes care of her 24 hours a day…that just makes you feel like what you do is just…just not worth anything. (Lauver, 2010; p. 295)

There was particular frustration with involving children's biological parents in decisions despite them not being responsible for daily care. For participants in two studies (Oke et al., 2011; Blythe et al., 2012), this appeared to be linked to viewing themselves as parents, rather than temporary carers. This created conflict for some, with one participant describing herself as a parent but feeling a need to hide this from social services for fear of judgement:

> …we don't think about ourselves a lot of the time as foster carers. Social Services would probably *die* if we said that because you have to be aware of this, have to be

> aware of that for the Department, but day-to-day I don’t feel aware of being a carer. I feel like we are parents. (Oke et al., 2011; p. 14)

If foster carers identify as parents, it seems unsurprising that they would feel frustrated when involving children’s biological parents in decision-making. This reflects a fundamental tension in their role; acting as parents but without parental rights. In this sense, the care system appears to exclude carers.

Attachment and Loss

This theme represents the forming and loss of attachments to LAC, as discussed in 13 studies (Wells and D'Angelo, 1994; Inch, 1999; Buehler et al., 2003; Allen and Vostanis, 2005; MacGregor et al., 2006; Lauver, 2008; Rosenwald and Bronstein, 2008; Broady et al., 2010; Daniel, 2011; Murray et al., 2011; Oke et al., 2011; Pickin et al., 2011; Blythe et al., 2013b). Foster carers described bonding with children as instinctual, almost inseparable from their role:

> …they [professionals] turn right back around and say to you, ‘You shouldn’t get that involved’…how the hell are you not going to get involved, if you’re a mother? … if you don’t get involved, then I don’t think you should be there. (Wells & D’Angelo, 1994; p.133)

This connects to the previous theme, with this participant describing herself as a parent and implying that this meant that bonding with foster children was inevitable. However, bonding created a dilemma due to carers being constantly mindful of the temporary nature of placements. This was described in one study as an “internal struggle” (Broady et al., 2010; p.566): “…how dare they take that child back that you’ve loved and cared for as your own, even though it’s not your own” (Broady et al., 2010; p. 567). Forming attachments with LAC appears to create an internal conflict for carers. In the second quotation, the participant rationalises that the child was not their own but, at the same time, the attachment process created a feeling of being a parent and subsequent shock when a placement ended. In one study, a foster father seemed to use part of his interview to advise other carers on this dilemma:

> I've got one problem with foster care. You grow to love those kids … it's hard not to get attached to them. . . Don't fall in love with the kids if you can help it… They are foster children and they are set to be removed at any time, without notice. (Inch, 1999; p. 403)

Even in giving this advice, he describes bonding as instinctual when saying, "…if you can help it" (Inch, 1999; p. 403). This demonstrates the potential emotional impact of caring, almost fighting any bonding instincts to guard against subsequent feelings of loss.

The temporary nature of foster care and the potential for loss seemed always to be in the minds of carers. One foster father described significant concerns about losing a child from his care, replaced with relief when he was able to adopt the child: "…knowing now that they're probably not going to be going back to their biological parent and that you know, we may be adopting them; it relieves a little bit of the stress" (Beuhler et al., 2003; p.70). This participant highlights the stress associated with constant anticipation of loss. Losing a child from their care was associated with a range of emotions for carers including sadness, anger, powerlessness and shock (MacGregor et al., 2006; Lauver, 2008; Broady et al., 2010; Daniel, 2011; Pickin et al., 2011). The grieving process was sometimes akin to bereavement from death: "We actually went through a grieving period like you would with any death in the family…not to have him there, ya know was VERY DIFFICULT" (Lauver, 2008; p.88). This participant describes a foster child as a family member, connecting to the conflict associated with identifying as a parent.

Many participants described a lack of reciprocity in attachments due to children maintaining loyalty to their biological parents (Allen and Vostanis, 2005; Broady et al., 2010). This evoked mixed feelings, including anger and frustration towards biological parents (Allen and Vostanis, 2005; Murray et al., 2011; Pickin et al., 2011) but also a sense of sadness:

> They can be so cruel to their children and so neglectful, but if they have known their parents for any length of time…*[sigh]*… if someone came up to him tomorrow and said, 'get your cases, you're going back to mummy', he'd be in that car and barely bother waving goodbye. (Allen & Vostanis, 2005; p.72)

For carers, the loyalty children may have to their biological parents may reinforce feelings of being undervalued and unappreciated. Therefore, in addition to losing an attachment, losing a child from a placement may further disempower carers.

Some participants discussed trying to understand the reasons for parents' inability to provide care, and using this to promote children's relationships with their biological parents (Broady et al., 2010; Oke et al., 2011). When this was done, along with an acknowledgement that a placement was temporary (Oke et al., 2011), carers reported reduced stress and sadness. Other participants described coping with loss in various ways, such as keeping photographs for each child and accessing professional support (Lauver, 2008). However, support was not always available and several participants reported wanting training around loss, grief, and managing relationships with children's biological parents (MacGregor et al., 2006; Daniel, 2011; Murray et al., 2011).

Value and frustration: Two sides of professional support

Sixteen studies discussed support provided by professionals (Wells and D'Angelo, 1994; Buehler et al., 2003; McDonald et al., 2003; Sargent and O'Brien, 2004; Allen and Vostanis, 2005; MacGregor et al., 2006; Maclay et al., 2006; Lauver, 2008; Laybourne et al., 2008; Rosenwald and Bronstein, 2008; Broady et al., 2010; Lauver, 2010; Murray et al., 2011; Oke et al., 2011; Pickin et al., 2011; Metcalfe and Sanders, 2012). Participants reported that support from social workers or foster care agencies was key to helping them provide placements (Lauver, 2008; Broady et al., 2010; Murray et al., 2011; Metcalfe and Sanders, 2012). For some, this support was particularly vital at the beginning of their journey (Maclay et al., 2006). This links to the first theme that identified many carers reported feeling lowest in confidence when first providing placements. Professional support provided reassurance and an opportunity for carers to reflect on their own needs (McDonald et al., 2003; Sargent and O'Brien, 2004; Allen and Vostanis, 2005). Many participants also described professional support as confidence building, validating and empowering (McDonald et al., 2003; Sargent and O'Brien, 2004), which contrasts with the day-to-day experiences of providing care described in previous themes. Additionally, several carers reported a reduction in their feelings of self-blame following accessing support from professionals (Allen and Vostanis, 2005; Laybourne et al., 2008): “I no longer think, ‘What am I doing wrong?’ all the time” (Laybourne et al., 2008; p. 71). Having the opportunity for personal reflection seems to have been key in helping carers cope with the range of emotions accompanying their roles.

However, although support was highly valued, many participants felt that workers were unable to meet their needs (Wells and D'Angelo, 1994; Buehler et al., 2003; Pickin et al., 2011). Some participants expressed anger and frustration towards professionals when they did not receive promised support. Others felt let down when unable to access immediate support: “…I phoned three different people. One person called me back in the morning. I was so upset. I shouldn’t have been alone” (MacGregor et al., 2006; p. 360). This further highlights the isolation many participants reported, which seems to have been reinforced by professional support being experienced as unreliable. One participant likened caring to a train, being expected to continue without stopping to access support:

> I think a lot of carers just feel that they're just a train and the door opens and they throw a kid in and the door shuts and you go along a bit and the door opens and they take that one out till the next stop and then the door opens again. And you just get on with it because you're a carer and that's what you do. You don't have feelings and you don't have any say and you know you're used to it. (Maclay et al., 2006; p. 34)

Some studies discussed professional support provided outside of social care. In one UK study, participants reported uncertainty about accessing support from CAMHS due to fearing being judged as having mental health difficulties (Sargent and O'Brien, 2004). Additionally, participants in another UK study highlighted that training could be overwhelming due to addressing potentially sensitive topics, such as abuse (Allen and Vostanis, 2005). Despite this, carers valued professional support, with participants in UK and USA studies reporting wanting training to be ongoing, not one-off opportunities (Allen and Vostanis, 2005; Wells and D'Angelo, 1994).

Being truly understood: The value of peer support

When participants were able to access professional support, they reported feeling valued and respected which, in turn, increased their confidence (Lauver, 2008; Oke et al., 2011; Pickin et al., 2011). However, many acknowledged that professionals often had large workloads which affected their availability (Wells and D'Angelo, 1994; Buehler et al., 2003; Sargent and O'Brien, 2004; Maclay et al., 2006; Rosenwald and Bronstein, 2008), and felt this left a gap in support: "We really do need someone to talk to – social workers are often too stressed to listen" (Sargent & O'Brien, 2004; p. 34). Support provided by non-professionals was discussed in 15 papers (Allen and Vostanis, 2005; McDonald et al., 2003; Laybourne et al., 2008; MacGregor et al., 2006; Metcalfe and Sanders, 2012; Buehler et al., 2003; Rosenwald and Bronstein, 2008; Maclay et al., 2006; Lauver, 2010; Lauver, 2008; Murray et al., 2011; Oke et al., 2011; Pickin et al., 2011; Daniel, 2011; Blythe et al., 2012).

The core of this theme is the value participants placed on support from other foster carers: "…they maybe have had the same problems, they understand where you are coming from and what you may be asking for support…some people…can't believe this…that you would work with something like that" (Metcalfe & Sanders, 2012; p. 136). Participants reported believing that only other carers could truly understand the experience of being a foster carer, with peer-support reducing feelings of isolation, loneliness and self-blame (Murray et al., 2011; Oke et al., 2011; Maclay et al., 2006; Rosenwald and Bronstein, 2008; Blythe et al., 2012). For many, a key benefit of any training was the opportunity to share experiences with other carers: "To hear the difficult experiences of other carers and know that you are not the only one helped me a lot" (Laybourne et al., 2008; p.71). In this way, peer support appeared to be central to foster carers' wellbeing, particularly in terms of reducing feelings of isolation and of being unique in experiencing difficulties.

Some participants had established their own support networks, particularly when professionals were not available (Maclay et al., 2006; Blythe et al., 2012). For others, support networks were yet to be established but the concept was highly valued: "If we had a buddy system that would be better. Then you could call your buddy instead of talking to your neighbor or talking to a friend" (MacGregor et al., 2006; p. 362). Sharing experiences with other carers provided a contrast to any negative feelings and demonstrated hope during times of despair. Support from other carers appears to be central to maintaining motivation and hope, particularly during difficult experiences.

Discussion

This review aimed to synthesise qualitative research to develop an understanding of the psychological impact of providing foster care and how the psychological needs of foster carers may be met. The reviewed studies used a variety of research methods and varied according to participant characteristics, such as age, gender and caring experience. However, the key issues seemed to span these differences, suggesting they are representative of carers in a range of situations. The studies were conducted in several countries, suggesting the findings appear to be representative internationally. However, for the purpose of this discussion, the findings will be considered within the context of UK foster care.

The reviewed papers varied in quality, as assessed using the CASP (Public Health Resource Unit, 2006). For example, several papers provided little or no original data, such as participant quotations, and minimal explanations of the analysis method. As such, these papers received low scores on the criteria assessing reporting of the analysis process. Several papers were descriptive, which meant some interpretations made in this review were based on participant data, rather than author interpretations. Although the themes incorporated findings from all studies, some papers were used for evidence more than others due to the lack of original data or author interpretation in some papers.

The first theme identified a range of emotions associated with providing foster care. For many participants, the realities of caring did not meet their expectations and they felt unprepared. Many lacked confidence in their skills, though confidence appeared to increase over time with more experience. This was often coupled with feeling that they had to prove their capability and many participants reported feeling judged and scrutinised. For some, this was interpreted as not being trusted to carry out their role. Cognitive behavioural theory would suggest that, if others reinforce an individual’s self-beliefs, they are likely to believe them more strongly (Beck, 2011). In relation to foster carers, it is possible that feeling not trusted could reinforce any lack of self-confidence.

Connected to these feelings, the second theme highlighted the conflict felt by carers in being responsible for children’s care while being reminded that they do not have parental responsibility. Many participants described exclusion from decision-making, which compounded feelings of being undervalued. This is an issue that has been discussed more widely, with carers often reporting feeling unvalued in the caring system (Triseliotis et al., 1998; Riggs et al., 2009; Jones and Morrissette, 1999; Kirton, 2007).

This conflict between high expectations yet feeling undervalued may be understood through attachment theory. Although attachment theory was developed to understand child development (Bowlby, 1979), it has also been applied to supervisory relationships. Pistole and Fitch (2008) suggest that the term caregiver may refer to any person who is considered important. For foster carers, this may include their social worker or agency worker. If this person is experienced as caring and reliable, attachment theory would suggest the individual is likely to feel more confident and able to work independently (Pistole and Fitch, 2008). This is supported by the findings of this review as, when participants experienced professionals to be invalidating or unavailable, they felt let down, isolated, and under-confident. In contrast, participants reported increased confidence when they felt valued, respected and supported by professionals.

It has been suggested that if foster care was developed into a more defined occupation, possibly achieved through paying carers a wage and providing training, carers may feel more valued in the caring team. This has been described as the professionalisation of foster care (Wilson and Evetts, 2006; Kirton, 2007; Hollin and Larkin, 2011) and has already begun, with a recent increase in independent foster care agencies (Kirton, 2007). However, there is a risk that offering a financial incentive could mean that the nurturing element of providing foster care could be reduced or lost (Wilson and Evetts, 2006; Kirton, 2007). Furthermore, Wilson and Evetts (2006) caution that, if local authorities implemented changes, foster carers may feel pressurised rather than empowered. If carers were involved in making changes to the fostering system, they may feel more equal.

A key concept that ran through the findings was that carers often felt isolated within the care system and wider society. Many only felt understood by other carers, describing peer support as vital to their coping. Psychological theory on group therapy suggests several factors appear to contribute to change in therapeutic groups, such as learning from others, realising others may experience similar situations and forming relationships with other group members (Yalom and Leszcz, 2005). Although this review was not related to therapeutic groups, these factors appear applicable to the peer-support discussed by many participants. Indeed, participants reported feeling reassured by other foster carers, reducing feelings of isolation and loneliness.

The value of peer-support has been demonstrated through support groups for foster carers. For example, Golding (2003) reported on a UK foster care support service that included groups facilitated by clinical psychologists. Similar to the findings of this review, feedback from carers included feeling reassured and encouraged by other people’s stories, which helped them to cope with their own difficulties. Additionally, although some groups were difficult for carers to manage, such as discussions of children’s histories, carers continued to attend, further demonstrating the value of peer-support (Golding, 2003). Similarly, Pallett et al., (2002) report on a training group established to assist foster carers in developing behaviour-management skills. Carers who accessed this service reported increased confidence and self-efficacy. Both papers (Pallett et al., 2002, Golding, 2003) described providing space for foster carers to reflect upon difficulties, as well as drawing on attachment theory to help carers reflect on their relationships with foster children. These group-based approaches may help foster carers to understand children’s difficulties and the attachment process through sharing stories, potentially reducing isolation.

Clinical Implications

The findings suggest foster carers often feel excluded from the network of professionals around LAC, contributing to feelings of isolation, powerlessness and worthlessness. As research suggests that empowerment and self-esteem are correlated with mental health (Klepp et al., 2007), this is an important consideration for professionals working with carers. Multi-agency consultation would provide an opportunity to bring together carers and professionals, potentially reducing feelings of exclusion, isolation and powerlessness. In Golding's (2003) report, a psychological consultation service for carers and professionals is discussed. While several professionals may attend, consultations are centred on the needs of carers. Research into service user involvement programmes suggests that promoting shared decision-making can reduce power imbalances between service users and professionals (Harding et al., 2011). In this way, a carer-centred consultation service is likely to promote the role of carers in the wider system. Indeed, carers reported that having opportunity for reflection and to expand their understanding has validated their views and increased their confidence (Golding, 2003). This suggests that clinical psychology services are well placed to provide carers with an opportunity to be heard, promoting empowerment without major organisational change. This empowerment and inclusion is likely to have a positive impact upon carers' wellbeing, in addition to helping individuals to cope with future placements. Furthermore, providing space for discussion between carers and professionals may help to improve working relationships and meet recommendations for multi-agency working (Department for Education, 2003, Department of Health, 2004).

Given the value of peer-support to participants, the development of support groups is an important consideration for services. While some participants had established support networks, others reported difficulty in meeting other carers. If groups such as those discussed by Golding (2003) and Pallett et al., (2002) were established more widely, they could provide opportunities for peer-support. Furthermore, if such groups could be accessed ahead of providing placements, carers may feel more prepared. If groups were promoted as being carer-centred, despite being facilitated by clinical psychologists or other professionals, this may help to overcome any uncertainty about accessing support through CAMHS.

A key finding of this review is that foster carers valued professional support but frequently found that social workers were unavailable. Other professionals, such as through CAMHS, may be able to fill this gap and increase carer support. In turn, this could improve wellbeing, by reducing feelings of isolation and exclusion. Additionally, mental health professionals, including clinical psychologists, may be better placed to provide emotional support. For example, participants reported wanting training to help them cope with the process of forming attachments with foster children. The training that clinical psychologists receive places them in a strong position to be able to work within attachment-focused, relational models with carers. This could include facilitating peer-support groups, facilitating psycho-educational groups on specific issues, such as attachment, and providing individual therapeutic work.

Limitations and Further Research

This review aimed to understand the psychological impact of providing foster care. The findings offer support to the quantitative literature which has identified factors such as understanding children's behaviour (Gilbertson and Barber, 2003; Farmer et al., 2005), social support (Soliday et al., 1994; Rhodes et al., 2003; Cole and Eamon, 2007), relationships with foster children (Whennan et al., 2009; Kinsey and Schlosser, 2012) and training and professional support (Whennan et al., 2009; Ivanova and Brown, 2010) as key to foster carer wellbeing. This review adds to the quantitative literature in providing more detailed discussions of foster carer experiences from the perspective of the carers. For example, although previous research has highlighted the value of social support, this review has provided a detailed discussion of how foster carers appear to use social support, particularly as provided by other carers.

Further to adding to the quantitative literature, this meta-synthesis goes beyond the individual qualitative research papers that were included in the review. The aim of a meta-synthesis is to develop a more detailed and complete understanding of a subject that is already available (Paterson et al., 2001). Through bringing the individual findings together, this review provides a deeper understanding of the key issues identified. For example many of the individual papers discussed how isolated foster carers can feel. In bringing together the individual papers, this review has identified the extent of these feelings of isolation and exclusion extending across many aspects of foster carers' lives. In this way, the review has gone beyond the individual papers and identified broader, overarching concepts that could be applied in clinical practice. Additionally, the review provides a psychological perspective on foster carers' experiences, which goes beyond the individual studies that were conducted from a range of professional backgrounds.

Although the findings were represented across the papers, many of the studies were conducted outside the UK. Thus it is unclear whether all the findings would be applicable within the UK or other international contexts. Further research into the psychological needs of foster carers within the context of national policies around fostering would be beneficial. Additionally, the studies were conducted across a range of foster care settings, though these were not differentiated within the review, such as whether participants were providing short-term, long-term or respite foster placements. Thus it remains unclear as to how the psychological experiences of foster carers may differ depending upon the type of care provided. Foster carers are not a homogenous population (Rork and McNeil, 2011) and so it would be expected that different issues would affect individual carers in different ways. Research has suggested that issues that become apparent during foster care, such as attachment, may trigger carer responses in relation to their own histories (Golding, 2003; Rork and McNeil, 2011; Dozier and Sepulveda, 2004). Future research could investigate these links in more detail to further develop understanding of the psychological experience of being a foster carer.

This review focused on the experiences of foster carers, with literature on the psychological needs of kinship carers and adoptive parents being excluded. Further research into the needs of these other groups is required to clarify the differences and contribute towards clinical recommendations for these other key groups in the LAC system. Additionally, the papers in this review varied in the quality of reporting. Eighteen papers were scored 'weak' on their reporting of researcher reflexivity, despite this being viewed as a key element of qualitative research (Smith, 2011; Yardley, 2008). This lack of reflexivity made it difficult to understand the basis for some author interpretations. While it is acknowledged that quality assessment can only be based on what is reported, which may not reflect what was actually addressed by researchers, future research would benefit from reporting these issues in order to ensure transparency of findings (Elliott et al., 1999, Yardley, 2008).

Conclusion

This review identified five key themes, which highlighted the psychological experience of being a foster carer. The findings highlight the complex psychological impact that being a foster carer can have upon individual's wellbeing, including feelings of isolation, loneliness and feeling undervalued in their role. These all linked in to carers often reporting under-confidence in their own skills and, at times, difficulties in coping with their role. Carers reported significant conflict between being required to act as parents but having no parental rights when decisions are made about the children. This conflict was further evident when carers spoke about the difficulties in forming relationships with children while also being mindful of the temporary nature of foster care. In terms of how these needs may be met, foster carers reported improvements in their wellbeing and ability to cope in their role when they were included in decision-making. When treated as a valued and respected part of the care team, foster carers reported having greater confidence in their roles and being more likely to continue to provide placements. The review highlighted how vital peer support from other carers is to maintaining and improving foster carers' wellbeing, and suggestions have been made as to how clinical psychologists may be able to facilitate peer support so that it is more readily available. In light of the ever-increasing demand for foster placements, supporting the wellbeing and psychological needs of foster carers is vital in ensuring that there are enough placements available for LAC.

References

Allen, J. & Vostanis, P. 2005. The impact of abuse and trauma on the developing child: An evaluation of a training programme for foster carers and supervising social workers. *Adoption & Fostering,* 29**,** 68-81.

Atkins, S., Lewin, S., Smith, H., Engel, M., Fretheim, A. & Volmink, J. 2008. Conducting a meta-ethnography of qualitative literature: Lessons learnt. *BMC Medical Research Methodology,* 8.

Atkinson, A. & Gonet, P. 2007. Strengthening adoption practice, listening to adoptive families. *Child Welfare,* 86**,** 87-104.

Austerberry, H., Stanley, N., Larkins, C., Ridley, J., Farrelly, N., Manthorpe, J. & Hussein, S. 2013. Foster carers and family contact: Foster carers' views of social work support. *Adoption & Fostering,* 37**,** 116-129.

Backhouse, J. & Graham, A. 2013. Grandparents raising their grandchildren: Acknolwedging the experience of grief. *Australian Social Work,* 66**,** 440-454.

Barratt, S. 2002. Fostering care: The child, the family and the professional system. *Journal of Social Work Practice: Psychotherapeutic Approaches in Health, Welfare and the Community,* 16**,** 163-173.

Beck, J. S. 2011. *Cognitive behaviour therapy: Basics and beyond,* New York, Guildford Press.

Blythe, S. L., Halcomb, E. J., Wilkes, L. & Jackson, D. 2013a. Caring for vulnerable children: Challenges of mothering in the Australian foster care system. *Contemporary Nurse,* 44**,** 87-98.

Blythe, S. L., Halcomb, E. J., Wilkes, L. & Jackson, D. 2013b. Perceptions of long-term female foster-carers: I'm not a carer, I'm a mother. *British Journal of Social Work,* 43**,** 1056-1072.

Blythe, S. L., Jackson, D., Halcomb, E. J. & Wilkes, L. 2012. The stigma of being a long-term foster carer. *Journal of Family Nursing,* 18**,** 234-260.

Bowlby, J. 1979. *The Making and Breaking of Affectional Bonds,* London, Tavistock Routledge.

Broady, T. R., Stoyles, G. J., Mcmullan, K., Caputi, P. & Crittenden, N. 2010. The experiment of foster care. *Journal of Family Studies,* 19**,** 559-571.

Britten, N., Campbell, R., Pope, C., Donovan, J., Morgan, M. & Pill, R. 2002. Using meta-ethnography to synthesis qualitative research: A worked example. *Journal of Health Services Research & Policy,* 7, 209-215.

Buehler, C., Cox, M. E. & Cuddeback, G. 2003. Foster parents' perceptions of factors that promote or inhibit successful fostering. *Qualitative Social Work,* 2**,** 61-83.

Burke, S. & Schmidt, G. G. 2009. Kinship care in Northern British Columbia. *Child Welfare,* 88**,** 127-142.

Callaghan, J., Young, B., Pace, F. & Vostanis, P. 2004. Evaluation of a new mental health service for looked after children. *Clinical Child Psychology and Psychiatry,* 9**,** 130-148.

Cole, S. A. & Eamon, M. K. 2007. Predictors of depressive symptoms among foster caregivers. *Child Abuse & Neglect,* 31, 295-310.

Colton, M., Roberts, S. & Williams, M. 2008. The recruitment and retention of family foster-carers: An international and cross-cultural analysis. *British Journal of Social Work,* 38**,** 865-884.

Daniel, E. 2011. Gentle iron will: Foster parents' perspectives. *Children and Youth Services Review,* 33**,** 910-917.

Daniluk, J. C. & Hurtig-Mitchell, J. 2003. Themes of hope and healing: Infertile couples' experiences of adoption. *Journal of Counseling & Development,* 81**,** 389-399.

Department for Education 2003. Every child matters. London: The Stationery Office.

Department for Education 2011. The Foster Carers' Charter.

Department of Health 2004. Children Act 2004. London: The Stationery Office.

Dozier, M. & Sepulveda, S. 2004. Foster mother state of mind and treatment use: Different challenges for different people. *Infant Mental Health Journal,* 25**,** 368-378.

Duggleby, W., Holtslander, L., Kylma, J., Duncan, V., Hammond, C. & Williams, A. 2010. Metasynthesis of the hope experience of family caregivers of persons with chronic illness. *Qualitative Health Research,* 20**,** 148-158.

Elliott, R., Fischer, C. T. & Rennie, D. L. 1999. Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology,* 38**,** 215-229.

Farmer, E., Lipscombe, J. & Moyers, S. 2005. Foster carer strain and its impact on parenting and placement outcomes of adolescents. *British Journal of Social Work,* 35**,** 237-253.

Festinger, L. & Baker, A. J. L. 2013. The quality of evaluations of foster parent training: An empirical review. *Children and Youth Services Review,* 35**,** 2147-2153.

Forbes, H. & Dziegielewski, S. F. 2003. Issues facing adoptive mothers of children with special needs. *Journal of Social Work,* 3**,** 301-320.

Gilbertson, R. & Barber, J. G. 2003. Breakdown of foster care placement: Carer perspectives and system factors. *Australian Social Work,* 56**,** 329-339.

Golding, K. 2003. Helping foster carers, helping children: Using attachment theory to guide practice. *Adoption & Fostering,* 27**,** 64-73.

Harding, E., Johnson Pettinari, C., Brown, D., Hayward, M. & Taylor, C. 2011. Service user involvement in clinical guideline development and implementation: Learning from mental health service users in the UK. *International Review of Psychiatry,* 23, 352-357.

Hibbert, G. & Frankl, J. 2011. A psychology consultation service for social workers and foster carers in a child and adolescent mental health service. *Educational and Child Psychology,* 28**,** 63-72.

Hollin, G. & Larkin, M. 2011. The language and policy of care and parenting: Understanding the uncertainty about key players' roles in foster care provision. *Children and Youth Services Review,* 33**,** 2198-2206.

Inch, L. J. 1999. Aspects of foster fathering. *Child and Adolescent Social Work Journal,* 16**,** 393-412.

Ivanova, V. & Brown, J. 2010. Support needs of Aboriginal foster parents. *Children and Youth Services Review*, 32**,** 1796-1802.

Jones, G. & Morrissette, P. J. 1999. Foster parent stress. *Canadian Journal of Counselling,* 33**,** 13-27.

King, S., Kropf, N. P., Perkins, M., Sessley, L., Burt, C. & Lepore, M. 2009. Kinship care in rural Georgia communities: Responding to needs and challnges of grandparent caregivers. *Journal of Intergenerational Relationships,* 7**,** 225-242.

Kinsey, D. & Schlosser, A. 2012. Interventions in foster and kinship care: A systematic review. *Clinical Child Psychology and Psychiatry,* 18**,** 429-463.

Kirton, D. 2007. Step forward? Step back? The professionalisation of fostering. *Social Work & Social Sciences Review,* 13**,** 6-24.

Klepp, O. M., Sorensen, T. & Kleiner, R. 2007. Empowerment: Additive, overlapping and interative relation to sense of coherence, with regard to mental health and its promotion. *International Journal of Mental Health Promotion,* 9, 5-26.

Lauver, L. S. 2008. Parenting foster children with chronic illness and complex medical needs. *Journal of Family Nursing,* 14**,** 74-96.

Lauver, L. S. 2010. The lived experience of foster parents of children with special needs living in rural areas. *Journal of Pediatric Nursing,* 25**,** 289-298.

Laybourne, G., Andersen, J. & Sands, J. 2008. Fostering attachments in looked after children: Further insight into the group-based programme for foster carers. *Adoption & Fostering,* 32**,** 64-76.

Macgregor, T. E., Rodger, S., Cummings, A. L. & Leschied, A. W. 2006. The needs of foster parents: A qualitative study of motivation, support, and retention. *Qualitative Social Work,* 5**,** 351-368.

Maclay, F., Bunce, M. & Purves, D. 2006. Surviving the system as a foster carer. *Adoption & Fostering,* 30**,** 29-38.

Maluccio, A. N., Canali, C. & Vecchiato, T. 2006. Family foster care: Cross-national research perspectives. *Families in Society,* 87**,** 491-495.

Mcdonald, P. S., Burgess, C. & Smith, K. 2003. A support team for foster carers: The views and perspectives of service users. *British Journal of Social Work,* 33**,** 825-832.

Mckay, K. & Ross, L. E. 2010. The transition to adoptive parenthood: A pilot study of parents adopting in Ontario, Canada. *Children and Youth Services Review,* 32**,** 604-610.

Metcalfe, W. A. & Sanders, G. F. 2012. Foster parent experience: The later years. *Child Welfare,* 91**,** 127-145.

Minnis, H., Devine, C. & Pelosi, T. 1999. Foster carers speak about training. *Adoption & Fostering,* 23**,** 42-47.

Murray, L., Tarren-Sweeney, M. & France, K. 2011. Foster carer perceptions of support and training in the context of high burden of care. *Child & Family Social Work,* 16**,** 149-158.

National Society for the Prevention of Cruelty to Children. 2014. *Statistics on looked after children*. Retrieved from http://www.nspcc.org.uk/Inform/resourcesforprofessionals/lookedafterchildren/statistics_wda88009.html.

Noblit, G. W. & Hare, R. D. 1988. *Meta-ethnography: Synthesizing qualitative studies,* Newbury Park CA, Sage.

Oke, N., Rostill-Brookes, H. & Larkin, M. 2011. Against the odds: Foster carers' perceptions of family, commitment and belonging in successful placements. *Clinical Child Psychology and Psychiatry,* 18**,** 7-24.

Pallett, C., Scott, S., Blackeby, K., Yule, W. & Weissman, R. 2002. Fostering changes: A cognitive-behavioural approach to help foster carers manage children. *Adoption & Fostering,* 26**,** 39-48.

Paterson, B. L., Thorne, S. E., Canam, C. & Jillings, C. 2001. *Meta-study of qualitative health research: A practical guide to meta-analysis and meta-synthesis.* California, Sage.

Pickin, L., Brunsden, V. & Hill, R. 2011. Exploring the emotional experiences of foster carers using the photovoice technique. *Adoption & Fostering,* 35**,** 61-75.

Pistole, M. C. & Fitch, J. C. 2008. Attachment theory in supervision: A critical incident experience. *Counselor Education & Supervision,* 47**,** 193-205.

Public Health Resource Unit 2006. Critical Appraisal Skills Programme (CASP): Making sense of evidence. England: Public Health Resource Unit.

Riggs, D. W., Delfabbro, P. H. & Augoustinos, M. 2009. Negotiating foster-families: Identification and desire. *British Journal of Social Work,* 39**,** 789-806.

Rhodes, K. W., Orme, J. G., Cox, M. E. & Buehler, C. 2003. Foster family resources, psychosocial functioning, and retention. *Social Work Research,* 27, 135-150.

Rork, K. E. & Mcneil, C. B. 2011. Evaluation of foster parent training programs: A critical review. *Child & Family Behavior Therapy,* 33**,** 139-170.

Rosenwald, M. & Bronstein, L. 2008. Foster parents speak: Preferred characteristics of foster children and experiences in the role of foster parent. *Journal of Family Social Work,* 11**,** 287-302.

Sandelowski, M. & Barroso, J. 2003. Classifying the findings in qualitative studies. *Qualitative Health Research,* 13**,** 905-923.

Sandelowski, M., Docherty, S. & Emden, C. 1997. Qualitative metasynthesis: Issues and techniques. *Research in Nursing & Health,* 20**,** 365-371.

Sargent, K. & O'brien, K. 2004. The emotional and behavioural difficulties of looked after children: Foster carers' perspective and an indirect model of placement support. *Adoption & Fostering,* 28**,** 31-37.

Smith, J. A. 2011. Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review,* 5**,** 9-27.

Soliday, E., Mcclusky-Fawcett, K. & Meck, N. 1994. Foster mothers' stress, coping, and social support in parenting drug-exposed and other at-risk toddlers. *Children's Health Care,* 23**,** 15-32.

The Fostering Network 2004. Getting the support they need: Findings of a survey of foster carers in the UK.

Thomas, J. & Harden, A. 2008. Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology,* 1-10.

Triseliotis, J., Borland, M. & Hill, M. 1998. Foster carers who cease to foster. *Adoption & Fostering,* 22**,** 54-61.

Walsh, D & Downe, S. 2006. Appraising the quality of qualitative research. *Midwifery,* 22, 108-119.

Wells, K. & D'angelo, L. 1994. Specialized foster care: Voices from the field. *Social Service Review,* 68**,** 127-144.

Whenan, R., Oxlad, M. & Lushington, K. 2009. Factors associated with foster carer well-being, satisfaction and intention to continue providing out-of-home care. *Children and Youth Services Review,* 31**,** 752-760.

Wilson, K. & Evetts, J. 2006. The professionalisation of foster care. *Adoption & Fostering,* 30**,** 39-47.

Yalom, I. D. & Leszcz, M. 2005. *The theory and practice of group psychotherapy,* New York, Basic Books.

Yardley, L. 2008. Demonstrating validity in qualitative psychology. *In:* Smith, J. A. (ed.) *Qualitative psychology a practical guide to research methods.* 2nd ed. London: Sage Publications Ltd.

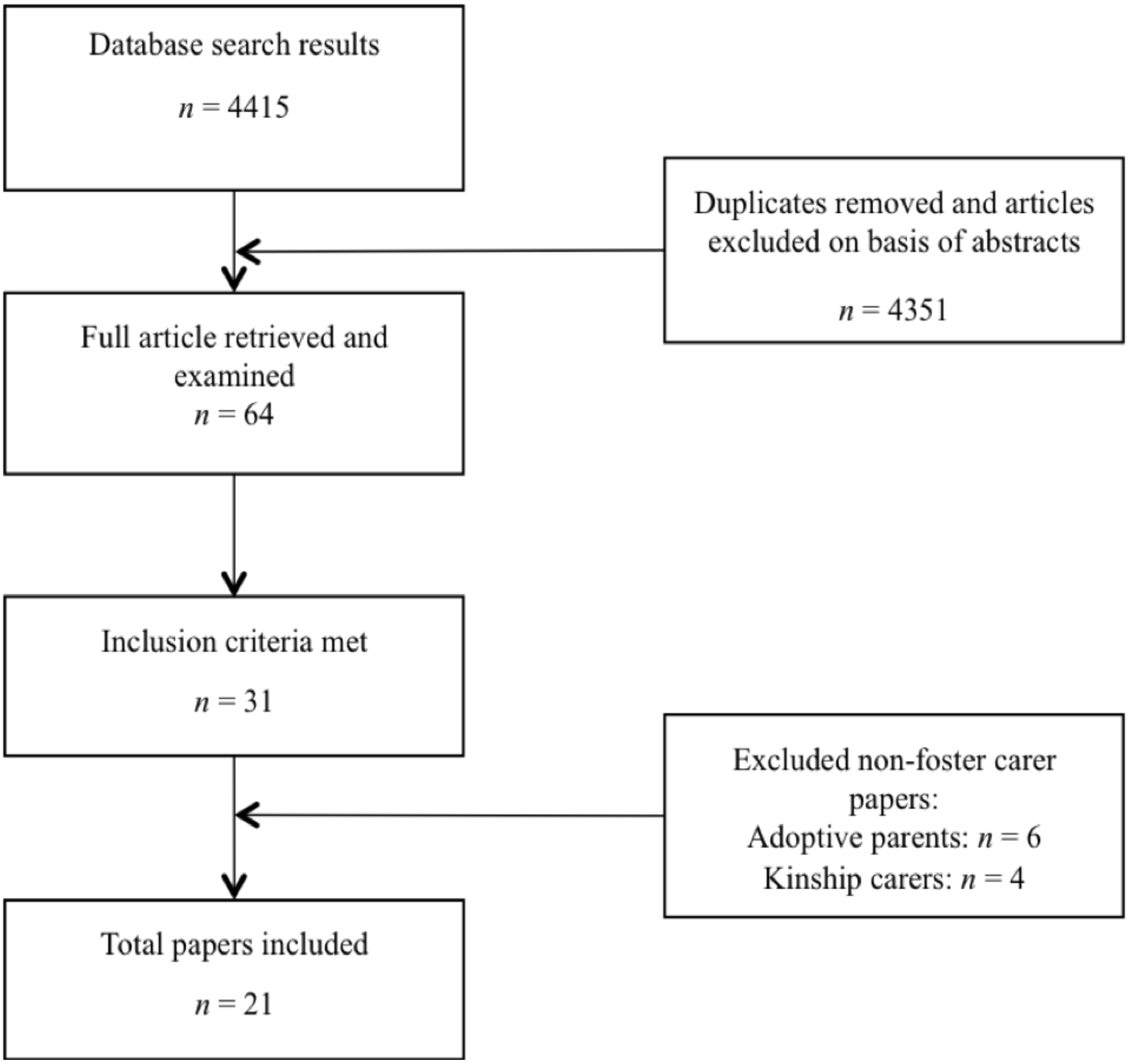


Figure 1. Flow chart of literature search process.

Table 1

Quality scores for each study as assessed using the Critical Appraisal Skills Programme (CASP) Qualitative Research Checklist

Study	Research design	Recruitment & sampling	Data collection	Reflexivity	Ethical issues	Data analysis	Findings	Value of research	Total score
Allen & Vostanis (2005)	3	3	2	1	1	1	2	2	15
Blythe, Jackson, Halcomb, & Wilkes (2012)	1	2	2	3	3	2	2	2	15
Blythe, Halcomb, Wilkes, & Jackson (2013a)	3	2	1	2	3	2	3	2	18
Blythe, Halcomb, Wilkes, & Jackson (2013b)	3	2	1	1	3	2	2	3	17
Broady, Stoyles, McMullan, Caputi, & Crittenden (2010)	3	3	2	2	3	2	3	2	20
Buehler, Cox, & Cuddeback (2003)	2	2	2	1	1	2	3	3	16
Daniel (2011)	3	2	3	1	2	1	1	3	16
Inch (1999)	3	2	3	1	1	2	2	3	17
Lauver (2008)	3	2	2	1	3	2	3	3	19
Lauver (2010)	3	2	3	1	3	2	3	3	20
Laybourne, Andersen, & Sands (2008)	3	3	2	1	1	1	1	3	15
MacGregor, Rodger, Cummings, & Leschied (2006)	3	3	3	1	2	2	2	2	18
Maclay, Bunce & Purves (2006)	3	3	3	1	2	2	2	3	19
McDonald, Burgess, & Smith (2003)	1	1	2	1	1	2	2	1	11
Metcalfe & Sanders (2012)	3	3	3	1	3	2	3	3	21
Murray, Tarren-Sweeney, & France (2011)	3	3	3	1	1	2	2	2	17
Oke, Rostill-Brookes, & Larkin (2011)	3	3	3	1	3	2	3	2	20
Picken, Brunsden & Hill (2011)	3	2	3	1	2	2	3	2	18
Rosenwald & Bronstein (2008)	3	2	2	1	1	2	2	3	16
Sargent & O'Brien (2004)	2	1	1	1	1	1	2	2	11
Wells & D'Angelo (1994)	3	2	3	1	2	2	3	3	19

Note. A score of 1 = weak, 2 = moderate, 3 = strong. Based upon scoring system developed by Duggleby et al. (2010).

Table 2

Summary of studies included in the review

Paper	Location	Research question/aim	Participants	Methodology
Allen & Vostanis (2005)	UK	To evaluate a foster carer (and social worker) training programme	Sample size: n = 17; Sex: 4 male, 13 female; Experience: <1-35 years; Placement types: emergency, short-term; long-term, contract care placements	Focus groups; thematic analysis
Blythe, Jackson, Halcomb & Wilkes (2012)	Australia	To gain insight into foster carer experiences from the perspective of the foster mothers.	Sample size: n = 20; Sex: 20 female; Age: 41-73 years; Experience: 3-44 years; Placement type: long-term	Semi-structured interviews; thematic analysis
Blythe, Halcomb, Wilkes & Jackson (2013a)	Australia	As above	As above	As above
Blythe, Halcomb, Wilkes & Jackson (2013b)	Australia	As above	As above	As above
Broady, Stoyles, McMullan, Caputi & Crittenden (2010)	Australia	To develop a framework to understand the implications of inadequate training and the importance of ongoing support for foster carers.	Sample size: n = 12; Sex: 1 male, 11 female; Age: 35-62 years; Varied in experience	Focus groups and individual interviews; unspecified analysis

Paper	Location	Research question/aim	Participants	Methodology
Buehler, Cox & Cuddeback (2003)	USA	To understand foster carers' perceptions of the stresses and rewards of fostering. To understand parental beliefs and behaviours that may make fostering easier or more difficult.	Sample size: n = 22; Sex: 8 male, 14 female; Varied in experience.	Structured interviews; thematic analysis
Daniel (2011)	Canada	To explore the experiences of foster parents in eastern Canada.	Sample size: n = 8; Sex: 2 male, 6 female; Age: 40-75 years; Experience: 7-44 years	Structured interviews; grounded theory
Inch (1999)	USA	To understand foster fathering from the perspective of the men themselves	Sample size: n = 15; Sex: 15 male; Age: 35-69 years; Experience: 1.5-15 years;	Individual interviews; grounded theory
Lauver (2008)	USA	To understand the experiences of foster carers caring for children with complex health needs.	Sample size: n = 13; Sex: 3 male; 10 female; Age: 24-66 years; Experience: 8 months - 20 years	Unstructured interviews; phenomenological analysis
Lauver (2010)	USA	To compose a vivid description of foster carer experiences to increase understanding of their needs.	Sample size: n = 10; Sex: 10 female; Age: 24-66 years; Experience: 8 months - 2 years	Unstructured interviews; phenomenological analysis
Laybourne, Andersen & Sands (2008)	UK	To evaluate a parent training programme. The aim was to explore whether parenting programme made a difference to their parenting.	Sample size: n = 6; Other participant details not specified	Semi-structured interviews; thematic analysis

Paper	Location	Research question/aim	Participants	Methodology
MacGregor, Rodger, Cummings & Leschied (2006)	Canada	To examine foster parents' experiences from their own perspective.	Sample size: n = 54; Sex: 5 male; 49 female; Mean age: 45 years; Experience: mean 8 years	Focus groups; analysis based on 'consensual qualitative research'
Maclay, Bunce & Purves (2006)	UK	To explore the relationship between social workers & foster carers, with a view to understanding the dynamics between them.	Sample size: n = 9; Sex: 1 male, 8 female; Age: 30s-50s; Experience: 2-20 years; Placement types: emergency, short-term, long-term	Semi-structured interviews; interpretative phenomenological analysis
McDonald, Burgess & Smith (2003)	UK	To determine foster carers' experiences and perceptions of the an interventions.	Sample size: n = 10; Other participant details not specified	Interviews; unspecified analysis
Metcalfe & Sanders (2012)	USA	To increase the knowledge of qualities and of the needs of older foster parents.	Sample size: n = 37; Sex: 43% male, 57% female; Age: 62-74 years; Experience: 1-36 years	Semi-structured interviews; thematic analysis
Murray, Tarren-Sweeney & France (2011)	New Zealand	To survey carers' perceptions of support and training they were receiving and to explore any further support that they thought would be needed.	Sample size: n = 17; Sex; 3 males; 14 females; Age: 39-71 years; Experience: 2-42 years	Structured interviews & questionnaires; domain analysis
Oke, Rostill-Brookes & Larkin (2011)	UK	To explore foster carers' perceptions of successful placements.	Sample size: n = 9; Sex: 9 female; Age: 48-65 years; Experience: 9-37 years; Placement types: long-term	Semi-structured interviews; interpretative phenomenological analysis
Picken, Brunsden & Hill (2011)	UK	To explore the emotional well-being of foster carers. Aim was to focus on the carers rather than on the children.	Sample size: n = 5; Sex: 1 male, 4 female; Experience: 1-10 years; Placement types: full-time, respite.	Photovoice technique; interpretative phenomenological analysis

Paper	Location	Research question/aim	Participants	Methodology
Rosenwald & Bronstein (2008)	USA	To look at preferred child characteristics. Study also yielded data on the experiences of being a foster carer and so this was included in the anlysis.	Sample size: n = 13; Sex: 2 male, 11 female; Experience: varied. Other participant details not specified	Focus groups; grounded theory
Sargent & O'Brien (2004)	UK	To obtain foster carers' perspectives in an evaluation of specialist CAMHS.	Sample size: n = 10; Sex: 10 female; Experience: 2-15 years; Placement type: short-term, long-term	Interviews; unspecified analysis
Wells & D'Angelo (1994)	USA	To explore how foster parents view the experience of providing treatment and care to children.	Sample size: n = 40; Sex: 29% male, 71% female; Other participant details not specified	Focus groups; content analysis

Appendix 1-A
Example Quality Assessment

Name of Study	The impact of abuse and trauma on the developing child
Authors	Allen & Vostanis
Date	2005
Method of analysis	Thematic Analysis
Participants	17 foster carers
Location	UK

Scores: 1 = weak little or no justification or explanation of a particular issue

2 = moderate Addressed issue but didn't fully elaborate (e.g. justification for use of method but no procedure)

3 = strong Extensively justified and explained issues (e.g. semi-structured interviews, transcribed, sample interview questions)

			Score
Research Aims **Was there a clear statement of the aims of the research?**	Goal of the research	Clear aim – to evaluate FC and SW training programme	N/A
	Why is it important?	Discusses how it adds to previous research in the area	
	What is its relevance?	To evaluate the contribution of attachment based model to training carers in understanding the difficulties foster children may face.	
Research Design **Was the research design appropriate?**	Justified the design? Have they discussed their decision process?	Focus groups – explained why chosen over other methods – to provide richer and deeper information than an evaluation questionnaire, making suitable to explore varied experiences. Full explanation of the various focus groups that were run and why done.	3

Recruitment Strategy / Sampling **Was the recruitment strategy appropriate to the aims of the research?**	Has the research explained how participants were selected?	Yes – attended a training programme and participated in this evaluation	3
	Have they explained why these participants were the most appropriate to provide access to knowledge sought?	Yes – meets research aim to evaluate the programme as participants attended the training.	
	Are there any discussions around recruitment e.g. why some people chose not to take part?	Yes – explains that some FCs did not attend the programme and so couldn't participate in evaluation	
Data collection **Was the data collected in a way that addressed the research issue?**	Was the setting for data collection justified?	Yes – collected following the training programme	2
	Is it clear how data were collected (e.g. focus group, interviews etc)?	Yes – focus groups and details given of each focus group that was carried out	
	Has the researcher justified the methods?	Yes – explanation of why focus groups most appropriate	
	Has the researcher made the methods explicit e.g. topic guides in interviews?	No – explains that focus groups done but no indication as to the types of questions asked	
	If methods were modified during study – how and why?	N/A	
	Form of data clear (e.g. audio, video, notes)?	Yes – audio taped and transcribed verbatim	
	Saturation of data discussed?	No	

Reflexivity **Has the relationship between researcher and participants been adequately considered?**	Has the researcher critically examined their own role, potential bias and influence during: • Formulation of research questions • Data collection, including sample recruitment & location	No – not discussed in write up	1
	How the researcher responded to events during the study & if they considered implications of any changes in design	No – not discussed in write up	
Ethical Issues **Have ethical issues been taken into consideration?**	Is there sufficient details of how the research was explained to participants?	No – doesn't explain this in detail, just outlines that they were giving feedback on the training they had completed	1
	Has the researcher discussed issues raised by the study (e.g. informed consent / confidentiality / debriefing)?	No – not explained in the write up of the paper	
	Has approval been sought from ethics?	No - Does not state whether ethical approval sought/obtained	

Data Analysis **Was the data analysis sufficiently rigorous?**	Is there an in-depth description of the analysis process?	No – just explains that did thematic analysis, no detail of how this was actually done	1
	If thematic analysis – is it clear how the themes were derived from the data?	No – no description of how this was done apart from “key themes identified”	
	Does the researcher explain how the data were selected from the original sample?	Yes – split into foster carers/social workers and responses for each focus group pre and post-training	
	Is sufficient data presented to support the findings?	Yes – quotes provided for each theme to show where it has developed from and to support suggestions	
	To what extent is contradictory data taken into account?	No – not discussed in the results	
	Did the researcher critically examine their own role, potential bias and influence during analysis and selection of data for presentation?	No – researcher’s role not discussed	
Findings **Is there a clear statement of findings?**	Are the findings explicit?	Yes – clearly laid out, clear where themes have developed from	2
	Is there adequate discussion of the evidence both for and against the researcher’s arguments?	Not discussed	
	Has the researcher discussed the creditability (e.g. triangulation, respondent validation, more than one analyst?)	Yes – two analysts used	
	Are the findings discussed in relation to the original research questions?	Yes – refer back to the research aims/question in the discussion	

Value of the research **How valuable is the research?**	Does the researcher discuss the contribution the study makes to existing knowledge or understanding?	Yes – explains how adds to attachment theory around LAC and the importance of ongoing training, rather than one-off opportunities. Also outlines suggestions for similar support groups.	2
	Do they identify new areas where research is necessary?	Yes – recommendation for follow up to this evaluation	
	Do the researchers discuss whether or how the findings can be transferred to other populations or considered other ways the research may be used?	Suggests how could be used to inform further training programmes for other groups of carers, such as adopters or residential carers.	
TOTAL SCORE (OUT OF 24)			**15**

Appendix 1-B
Author Guidelines for Journal

Child & Family Social Work © John Wiley & Sons Ltd
Edited By: Susan White
Impact Factor: 0.831
ISI Journal Citation Reports © Ranking: 2012: 20/38 (Social Work); 26/38 (Family Studies)
Online ISSN: 1365-2206

Author Guidelines

The journal to which you are submitting your manuscript employs a plagiarism detection system. By submitting your manuscript to this journal you accept that your manuscript may be screened for plagiarism against previously published works.

The journal to which you are submitting your manuscript employs a plagiarism detection system. By submitting your manuscript to this journal you accept that your manuscript may be screened for plagiarism against previously published works.

3.1. Getting Started

1. GENERAL

Child & Family Social Work provides a forum where researchers, practitioners, policy-makers and managers in the field exchange knowledge, increase understanding and develop notions of good practice. In its promotion of research and practice, which is both disciplined and articulate, the Journal is dedicated to advancing the wellbeing and welfare of children and their families throughout the world.

Child & Family Social Work publishes original and distinguished contributions on matters of research, theory, policy and practice in the field of social work with children and their families. The Journal gives international definition to the discipline and practice of child and family social work.

Please read the instructions below carefully for details on the submission of manuscripts, the journal's requirements and standards as well as information concerning the procedure after a manuscript has been accepted for publication in *Child & Family Social Work*. Authors are encouraged to visit Author Services for further information on the preparation and submission of articles and figures.

2. ETHICAL GUIDELINES

Child & Family Social Work adheres to the below ethical guidelines for publication and research.

2.1. Authorship and Acknowledgements

Authorship: Authors submitting a paper do so on the understanding that the manuscript has been read and approved by all authors and that all authors agree to the submission of the manuscript to the Journal. ALL named authors must have made an active contribution to the conception and design and/or analysis and interpretation of the data and/or the drafting of the paper and ALL must have critically reviewed its content and have approved the final version submitted for publication. Participation solely in the acquisition of funding or the collection of data does not justify authorship.

Child & Family Social Work adheres to the definition of authorship set up by The International Committee of Medical Journal Editors (ICMJE). According to the ICMJE authorship criteria should be based on 1) substantial contributions to conception and design of, or acquisition of data or analysis and interpretation of data, 2) drafting the article or revising it critically for important intellectual content and 3) final approval of the version to be published. Authors should meet conditions 1, 2 and 3.
It is a requirement that all authors have been accredited as appropriate upon submission of the manuscript. Contributors who do not qualify as authors should be mentioned under Acknowledgements.

Acknowledgements: Under Acknowledgements please specify contributors to the article other than the authors accredited. Please also include specifications of the source of funding for the study and any potential conflict of interests if appropriate. Suppliers of materials should be named and their location (town, state/county, country) included.

2.2. Ethical Approvals

Experimental Subjects: experimentation involving human subjects will only be published if such research has been conducted in full accordance with ethical principles, including the World Medical Association Declaration of Helsinki (version 2002) and the additional requirements, if any, of the country where the research has been carried out. Manuscripts must be accompanied by a statement that the experiments were undertaken with the understanding and written consent of each subject and according to the above mentioned principles. A statement regarding the fact that the study has been independently reviewed and approved by an ethical board should also be included. Editors reserve the right to reject papers if there are doubts as to whether appropriate procedures have been used.

2.3. Appeal of Decision

Authors who wish to appeal the decision on their submitted paper may do so by e-mailing the editor with a detailed explanation for why they find reasons to appeal the decision.

2.4. Permissions

If all or parts of previously published illustrations are used, permission must be obtained from the copyright holder concerned. It is the author's responsibility to obtain these in writing and provide copies to the Publishers.

2.5. Copyright Assignment
If your paper is accepted, the author identified as the formal corresponding author for the paper will receive an email prompting them to login into Author Services; where via the Wiley's Author Licensing Service (WALS) they will be able to complete the license agreement on behalf of all authors on the paper.

For authors signing the copyright transfer agreement

If the OnlineOpen option is not selected the corresponding author will be presented with the copyright transfer agreement (CTA) to sign. The terms and conditions of the CTA can be previewed in the samples associated with the Copyright FAQs below:

CTA Terms and Conditions http://authorservices.com/bauthor/faqs_copyright.asp

3. ONLINEOPEN

For authors choosing OnlineOpen

If the OnlineOpen option is selected the corresponding author will have a choice of the following Creative Commons License Open Access Agreements (OAA):

Creative Commons Attribution License OAA

Creative Commons Attribution Non-Commercial License OAA

Creative Commons Attribution Non-Commercial -NoDerivs License OAA

To preview the terms and conditions of these open access agreements please visit the Copyright FAQs hosted on Wiley Author Services http://authorservices.wiley.com/bauthor/faqs_copyright.asp and visit http://www.wileyopenaccess.com/details/content/12f25db4c87/Copyright--License.html.

If you select the OnlineOpen option and your research is funded by The Wellcome Trust and members of the Research Councils UK (RCUK) you will be given the opportunity to publish your article under a CC-BY license supporting you in complying with Wellcome Trust and Research Councils UK requirements. For more information on this policy and the Journal’s compliant self-archiving policy please visit: http://www.wiley.com/go/funderstatement.

4**. SUBMISSION OF MANUSCRIPTS**
Manuscripts should be submitted electronically via the online submission site http://mc.manuscriptcentral.com/cfsw. The use of an online submission and peer review site enables immediate distribution of manuscripts and consequentially speeds up the review process. It also allows authors to track the status of their own manuscripts.
Complete instructions for submitting a paper are available online and below.

4.1. Getting Started

Launch your web browser (supported browsers include Internet Explorer 6 or higher, Netscape 7.0, 7.1, or 7.2, Safari 1.2.4, or Firefox 1.0.4) and go to the journal's online Submission Site: http://mc.manuscriptcentral.com/cfswhttp://mc.manuscriptcentral.com/cfsw.

- Log-in or click the 'Create Account' option if you are a first-time user.
- If you are creating a new account.
  - After clicking on 'Create Account', enter your name and e-mail information and click 'Next'. Your e-mail information is very important.
  - Enter your institution and address information as appropriate, and then click 'Next.'
  - Enter a user ID and password of your choice (we recommend using your e-mail address as your user ID), and then select your area of expertise. Click 'Finish'.
- If you have an account, but have forgotten your log in details, go to “Password Help” on the journals online submission system http://mc.manuscriptcentral.com/cfsw and enter your e-mail address. The system will send you an automatic user ID and a new temporary password.
- Log-in and select 'Author Center

4.2. Submitting Your Manuscript

- After you have logged in, click the 'Submit a Manuscript' link in the menu bar.
- Enter data and answer questions as appropriate. You may copy and paste directly from your manuscript and you may upload your pre-prepared covering letter.
- Click the 'Next' button on each screen to save your work and advance to the next screen.
- You are required to upload your files.
  - Click on the 'Browse' button and locate the file on your computer.
  - Select the designation of each file in the drop-down menu next to the Browse button.
  - When you have selected all files you wish to upload, click the 'Upload Files' button.
- Review your submission (in HTML and PDF format) before sending to the Journal. Click the 'Submit' button when you are finished reviewing.

Getting Help with Your Submission

Each page of the ScholarOne Manuscripts website has a ‘Get Help Now’ icon connecting directly to the online support system at http://mcv3support.custhelp.com. Telephone support is available 24 hours a day, 5 days a week through the US ScholarOne Support Office on: +1 434 817 2040, ext 167. If you do not have Internet access or cannot submit online, the Editorial Office can assist. Please contact Paula Doherty at CFSEditorialOffice@lancaster.ac.uk at the Editorial Office.

4.3. Copyright Transfer Agreement

It is a condition of publication that authors grant the Publisher the exclusive licence to publish all articles including abstracts. Papers will not be passed to the publisher for production unless the exclusive licence to publish has been granted.

This form can be downloaded by following the 'Instructions & Forms' link from http://mc.manuscriptcentral.com/cfsw.

4.4. Manuscript Files Accepted

Manuscripts should be uploaded as Word (.doc) or Rich Text Format (.rft) files (not write-protected) plus separate figure files. GIF, JPEG, PICT or Bitmap files are acceptable for submission, but only high-resolution TIF or EPS files are suitable for printing. The files will be automatically converted to HTML and PDF on upload and will be used for the review process. The text file must contain the entire manuscript including title page, abstract, text, references, tables, and figure legends, but no embedded figures. Figure tags should be included in the file. Manuscripts should be formatted as described in the Author Guidelines= below.

Please note that any manuscripts uploaded as Word 2007 (.docx) will be automatically rejected. Please save any .docx file as .doc before uploading.

4.5. Blinded Review

All manuscripts submitted to *Child & Family Social Work* will be reviewed by two experts in the field. *Child & Family Social Work* uses double-blinded review. The names of the reviewers will thus not be disclosed to the author submitting a paper and the name(s) of the author(s) will not be disclosed to the reviewers.

To allow double-blinded review, please submit (upload) your main manuscript and title page as separate files.

Please upload:

- Your manuscript without title page under the file designation 'main document'
- Figure files under the file designation 'figures'
- The title page, Acknowledgements and Conflict of Interest Statement where applicable, should be uploaded under the file designation 'title page'

  All documents uploaded under the file designation 'title page' will not be viewable in the HTML and PDF format you are asked to review at the end of the submission process. The files viewable in the HTML and PDF format are the files available to the reviewer in the review process.

4.6. Suspension of Submission Mid-way in the Submission Process

You may suspend a submission at any phase before clicking the 'Submit' button and save it to submit later. The manuscript can then be located under 'Unsubmitted Manuscripts' and you can click on 'Continue Submission' to continue your submission when you choose to.

4.7. E-mail Confirmation of Submission

After submission you will receive an e-mail to confirm receipt of your manuscript. If you do not receive the confirmation e-mail after 24 hours, please check your e-mail address carefully in the system. If the e-mail address is correct please contact your IT department. The error may be caused by spam filtering software on your e-mail server. Also, the e-mails should be received if the IT department adds our e-mail server (uranus.scholarone.com) to their whitelist.

4.8. Manuscript Status

You can access Manuscript Central any time to check your 'Author Center' for the status of your manuscript. The Journal will inform you by e-mail once a decision has been made.

4.9. Submission of Revised Manuscripts

Revised manuscripts must be uploaded within 3 months of authors being notified of conditional acceptance pending satisfactory revision. Locate your manuscript under 'Manuscripts with Decisions' and click on 'Submit a Revision' to submit your revised manuscript. Please remember to delete any old files uploaded when you upload your revised manuscript. Please also remember to upload your manuscript document separate from your title page.

5. MANUSCRIPT TYPES ACCEPTED

Manuscripts should normally be a maximum of 7000 words, including abstract and references, although shorter papers will be welcomed. One copy of an abstract, not exceeding 200 words, should accompany the manuscript. The abstract should be followed by up to six keywords. The title page should display the title of the paper; names of the author(s); position and place of work; and the full postal address, telephone number and e-mail address of the author to whom correspondence should be addressed. All figures and tables should be referred to in the text and their appropriate positions indicated in the text. The use of footnotes should be avoided. Details of research methodology should be included in the manuscript where appropriate.

The Editors welcome the following scholarly papers:

Review Papers These will be actively encouraged. Prospective authors should initially discuss their proposals with the Editor.

Research Review Section A review of recent research in a particular area or report on research currently underway are welcomed in this section and should be sent direct to the Research Review Editor. These articles should be 3000 words in length and should provide an opportunity to consider the research in some detail.
Policy Digest Section This section publishes brief contributions (around 1000 words) on policy debates in different countries or short policy articles. Contributions are welcomed.

Special Issues From time to time the Editor may commission a special issue of the Journal which will take the form of a number of papers devoted to a particular theme.

Book Reviews Books for review should be sent to Paula Doherty. Email: CFSEditorialoffice@lancaster.ac.uk

6. MANUSCRIPT FORMAT AND STRUCTURE

6.1. Format

Language: The language of publication is English. Authors for whom English is a second language must have their manuscript professionally edited by an English speaking person before submission to make sure the English is of high quality. It is preferred that manuscripts are professionally edited. A list of independent suppliers of editing services can be found at http://authorservices.wiley.com/bauthor/english_language.asp. All services are paid for and arranged by the author, and use of one of these services does not guarantee acceptance or preference for publication.

Optimizing Your Abstract for Search Engines

Many students and researchers looking for information online will use search engines such as Google, Yahoo or similar. By optimizing your article for search engines, you will increase the chance of someone finding it. This in turn will make it more likely to be viewed and/or cited in another work. We have compiled these guidelines to enable you to maximize the web-friendliness of the most public part of your article.

6.2. References

Harvard style must be used. In the text the names of authors should be cited followed by the date of publication, e.g. Adams & Boston (1993). Where there are three or more authors, the first author's name followed by *et al.* should be used in the text, e.g. Goldberg *et al.* (1994). The reference list should be prepared on a separate sheet with names listed in alphabetical order. The references should list authors' surnames and initials, date of publication, title of article, name of book or journal, volume number or edition, editors, publisher and place of publication. In the case of an article or book chapter, page numbers should be included routinely.

Examples of references

- Glaser, D. & Frosh, S. (1988) *Child Sexual Abuse*. Macmillan, Basingstoke.
- Buchanan, A. (1997) The Dolphin Project: the impact of the Children Act. In: *Participation and Empowerment in Child Protection* (eds C. Cloke & M. Davies), pp. 120-139. John Wiley, Chichester.
- Packman, J. & Jordan, W. (1991) The Children Act: looking forward, looking back. *British Journal of Social Work*, **21**, 315-327.

The editor and publisher recommend that citation of online published papers and other material should be done via a DOI (digital object identifier), which all reputable online published material should have - see www.doi.org/ for more information. If an author cites anything which does not have a DOI they run the risk of the cited material not being traceable.

We recommend the use of a tool such as EndNote or Reference Manager for reference management and formatting.

EndNote reference styles can be searched for here:
www.endnote.com/support/enstyles.asp

Reference Manager reference styles can be searched for here:
www.refman.com/support/rmstyles.asp

6.3. Tables, Figures and Figure Legends

Tables: These should only be used to clarify important points. Tables must, as far as possible, be self-explanatory. Tables must be typewritten on a separate sheet. No vertical rules should be used. Units should appear in parentheses in the column headings. All abbreviations should be defined in a footnote. The tables should be numbered consecutively with Arabic numerals.

Figures: All graphs, drawings and photographs are considered figures and should be numbered in sequence with Arabic numerals. Each figure should have a legend and all legends should be typed together on a separate sheet and numbered correspondingly.

All figures and artwork must be provided in electronic format. Please save vector graphics (e.g. line artwork) in Encapsulated Postscript Format (EPS) and bitmap files (e.g. halftones) or clinical or in vitro pictures in Tagged Image Format (TIFF). In the full-text online edition of the Journal, figure legends must be truncated in abbreviated links to the full screen version. Therefore, the first 100 characters of any legend should inform the reader of key aspects of the figure.

Colour illustrations are acceptable when found necessary by the Editor; however, the author may be asked to contribute towards the cost of printing.

Preparation of Electronic Figures for Publication

Although low quality images are adequate for review purposes, print publication requires high quality images to prevent the final product being blurred or fuzzy. Submit EPS (line art) or TIFF (halftone/photographs) files only. MS PowerPoint and Word Graphics are unsuitable for printed pictures. Do not use pixel-oriented programmes. Scans (TIFF only) should have a resolution of at least 300 dpi (halftone) or 600 to 1200 dpi (line drawings) in relation to the reproduction size (see below). Please submit the data for figures in black and white. EPS files should be saved with fonts embedded (and with a TIFF preview if possible).

For scanned images, the scanning resolution (at final image size) should be as follows to ensure good reproduction: line art: >600 dpi; halftones (including gel photographs): >300 dpi; figures containing both halftone and line images: >600 dpi.
Further information can be obtained at Wiley's guidelines for figures:
http://authorservices.wiley.com/prep_illust.asp

Check your electronic artwork before submitting it:
http://authorservices.wiley.com/bauthor/eachecklist.asp

Permissions: If all or parts of previously published illustrations are used, permission must be obtained from the copyright holder concerned. It is the author's responsibility to obtain these in writing and provide copies to the Publisher.

6.4. Supporting Information

Publication in electronic formats has created opportunities for adding details or whole sections in the electronic version only. Authors need to work closely with the editors in developing or using such new publication formats.

Supporting information, such as data sets or additional figures or tables, that will not be published in the print edition of the journal, but which will be viewable via the online edition, can be submitted.

It should be clearly stated at the time of submission that the Supporting Information is intended to be made available through the online edition. If the size or format of the Supporting Information is such that it cannot be accommodated on the Journal's website, the author agrees to make the Supporting Information available free of charge on a permanent website, to which links will be set up from the Journal's website. The author must advise John Wiley & Sons Pte Ltd if the URL of the website where the Supporting Information is located changes. The content of the Supporting Information must not be altered after the paper has been accepted for publication.

The availability of Supporting Information should be indicated in the main manuscript by a paragraph, to appear after the References, headed 'Supporting Information' and providing titles of figures, tables, etc. In order to protect reviewer anonymity, material posted on the author’s website cannot be reviewed. The Supporting Information is an integral part of the article and will be reviewed accordingly.

7. AFTER ACCEPTANCE

Upon acceptance of a paper for publication, the manuscript will be forwarded to the Production Editor who is responsible for the production of the journal.

7.1. Proof Corrections

The corresponding author will receive an e-mail alert containing a link to a website. A working e-mail address must therefore be provided for the corresponding author. The proof can be downloaded as a PDF (portable document format) file from this site.

Acrobat Reader will be required in order to read this file. This software can be downloaded (free of charge) from the following website:
www.adobe.com/products/acrobat/readstep2.html. This will enable the file to be opened, read

on screen, and printed out in order for any corrections to be added. Further instructions will be sent with the proof. Hard copy proofs will be posted if no e-mail address is available; in your absence, please arrange for a colleague to access your e-mail to retrieve the proofs.

Proofs must be returned to the Production Editor within three days of receipt.
Proofs must be returned to the typesetter within three days of receipt. Please note that if you have registered for production tracking e-mail alerts in Author Services, there will be no e-mail for the proof corrections received stage. This will not affect e-mails alerts for any later production stages.

As changes to proofs are costly, we ask that you only correct typesetting errors. Excessive changes made by the author in the proofs, excluding typesetting errors, will be charged separately. Other than in exceptional circumstances, all illustrations are retained by the publisher. Please note that the author is responsible for all statements made in their work, including changes made by the copy editor.

7.2. Early View (Publication Prior to Print)

Child & Family Social Work is covered by John Wiley & Sons' Early View service. Early View articles are complete full-text articles published online in advance of their publication in a printed issue. Early View articles are complete and final. They have been fully reviewed, revised and edited for publication, and the authors' final corrections have been incorporated. Because they are in final form, no changes can be made after online publication. The nature of Early View articles means that they do not yet have volume, issue or page numbers, so Early View articles cannot be cited in the traditional way. They are therefore given a Digital Object Identifier (DOI), which allows the article to be cited and tracked before it is allocated to an issue. After print publication, the DOI remains valid and can continue to be used to cite and access the article.

7.3. Author Services

Online production tracking is available for your article through Wiley's Author Services. Author Services enables authors to track their article - once it has been accepted - through the production process to publication online and in print. Authors can check the status of their articles online and choose to receive automated e-mails at key stages of production. The author will receive an e-mail with a unique link that enables them to register and have their article automatically added to the system. Please ensure that a complete e-mail address is provided when submitting the manuscript. Visit http://authorservices.com/bauthor/ for more details on online production tracking and for a wealth of resources including FAQs and tips on article preparation, submission and more.
For more substantial information on the services provided for authors, please see -Blackwell Author Services

7.4. Author Material Archive Policy

Please note that unless specifically requested, Blackwell Publishing will dispose of all hardcopy or electronic material submitted two months after publication.
If you require the return of any material submitted, please inform the editorial office or

production editor as soon as possible.

7.5. Offprints and Extra Copies

A PDF offprint of the online published article will be provided free of charge to the corresponding author, and may be distributed subject to the Publisher's terms and conditions. Additional paper offprints may be ordered online. Please click on the following link, fill in the necessary details and ensure that you type information in all of the required fields:
offprint.cosprinters.com/cos/bw/main.jsp?SITE_ID=bw&FID=USER_HOME_PG
If you have queries about offprints please e-mail offprint@cosp

Section Two: Empirical Paper

An Exploration of Social Workers' Experiences of Psychological Consultation

Word Count: 7, 987 words

Kate Houlihan

Lancaster University

Division of Health Research, Lancaster University

All correspondence should be sent to:

Kate Houlihan
Doctorate in Clinical Psychology
Furness College
Lancaster University
Lancaster
LA1 4YT
k.houlihan@lancaster.ac.uk

Prepared for Child and Adolescent Mental Health[2]

---

[2] See Appendix 2-B for 'Notes to Contributors'

Abstract

Background: The research paper aimed to explore social workers' experiences of psychological consultation around their work with looked after children. Research in this area suggests that support for professionals working with looked after children is vital. However, little research has been conducted to identify the impact of this support.

Method: Eight social workers participated in semi-structured interviews, in which they were asked to reflect upon their experiences of psychological consultation. All interviews were transcribed and then analysed using interpretative phenomenological analysis.

Results: Four themes were identified in the interview data: An alternative perspective: Seeking expertise; A dual-purpose: consultation for families and the self; Consultation as a lifeline: The final chance; and Validation and acknowledgement: The psychological experience of consultation.

Conclusions: The findings suggest that psychological consultation can be a highly valuable resource for social workers. A key concept of consultation providing a safe and containing space ran through all of the findings, highlighting the specialist role that clinical psychologists could take in working with looked after children. A number of clinical implications are identified, along with recommendations for future research in this field.

Keywords: social work; looked after children; psychological consultation; attachment; support.

Looked after children (LAC) are defined as those who are cared for or provided accommodation by a local authority (Department of Health, 1989). The number of LAC in the UK is rising, with an estimated increase of 10,000 children between 2008 and 2012 (NSPCC, 2014). It is possible that recent public inquiries have resulted in an increase in legal proceedings around the care of children, with the Children and Family Court Advisory and Support Service (CAFCASS, 2011) reporting significantly higher numbers of care proceedings following the inquiry into the death of Peter Connelly (Department for Education, 2010a, 2010b).

It is widely acknowledged that LAC are one of the most vulnerable groups in society (Everson-Hock et al., 2011; Golding, 2010; Hatfield et al., 1996; Preston-Shoot & Wigley, 2005; Scott, 2011). The nature of the reasons why children may be taken into state care, such as experiences of neglect, abuse and trauma, means that these children are likely to have complex psychological needs. Indeed, reports suggest that LAC have higher rates of mental health, interpersonal and behavioural difficulties than non-looked after children (Barth et al., 2005; Callaghan et al., 2004; Ford et al., 2007; Hibbert & Frankl, 2011; Kerr & Cossar, 2014).

Social Work with Looked After Children

Every LAC in the UK is allocated a local authority social worker (Garrett, 2010) who is responsible for assessing each child’s development (Department of Health, 1989). While social work has been described as rewarding due to being able to help some of the most disadvantaged people in society (Guerin et al., 2010; Huxley et al., 2005), it is also associated with high levels of stress and staff turnover (Collins, 2007; Huxley et al., 2005; Leeson, 2010). Although social workers tend to report enthusiasm for their work, research suggests they often become “disenchanted” (Garrett, 2010, p.96) with their roles due to issues such as high workloads and feeling that services are of poor quality (Fulcher & McGladdery, 2011;

Garrett, 2010; Guerin et al., 2010; Huxley et al., 2005; Leeson, 2010; McLeod, 2007; Watson, 2003). Guerin et al., (2010) surveyed recently qualified social workers in Ireland and found that many felt unsupported and that large caseloads reduced their direct work with clients. This dissatisfaction resulted in almost half of participants changing jobs three or more times in two to six years. Similarly, Leeson (2010) found that social workers reported reduced direct work due to administrative tasks and felt that services were cost-driven rather than needs-driven. Additionally, research suggests that prolonged exposure to vulnerable and often traumatised individuals can increase social workers' risk of emotional difficulties (Bride, 2007), stress and burnout (DePanfilis, 2006; Grady & Cantor, 2012; Leeson, 2010; Van Hook & Rothenberg, 2009).

Sprince (2000) suggested the complex emotions that LAC may experience are frequently projected onto the wider network of carers, which can result in complex dynamics being re-enacted by system. Emanuel (2002) describes this further, suggesting that LAC can experience three levels of deprivation, starting with the experiences resulting in their being taken into care. The second level results from defence mechanisms that the child developed as protection but that can prevent them from accepting support. Finally, the third level of deprivation arises when these defence mechanisms are projected onto, and re-enacted by, professionals around the child. Emanuel (2002) suggests that this transference can result in uncertainty about how to help a child, potentially replicating the child's experiences of neglect: the third level of deprivation (Emanuel, 2002). Both Sprince (2000) and Emanuel (2002) highlight the necessity of supporting professionals working with LAC to try to reduce issues such as stress, burnout and gaps in care provision.

Multi-Agency Working and Consultation

Government and professional guidelines highlight that the complex needs of LAC cannot be met by one agency alone. Rather, professionals should take collective responsibility for the care of LAC (Department for Education, 2003; Department of Health, 2004a; National Institute for Health and Care Excellence, 2010). However, recent public inquiries, such as The Victoria Climbié inquiry (Department of Health, 2003) and the inquiry following the death of Peter Connelly (Department for Education, 2010a, 2010b), have highlighted that these guidelines are not always implemented.

Specialist consultation services have developed, aiming to support the network of professionals and carers surrounding LAC. Mental health consultation has been defined as an individual seeking support from a professional believed to have greater expertise in that field (Evans et al., 2011). The consultation model was developed to try to improve the mental health of large numbers of clients when it would not be possible to complete individual, direct work (Caplan et al., 1994). The original model was based on mental health professionals consulting with other mental health professionals, often within the same services. While the consultant was perceived to have expertise, the model aimed to create equality in power by allowing the consultee to choose whether to follow any advice (Caplan et al., 1994). However, the model began to shift towards consultants being employed by non-mental health organisations, such as social services. Caplan et al., (1994) suggest that this creates an inevitable hierarchy as the consultant is treated as an outside expert, rather than a colleague offering advice. This power imbalance can result in a blurring between supervision and consultation, with the consultant often being pressured to find an effective answer (Caplan et al., 1994). This has been described as collaboration rather than consultation, whereby the consultant often may be expected to share responsibility for an outcome rather than only offering advice (Caplan et al., 1994).

Consultation has begun to be used in this second way to support the network surrounding LAC, with clinical psychologists and other mental health professionals being consulted as experts from outside of social care (Dent et al., 2006; Golding, 2004; Hibbert et al., 2011; Swann & York, 2011). Consultation can involve the whole or part of the network, providing specific advice on direct work with LAC or providing space for professionals and carers to reflect upon a child's and their own emotional needs (Dent et al., 2006). Additionally, it has been suggested that it is not safe to work therapeutically with LAC when they are not in placements that are secure and stable enough to support the therapeutic work. As such, consultation provides a way of providing an indirect intervention when direct therapy is not appropriate (Dent et al., 2006).

When considering the potential psychological needs of LAC, it would seem appropriate for clinical psychologists to be involved in their care. Indeed, it has been suggested that consultation is becoming a significant part of the role of clinical psychologists (Evans et al., 2011), with a core aspect of the role being "to enable colleagues in other professions to develop psychologically-informed ways of thinking" (Division of Clinical Psychology, 2010; p.4). Given the guidelines on multi-agency working and the uncertainty around direct therapeutic work with LAC, consultation appears to be a valuable model for clinical psychologists to use in working with this population.

Despite the history of the use of consultation in mental health, there has been little research to evaluate the effectiveness of this way of working (Evans et al., 2011). Some quantitative research has sought to indentify factors that may contribute to consultation outcome, including investigating the contribution of personal characteristics of consultants (Dougherty, 2000) and consultees (Brown et al., 2006). Additionally, Kurpuis et al., (1993) suggested that specific elements of the consultation process, such as establishing a clear definition of the problem, could determine the outcome. However, it has been suggested that quantitative studies of consultation lack rigour (Froehle & Rominger, 1993) and quantitative methods lack value for evaluating consultation, as they do not capture the flexible nature of the process (Froehle & Rominger, 1993; Wallace & Hall, 1996). Rather, qualitative methods may be of more value in helping to understand how consultation is used and experienced (Evans et al., 2011; Froehle & Rominger, 1993).

Some qualitative research has emerged to evaluate LAC consultation services. For example, Swann et al., (2011) reported feedback from social workers and carers following consultation from a child and adolescent mental health service (CAMHS). Feedback included feeling that consultation had improved communication within the care network, and both social workers and carers felt more confident in their roles. In a more comprehensive study, Hibbert et al., (2011) interviewed social workers and foster carers about their experiences of a psychological consultation service. Carers reported increased psychological understanding of their foster children, and groups of participants felt consultation had provided emotional and practical support.

However, the research into these services is limited and studies have involved carers and professionals, rather than providing detailed accounts from one group. Furthermore, the studies tend to focus on how consultation improves outcomes for LAC. There has, so far, been little insight into whether the consultations impact on the professional identity, coping and wellbeing of social workers, despite the need for an understanding of how to support these professionals.

Given the research outlined above suggesting that work with LAC can have a personal and professional impact on social workers, the aim of this study was to explore the role of psychological consultation across both of these domains. The study aimed to focus on the outcomes of the consultation for social workers, rather than for LAC. As such, the main research question was what are social workers' experiences of psychological consultation services offered by CAMHS?

Method

Design

This project was of a qualitative design, interviewing social workers about their experiences of psychological consultation as provided by CAMH services. A design employing interpretative phenomenological analysis (IPA) was chosen, as IPA aims to obtain a detailed understanding of how individuals make sense of their experiences (Smith, 2011; Smith et al., 2009). This fit with the study aim, which was to develop a detailed understanding of how social workers made sense of psychological consultation in relation to their work with LAC.

Ethics

This project was reviewed by the Lancaster University Faculty of Health and Medicine Research Ethics Committee and approved by the Lancaster University Research Ethics Committee in August 2013. A copy of the documents approved by the committees, along with the letter confirming this approval, can be found in Section 4. Approval from the research governance committees for the local authorities from which participants were recruited was also granted (Appendix 4-G).

Sampling

The potential participants for this study were social workers from two local authorities in North West England. To be included, social workers were required to have accessed consultation offered by one of two CAMH teams on at least one occasion during the six months prior to taking part in the study. This time period was chosen to maximise the opportunity to obtain detailed accounts of participant experiences.

Recruitment

Clinical psychologists from two CAMH teams provided the researcher with contact details for the managers of social work teams that used the consultation services. The researcher contacted three teams from each local authority and arranged to attend team meetings to distribute study information packs. An electronic copy of the information was also provided to all team managers to distribute to those who could not attend the meetings. Social workers who were interested in taking part were asked to opt-in, either by completing and returning an opt-in form or contacting the researcher directly.

This initial stage resulted in the recruitment of five social workers. Two weeks following the initial contact, the researcher sent a reminder email and an electronic copy of the information packs to the team managers. Following this, a further four social workers opted into the study. Details on the number of social workers in each team, and the number who opted in, can be found in Table 1.

Insert Table 1

Participants

One social worker opted-in but was unable to participate due to personal circumstances, resulting in eight participants from across three teams. One male and seven female social workers participated and all were employed by the local authorities, rather than by social work agencies. Some participants were uncertain about the number of consultations they had accessed, though all had used the services on at least one occasion during the previous six months. For those who were able to state how many they had accessed, this varied from 2-12 sessions.

Interview Procedure

Before each interview, the researcher read through the participant information sheet to confirm participants' understanding of the study and allow for questions. Participants were then asked to read and complete a consent form. All interviews were conducted at the place of work of each participant. An interview topic guide (Appendix 4-E) was used during each interview, though this was used flexibly to allow open discussion. Each interview was between 40-80 minutes in duration and all were recorded using a digital voice recorder. All interviews were transcribed verbatim, removing identifying information and replacing names with pseudonyms.

Data Analysis

The interview data were analysed using IPA (Smith et al., 2009), which is based on theories of phenomenology, idiography and hermeneutics (Smith, 2011). The approach is phenomenological as it focuses on human experience and idiographic as it is concerned with identifying and analysing the experiences of individuals within a larger group (Smith, 2011; Smith et al., 2009). There is also an acknowledgement of the role of researcher interpretations. This has been referred to as the double hermeneutic – the researcher attempting to make sense of the participant making sense of their experience (Smith, 2011).

Analysis began with transcription, reading and re-reading of each interview to become familiar with the data. Initial notes were made on each transcript, reflecting descriptions of what participants had said, comments on the language used, and interpretative comments referring to thoughts about what participants may have meant (Smith et al., 2009). Emergent themes for each interview were then developed by grouping these initial notes. This captured key concepts from the interviews as well as the researcher interpretations (Smith et al., 2009). These emergent themes were grouped together into super-ordinate themes, with the aim of capturing each participant's experiences. For example, for one participant, the emergent themes of 'a two-way process', 'sharing responsibility' and 'an ongoing partnership' were clustered under the super-ordinate theme 'maintaining an active role'. An example of this analysis for one participant, Jen, can be found in Appendix 2-A. Once these stages were completed for each transcript, the super-ordinate themes were examined for similarities and differences between participants and the final themes were identified. The super-ordinate themes for each participant that contributed to the final themes can be found in Table 2, and a diagram of how the super-ordinate themes were grouped together can be found in Figure 1.

Insert Table 2

Insert Figure 1

Validity and Quality

Within qualitative research, it is acknowledged that a researcher will influence findings due to being involved in all stages of the process (Yardley, 2008). In IPA research, this is reflected in the double hermeneutic concept, as outlined above (Smith, 2011). As such, guidelines on enhancing the validity and quality of qualitative research outline the importance of the researcher acknowledging their own position to allow readers to judge any interpretations accordingly (Elliott et al., 1999; Yardley, 2008).

I am a trainee clinical psychologist in my final year of my doctoral training. I have experience in working with LAC during placements in CAMHS and with families involved in care proceedings prior to starting training. I have developed an understanding of systemic working with LAC but have also observed difficulties in bringing together a wide professional network. This developed my interest in consultation as a way of bringing together the network surrounding LAC, and my training has naturally given me an interest in the role that clinical psychologists could take in this. My understanding of consultation is that clinical psychologists and other mental health professionals are consulted by other professionals to gain a different perspective on a situation or problem. My experience is that consultants are often viewed as experts, consulted when other professionals are feeling stuck in moving forward in a case. In addition to seeking advice on client work, I have experienced consultation being used as a source of personal support. In this sense I have experienced a traditional, advisory model, as well as consultation that has felt more like supervision, providing a reflective space rather than only advice. In my clinical experience, and in developing my knowledge of the research around LAC, I noticed an overall focus on outcomes for the children. I felt it important to recognise the experiences of professionals, leading to the development of the current research.

Several other procedures also have been suggested to enhance the validity and quality of qualitative research. To ensure that data coding and interpretations were not confined to the researcher's perspective, I shared coding at each stage of analysis with a research supervisor. Additionally, I met with peers to check initial coding and discuss theme development within transcripts. These processes highlighted any additional themes and ways in which codes could be altered in order to further capture the data (Elliott et al., 1999; Yardley, 2008). To enhance the transparency of findings, all themes and interpretations were grounded in the data through the use of excerpts from the transcripts (Elliott et al., 1999; Yardley, 2008). A paper trail of each stage of analysis was kept for each participant to demonstrate how themes were developed (Yardley, 2008).

These procedures also reflect criteria used to evaluate the quality of qualitative research, such as The Critical Appraisal Skills Programme (Public Health Resource Unit, 2006). Further to suggestions about researcher reflexivity, the guidelines suggest research papers should provide a detailed explanation of the data analysis, including a clear demonstration of theme development. To ensure rigour in the analysis process, clear steps were followed, as outlined above, and the development of the final themes is transparent (Table 2; Figure 1). The criteria outline that findings should be supported by participant data, in line with the suggestions by Elliott et al., (1999) and Yardley (2008). These suggestions and procedures were followed throughout the research to enhance the validity and quality of the findings.

Results

Four main themes were identified and each will be discussed and illustrated using direct quotations from the interview transcripts. The relationships between the themes are depicted in Figure 2.

Insert Figure 2

Theme 1. An Alternative Perspective: Seeking Expertise

Participants described psychological consultation as a way of accessing expert knowledge, seeking explanations, solutions and ideas of how to progress with cases. This seemed to be a way to seek an alternative opinion when participants were uncertain about how to proceed. Julia accessed consultation when she felt she had reached the limits of her knowledge:

> I'd be prompted to use it when erm I've got a more complex case, one where I feel I, my knowledge, I haven't got enough knowledge to know how to support the child or the family so I'd then use that consultation because I feel they're more expert.

Some participants described specifically seeking a psychological perspective, such as Nicole, who discussed using consultation to develop her understanding of the applications of attachment theory:

> …having another person coming in and saying well have you thought of this, thought of that and coming in from, from an attachment perspective and whether you know they feel that you know the children are trusting of adults and whether they're available to them.

When this expert help was perceived as unavailable, there was a sense that participants felt let down. Jen described this several times, explaining she often felt her expectations of consultation had not been met. For her, the key purpose of consultation was to obtain an expert opinion and solutions that could be implemented with families, preferably through long-term input from CAMHS. On some of the occasions when her expectations were not met, Jen attributed this to there not having been a psychologist involved in the consultation. This links with participants specifically seeking a psychological perspective:

> I think my concern is that *[psychologist]* didn't get involved in that case…I mean having been to a *[psychologist]*, one that *[psychologist]* done I think he's very good at getting information out of people and asking the right questions so he becomes clear in his head what the issues are…that didn't happen.

There was a divide amongst participants in viewing consultation as a passive or active process. For some, there was an expectation that consultants would be experts and provide definitive answers. However, for others, there seemed to be a determination to ensure a collaborative process. Gill was clear about wanting to be prepared for a consultation session, providing the consultant with detailed information as though she was demonstrating her social work expertise alongside the consultants' psychological expertise: "I can say so this is what I've suggested, this is what they've tried, this is how long we've tried it for…I don't approach him for the solution, I approach him to assist me". Similarly, Chris referred to consultation as a 'discussion', emphasising collaboration. Although he viewed consultants as experts, he also placed himself in an expert role due to his knowledge of cases. When asked about how he might use consultation, Chris explained: "…we'd come to a discussion really about what work CAMHS could offer, any other work that they would advise that could go on at the same time from other services".

Helen initially described using consultation "to know I'm on the right road" and there seemed to be an underlying hope that the consultant would provide a definitive answer. However, Helen later described a time when she had interpreted a child's behaviour about which a consultant had been uncertain. There seemed to be a switch at this point to her viewing consultation as more collaborative. For Helen, this appeared to relate to her self-confidence; sharing her understanding seemed to boost her belief in her own skills. When participants felt valued by consultants, such as when Helen was asked for her opinion, they seemed to feel more confident in taking an active role in consultation.

This first theme highlighted that participants perceived consultation as a way of accessing an expert opinion. This tended to focus upon gaining help for families, though also linked to developments in their self-confidence. This dual-purpose of consultation will be discussed in the next theme.

Theme 2. A Dual-Purpose: Consultation for Families and the Self

All participants described obtaining support for children and families as a key aim when seeking consultation. For some, this seemed to be the sole purpose, with denial of seeking consultation for their own support. Chris described focusing consultation on the families rather than how he managed his work: "I think sometimes you'll have discussions about your professional opinion about the families but not necessarily about how it would be affecting me". However, all participants described some ways in which consultation had influenced them professionally or personally. This tended to be in terms of knowledge and skills development, feeling supported and reassured, and increased confidence in their work. Initially, Nicole described using consultation in a child-focused way, saving personal reflection for her supervision. However, she later reported that consultations have developed her knowledge and skills, influencing her ongoing work:

> …all of that knowledge and that research now, just it does impact on your work doesn't it 'cause really understanding, and understanding of trauma with children and trauma to the brain and I think that's, all of those things can only be good.

For Nicole, the changes in her understanding seemed to be a by-product of her primary aim of obtaining help for families. This concept of personal benefits as secondary to those for

LAC was apparent in several interviews, as though child-centred working was equated to having to put themselves second.

However, other participants were more open to using consultation for personal benefits, with some describing emotional support as central to their experience. For Helen, this support seemed to be key to her being able to manage her role: “overall if he’s supporting us, I think it’s keeping people going erm because it’s, it is emotional and it is stressful”. Similarly, Julia described consultation as a reliable source of support, almost as a secure base from which she could work independently while safe in the knowledge that it would “always” be there if needed:

> …if I have a similar situation I feel I’m gonna have more knowledge to give them because I’ve spoken to CAMHS than, than if I hadn’t…I know there’ll be times when again I’ll feel I need to have more expertise involved in a situation so I will use them again.

Similarly, Christine spoke about using consultation as a thinking space and an opportunity for personal reflection. For her, consultation seemed to provide a safe environment in which to reflect on her practice: “…why do you do that and you think well we’ve always done it, well why have you always done it…it makes you think, I think it’s quite challenging for some people but I quite like that”.

For Sarah, the key to consultation seemed to be in striking a balance between reflective practice and practical help. Sarah discussed accessing consultation in a previous role and finding it was too focused on reflection, feeling that she often left without any practical advice. However, in her current role, she has found consultation to be well balanced between practicalities and reflection. This seemed to be linked to the urgency of work, as, when caseloads have been smaller or non-urgent, she felt more able to use consultation for reflective practice:

> I feel frustrated in terms of having to be at a meeting to talk about this…all these different meetings and really not coming up with anything that I felt has offered anything sort of productive but here I think the numbers…are obviously smaller you know erm more manageable and erm I can have different forms of consultation.

This theme highlighted that all participants used consultation in a child-centred way, which links to the first theme of consultation as an expert perspective. For some, any personal or professional developments were a by-product of seeking support for children. For others, personal support was central to their experiences of consultation. This seemed to be linked to the nature of their work, with personal reflection seeming more acceptable at times of less pressure.

Theme 3. Consultation as a Lifeline: The Final Chance

For all participants, there was a sense of desperation for consultation, seeking it at times of uncertainty. Chris described consultation as being needed, rather than something that he would like, conveying a sense of desperation for additional help. Nicole seemed to describe a gradual change in the pace of consultation sessions. She outlined an initial practical focus, which seemed to be fast paced, possibly reflecting a sense of urgency in seeking answers. However, once this help was secured, the pace seemed to slow and Nicole described using consultation for reflection rather than broader decisions:

> …do we feel the children are gonna be able to move, do we feel we've got the capacity to move in terms of attachment, whether their behaviours are such or their age is such that actually are we gonna make this plan and then leave them in a you know for twelve months and then say oh you've gotta be long-term fostered now, so very much is around the care planning and whether it's gonna be appropriate for the child to have that plan, the rest of the consultation erm can be around sort of the actual challenges…

This links to the second theme, seeking a balance between practical advice and reflective thinking.

Consultation seemed to be a last chance to obtain specialist input for children, particularly for participants who worked with children placed for adoption. Participants may have felt additional pressure due to adoption being the end of the care process, with this stage being the last chance to secure the best possible outcomes for the children. Sarah made a clear link to seeking expert input to share the pressure of decision-making around adoption:

> I feel like perhaps it's the last chance for a child isn't it 'cause it's adoption, if it doesn't work then the chances are a child will stay in the care system for a long time so if the work's not put in now erm that's a worry really…it is an expert's field and I think that you know we are considered to be experts in, you know, and a lot is asked of us as social workers and I feel like I should ask a lot of you know whoever, whatever that professional is that I'm working with as well.

Jen described fighting for the service, again conveying a sense of desperation for help. Jen felt that her role in consultation was to persuade CAMHS to provide therapeutic input for children, linking to the first theme of CAMHS being experts. For her, consultation appeared to be a means to an end, rather than an intervention in its own right. This is similar to Sarah's experience above, with Jen seeming to want to share responsibility for children's care: "...it's about me persuading the psychological services that they need to be helping… I feel that my job is to persuade them that this, either the child or the carers or all of them need their input".

This theme highlighted desperation for consultation, which appeared to link to the client groups with which participants worked. As a result of adoption being seen as the end of the line for children and families, there appeared to be a pressure for social workers to get it right. This was reflected in the interviews, with a feeling of urgency around securing consultation, as though participants were seeking to share this pressure.

Theme 4. Validation and Acknowledgement: The Psychological Experience of Consultation

Several participants described feeling undervalued and unappreciated by the wider system, including by carers, families and other professionals. Christine particularly felt that social workers are not valued or respected when attending court during care proceedings. She described feeling that social workers are expected to carry significant responsibility for LAC but receive little acknowledgement. This seemed to be a no-win situation as the responsibility carries a high risk of blame: "…social work as a profession isn't held in high esteem, they're quite often blamed for things that could've you know would've happened anyway". Being undervalued and open to criticism was described by several participants and appeared to result in a lack of confidence in their own skills. For Helen, this was connected to a fear of negative consequences:

> …I'd like a second opinion, am I missing something with this child because if you place a child and who turns out to have more difficulties erm and you haven't either been made aware of it or the assessment is flawed in some way you know adopters can come back and sue the department.

Several participants described feeling frustrated that their reports would often not be acknowledged, but that carers and the courts would accept the same recommendations if given by CAMHS. Sarah appeared to have resigned herself to this happening:

> … to be honest it is very annoying that you're often are coming out with things and erm they're no different but erm you accept that you know, there's not an awful lot you can do to change that is there so it's not something that like gets me down it's just, it's to be expected a lot of the time.

In contrast, participants described consultation as a unique experience as they generally felt valued and respected by consultants. Christine felt that difficult situations faced by social workers become “an accepted norm” within social services, resulting in an expectation that workers will continue regardless of feeling stressed or pressured. For her, consultation provided an opportunity to be acknowledged:

> …what you get is him actually accep-, acknowledging that that is an accepted norm you know people don’t go to work in general and get threatened with a machete and acid everyday and that kind of thing, I think it just brings you back partly into reality and also into well somebody appreciates me.

Several participants described consultation as an opportunity to be heard. There was a sense of the experiences of social workers mirroring the experiences of LAC, struggling to be heard within the system, as highlighted by Helen:

> …he’s acknowledging your feelings for a start which is what you’re doing with a child erm because they’re genuine feelings aren’t they erm you’re allowing you to express your emotions ‘cause that’s what I’m saying to children, don’t bottle it up, express yourself erm because a lot of these children…they go in, nobody’s listened to them, nobody’s had their needs listened to erm so I mean I think he just erm it’s, it’s an acknowledgement that it’s a difficult job.

When participants had not felt heard, they described consultation as disappointing, as though it reinforced feelings of being undervalued and unappreciated. Jen felt her concerns had been overlooked during one consultation and that this meant she had to fight to be heard:

> …when the minutes did come out I don’t think they reflected the concerns of the people that were at the meeting … I think they really belittled what the concerns were…I then had to go and have a long conversation with the therapist that had been allocated to her and say I don’t agree with the minutes and that is, those aren’t, that isn’t the issue for me.

This again seems to mirror the experiences of LAC, with participants feeling lost in the system. For Jen, the only way to be heard was to become louder and put significant energy into ensuring that her concerns were considered.

Several participants described significant concerns that consultation services may be reduced or lost, seeming to reflect fears of being abandoned by the services. Gill seemed to feel lucky to have the service and as though it set her apart from social workers in other local authorities: “I know that when I appear before other adoption panels and within the support plan it talks about access to a child and adolescent psychotherapist people are just absolutely amazed that we have that service”. Helen described significant concern and anger that consultation may be affected by cuts to local services: “…I wouldn’t do it without the support from *[name of psychotherapist]*…you’ve got somebody, you’ve got a resource to go to erm I’d be bloody annoyed if he, if we don’t have him and I know we’d like him more”.

This theme illustrates that participants generally experienced consultation as valuing and validating. Consultation was a containing experience, contrasting with participants’ experiences in the wider system. When participants felt unheard during consultations, they felt let down. The descriptions of seeking containment, feeling let down when this did not happen and the significant concerns about potential loss of consultation services seemed to mirror the experiences of LAC.

Discussion

This research aimed to explore how social workers made sense of psychological consultation. Analysis using the principles of IPA (Smith et al., 2009) identified four main themes in the data: An alternative perspective: Seeking expertise; A dual-purpose: consultation for families and the self; Consultation as a lifeline: The final chance; and Validation and acknowledgement: The psychological experience of consultation.

The themes were connected through the concept of consultation being a containing experience, as though it provided a secure base for participants. In the first theme, participants described consultation as containing as they used it to obtain ideas and direction when feeling uncertain. Additionally, several participants described consultation as a collaborative process in which they felt validated and valued. The second theme encapsulated participants using consultation for their own benefits, both as primary and secondary gains. Consultation appeared to provide a reliable and safe place for participants to explore their reflections. Theme three highlighted that consultation appeared to contain participants' stress around decision-making. Finally, the concept of consultation as a containing experience was particularly evident in the fourth theme, in which participants described it as a unique opportunity for them to feel heard and validated.

This containment may be understood through attachment theory, which posits that children require a secure base from which to explore their environment (Bowlby, 1988). Research has suggested that professional supervision can trigger the attachment process for supervisees, who may seek the safety of the supervisory relationship to obtain support (Bennett, 2008; Bennett et al., 2013). Additionally, Bennett et al., (2013) suggested that supervisors can serve as a safe base in new situations, assisting supervisees in organising their thoughts and containing their emotional responses. The availability of this secure base can assist in the development of a supervisee's professional identity (Bennett, 2008; Bennett et al., 2013). This was apparent in the current study, with participants experiencing consultation as reassuring and validating, which seemed to increase their confidence while also feeling able to seek further consultation if needed. When this security was not evident, participants experienced consultation as unreliable and did not feel contained.

In addition to improving self-confidence, this experience of being valued may have a long-lasting impact. For example, Huxley et al., (2005) found that social workers who felt valued in their role also reported reduced stress, improved mental health and greater job satisfaction. When considering that stress, lack of support, and low job satisfaction have been associated with difficulties in retaining social workers (Mor Barak et al., 2001), addressing these issues seems vital. The current findings suggest that psychological consultation could go some way towards addressing these issues and could be applied more widely to promote the retention of social workers.

Several participants reported increased psychological understanding following consultation, which corresponds with previous research (Hibbert et al., 2011). Vygotsky (1978) proposed the concept of the zone of proximal development, the difference between an individual's current and potential development. The term scaffolding has been used to describe support provided by somebody who is more knowledgeable of a topic to help an individual achieve their potential (Bruner, 1975; Hetherington et al., 2006; Wass et al., 2011). Participants described this scaffolding in consultation, relying on the service initially but then gaining confidence in implementing interventions without support. In this sense, consultation almost provided training, suggesting ways of working and then supporting participants in implementing these approaches. Several participants described developing skills and knowledge that they transferred to other cases, suggesting consultation had a lasting impact on their professional identities.

Participants described consultation as a last opportunity to access expert input and reported high expectations of the services. This reflects the collaborative model of consultation outlined by Caplan et al., (1994), in which consultants are brought into organisations as experts. In the Caplan et al., (1994) definition, the term collaborative was used to refer to consultants being asked to share responsibility for an outcome. Several participants in the current study seemed to view consultation in this way, hoping for the consultants to provide definitive answers. However, others seemed to view consultation in the sense of the original model in which there was an aim for equality of power (Caplan et al., 1994), with some participants seeking to contribute significantly to the consultations. If participants were expecting an expert to provide definitive answers, it is perhaps unsurprising that they felt let down and disappointed when consultation did not meet these expectations.

The disappointment felt when participants' expectations were not met may be considered within attribution theory. Attribution theory refers to the perceptions that we make about the cause of our own or somebody else's behaviour. These interpretations then determine how we react (Stainton-Rogers, 2003). Kelley (1980) outlined one model in which he suggested that any attribution is based on three decisions: the extent to which an individual usually behaves in this way; the extent to which an individual has previously behaved in this way; and the extent to which others usually behave in this way. If participants perceived that a consultant had behaved differently to usual, and had been perceived as having been helpful in the past, any disappointment is likely to be attributed to being a result of the actions of the consultant. Indeed, when participants were disappointed in consultation, they attributed this to the consultant not having done as they had expected. Attributing disappointment to the consultants may serve to protect the self-esteem of participants, particularly if their confidence was already low due to constantly feeling scrutinised by the wider system.

Clinical Implications

Participants particularly valued consultation when there was a balance between practical advice and reflection, highlighting the importance of the service being flexible to meet the needs of each case. Additionally, the suggestion that consultation was the only opportunity for some to feel heard suggests that participants would benefit from increased access to professional supervision to allow them to reflect upon their work more regularly. The use of consultation as a containing and reflective space may not have been considered by the services providing the consultation. Additionally, participants who described confining personal reflection to supervision may not have been aware that consultation could be used in this way. These findings reflect my clinical experience, where I have found that the aim of consultation can vary between being solely for case advice and being a reflective space. The findings suggest CAMH services would benefit from having a clear definition of the service they are aiming to offer. A more explicit definition may ensure more realistic expectations of a service and reduce the variation in how the services are used. While there may be an inevitable hierarchy of power when clinicians are employed as experts (Caplan et al., 1994), having a clearly defined role may reduce the pressure for clinicians to provide definitive solutions and encourage consultees to take a more active role.

The findings demonstrate the specialist role that clinical psychologists can take in the care of LAC and suggest consultation may be a key resource for increasing adherence to systemic working guidelines. The value participants placed on consultation must be considered alongside their fears that the services could be reduced or lost as part of ongoing NHS changes. The NHS Agenda for Change outlined aims of providing high quality services "in as efficient and effective a way as possible, and organised to best meet the needs of patients" (Department of Health, 2004b; p.2). Arguably, these findings demonstrate that psychological consultation can be an effective way of meeting the needs of the networks around LAC, and ultimately improving the care of the children. It would, therefore, seem important that the outcomes of research such as this be considered when services are undergoing changes.

Consultation services are often offered to several members of the LAC network (Dent et al., 2006; Hibbert et al., 2011; Swann et al., 2011). Indeed, participants spoke about carers being involved in some consultation sessions. When considering how valued consultation was by participants, services may consider offering psychological consultation to social workers separately to carers. Being able to access support through consultation may go some way towards helping social workers to manage the emotional stress associated with working with LAC.

Limitations and Future Research

The findings of this study provided a detailed account of social workers' experiences of psychological consultation. However, it seems important to acknowledge that, despite recruiting across multiple social care teams, participants came from just three of these teams. This means that many participants reported on consultations that had been facilitated by the same psychologist or psychotherapist. As such, it is difficult to separate the practice of a small number of professionals from the broader impact that consultation could have. Further research is required to be able to assess whether these findings may apply to psychological consultation services in general, beyond the limited number of services involved in this study.

All participants were aware that the researcher is a trainee clinical psychologist with an interest in understanding the contribution that psychology could make to work with LAC. While it was emphasised that the researcher was separate to the services providing consultation, the knowledge of the researcher's role may have influenced participants' accounts of their experiences. While some participants discussed negative experiences of consultation, there was an overwhelming positivity towards the services. It is possible that the position of the researcher resulted in some participants feeling unable to express negative opinions. Additionally, it is possible that the highly positive accounts reflected participants' fears of losing the consultation services. As such, it is important to consider the findings within the political and organisational context of the services in which the research was conducted.

Although all of the social work teams that I contacted showed initial enthusiasm to participate in the study, this was not reflected in the final number of participants. As indicated in Table 2, a significant proportion of the total sample pool did not opt-in to the study. This discrepancy may have reflected the high workloads of social workers, with a commitment to taking part in research being too difficult when already under pressure in their day-to-day work. Additionally, while knowledge of my role as a trainee clinical psychologist may have influenced participants' accounts, this may also have influenced social workers' decisions to opt-in to the study. For example, they may have been concerned about how their feedback could impact their future involvement with CAMHS. Furthermore, social workers may simply have not been interested in taking part in the research. Whatever the reason for non-participation, the findings came from a small selection of the total sample, which limits the transferability of the findings to other consultation services. Future research in this field would benefit from collecting additional data on non-participation, such as by seeking anonymous feedback, in order to understand these issues.

Further to this, the number of consultations that each participant had accessed varied significantly. Some participants were unable to provide information on the exact number of consultations they had accessed, whereas others varied between 2-12 sessions. It is possible that the impact of consultation is cumulative; with benefits and changes building up over time as more consultations are accessed. As such, the variation in participant experiences may reflect the range in the number of sessions accessed. Future research in this area would benefit from collecting more precise data on the number of consultations accessed so that detailed comparisons could be made.

The findings suggest that a number of variables affect the relationship between psychological consultation and social workers' wellbeing. A quantitative research study would be able to investigate these factors further and directly test the power of each variable to explain variance in the outcome measure (social workers' wellbeing). For example, bearing in mind that the findings suggest that a greater number of consultation sessions, feelings of value and self worth, and more reflective practice had a positive impact on social workers' wellbeing, it could be hypothesised that together these variables would explain a significant amount of variance in reported wellbeing. Moreover, more detailed hypotheses could also test the role of particular variables in mediating between, for example, level of psychological consultation provided and stress levels.

Conclusion

This research explored the experiences of social workers who had accessed psychological consultation. The findings indicated that consultation was a valuable resource for participants, both in obtaining expert support for children and for their own personal and professional wellbeing. A key concept of consultation being a containing space for social workers ran through all of the findings, suggesting that psychological consultation could be a highly valuable resource in work with LAC. Although I made my position as a researcher clear, I acknowledge that my role may have influenced participants' interview responses and this should be considered as part of the readers' interpretation of the findings. However, I sought to adhere to guidelines around improving the validity and quality of qualitative research, suggesting that the findings offer a valuable contribution to the existing literature. The findings highlight the valuable role that clinical psychologists can play in supporting the network surrounding LAC, a value to be considered within the ongoing organisational change within the NHS.

References

Barth, R. P., Crea, T. M., John, K., Thoburn, J., & Quinton, D. (2005). Beyond attachment theory and therapy: Towards sensitive and evidence-based interventions with foster and adoptive families in distress. *Child and Family Social Work, 10,* 257-268.

Bennett, S. (2008). Attachment-informed supervision for social work field education. *Clinical Social Work Journal, 36,* 97-107.

Bennett, S., Mohr, J., Holtz Deal, K., & Hwang, J. (2013). Supervisor attachment, supervisory working alliance, and affect in social work field instruction. *Research on Social Work Practice, 23,* 199-209.

Bowlby, J. (1988). *A Secure Base - Clinical Applications of Attachment Theory*. London: Routledge.

Bride, B. E. (2007). Prevalence of secondary traumatic stress among social workers. *Social Work, 52,* 63-70.

Brown, D., Pryzwanksy, W. B., & Schulte, A. C. (2006). *Psychological consultation and collaboration* (6th ed). Boston, MA: Allyn & Bacon.

Bruner, J. (1975). From communication to language - A psychological perspective. *Cognition, 3,* 255-287.

Callaghan, J., Young, B., Pace, F., & Vostanis, P. (2004). Evaluation of a new mental health service for looked after children. *Clinical Child Psychology and Psychiatry, 9,* 130-148.

Caplan, G., Caplan, R. B., & Erchul, W. P. (1994). Caplanian mental health consultation: Historical background and current status. *Consulting Psychology Journal,* 46, 2-12.

Child and Family Court Advisory and Support Services. (2011). *Cafcass annual report and accounts 2010-11*. UK: The Stationery Office Limited Retrieved from http://www.cafcass.gov.uk/PDF/Cafcass%20Annual%20Report%20%20Accounts%202010-11%20web.pdf.

Collins, S. (2007). Social workers, resilience, positive emotions and optimism. *Practice, 19,* 256-269.

Dent, H. R., & Golding, K. S. (2006). Engaging the network: Consultation for looked after and adopted children. In K. S. Golding, H. R. Dent, R. Nissim & L. Stott (Eds.), *Thinking psychologically about children who are looked after and adopted: Space for reflection* (pp. 164-194). West Sussex: John Wiley & Sons Ltd.

DePanfilis, D. (2006). Compassion fatigue, burnout, and compassion satisfaction: Implications for retention of workers. *Child Abuse & Neglect, 30*, 1067-1069.

Department for Education. (2003). *Every child matters*. London: The Stationery Office Retrieved from https://www.gov.uk/government/publications/every-child-matters.

Department for Education. (2010a). *Haringey local safeguarding children board: First serious case review - Child A*. Retrieved from https://www.gov.uk/government/publications/haringey-local-safeguarding-children-board-first-serious-case-review-child-a.

Department for Education. (2010b). *Haringey local safeguarding children board: Second serious case review - Child A*. Retrieved from https://www.gov.uk/government/publications/haringey-local-safeguarding-children-board-second-serious-case-review-child-a.

Department of Health. (1989). *The Children Act*. London: The Stationery Office Retrieved from http://www.legislation.gov.uk/ukpga/1989/41/introduction.

Department of Health. (2003). *The Victoria Climbie Inquiry: Report of an inquiry by Lord Laming*. London: The Stationery Office Retrieved from https://www.gov.uk/government/publications/the-victoria-climbie-inquiry-report-of-an-inquiry-by-lord-laming.

Department of Health. (2004a). *Children Act 2004*. London: The Stationery Office Retrieved from http://www.legislation.gov.uk/ukpga/2004/31/contents.

Department of Health. (2004b). *Agenda for change - Final Agreement*. Retrieved from http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4095943

Division of Clinical Psychology. (2010). *The core purpose and philosophy of the profession*. Leicester: The British Psychological Society Retrieved from http://www.bpsshop.org.uk/Clinical-Psychology-The-core-purpose-and-philosophy-of-the-profession-P1394.aspx

Dougherty, A. M. (2000). *Psychological consultation and collaboration: A casebook*. Belmont, CA: Wadsworth/Thomson Learning.

Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology, 38*, 215-229.

Emanuel, L. (2002). Deprivation x 3: The contribution of organizational dynamics to the 'triple deprivation' of looked-after children. *Journal of Child Psychotherapy, 28*(2), 163-179.

Evans, K., Law, H., Turner, R. E., Rogers, A., & Cohen, K. (2011). A pilot study evaluating care staffs' perceptions of their experience of psychological consultation within a mental health setting. *Child Care in Practice,* 17, 205-219.

Everson-Hock, E. S., Jones, R., Guillaume, L., Clapton, J., Goyder, E., Chilcott, J., . . . Swann, C. (2011). The effectiveness of training and support for carers and other professionals on the physical and emotional health and well-being of looked-after children and young people: A systematic review. *Child: care, health and development, 38*, 162-174.

Ford, T., Vostanis, P., Meltzer, H., & Goodman, H. (2007). Psychiatric disorder among British children looked after by local authorities: Comparison with children living in private households. *The British Journal of Psychiatry, 190*, 319-325.

Froehle, T. C., & Rominger, R. L. (1993). Directions in consultation research: Bridging the gap between science and practice. *Journal of Counselling and Development*, 71, 693-699.

Fulcher, L., & McGladdery, S. (2011). Re-examining Social Work Roles and Tasks with Foster Care. *Child & Youth Services, 32*(1), 19-38.

Garrett, P. M. (2010). Creating Happier Children and More Fulfilled Social Workers: Neoliberalism, Privatization and the Reframing of Leftist Critiques in Britain. *Journal of Progressive Human Services, 21*(1), 83-101.

Golding, K. S. (2004). Providing specialist psychological support to foster carers: A consultation model. *Child and Adolescent Mental Health, 9*, 71-76.

Golding, K. S. (2010). Multi-agency and specialist working to meet the mental health needs of children in care and adopted. *Clinical Child Psychology and Psychiatry, 15*(4), 573-587.

Grady, M. D., & Cantor, M. (2012). Strengthening the professional selves of social workers through the lens of self psychology. *Smith College Studies in Social Work, 82*, 401-417.

Guerin, S., Devitt, C., & Redmond, B. (2010). Experiences of early-career social workers in Ireland. *British Journal of Social Work, 40*, 2467-2484.

Hatfield, B., Harrington, R., & Mohamad, H. (1996). Staff looking after children in local authority residential units: the interface with child mental health professionals. *Journal of Adolescence, 19*, 127-139.

Hetherington, E. M., Parke, R. D., Gauvain, M., & Locke, V. O. (2006). *Child psychology: A temporary viewpoint* (6th ed.). New York: McGraw-Hill.

Hibbert, G., & Frankl, J. (2011). A psychology consultation service for social workers and foster carers in a child and adolescent mental health service. *Educational and Child Psychology, 28*(3), 63-72.

Huxley, P., Evans, S. F., Gately, C., Webber, M., Mears, A., Pajak, S., . . . Katona, C. (2005). Stress and pressures in mental health social workers: The wonder speaks. *British Journal of Social Work, 35*, 1063-1079.

Kerr, L., & Cossar, J. (2014). Attachment interventions with foster and adoptive parents: A systematic review. *Child Abuse Review*.

Kelley, H. K., & Michela, J. L. (1980). Attribution theory and research. *Annual Review of Psychology,* 31, 457-501.

Kurpuis, D. J., Fuqua, D. R., & Rozecki, T. (1993). The consulting process: A multidimensional approach. *Journal of Counselling and Development*, 71, 601-606.

Leeson, C. (2010). The emotional labour of caring about looked-after children. *Child & Family Social Work, 15*(4), 483-491.

McLeod, A. (2007). Whose agenda? Issues of power and relationship when listening to looked-after young people. *Child & Family Social Work, 12*, 278-286.

Mor Barak, M. E., Nissly, J. A., & Levin, A. (2001). Antecedents to retention and turnover among child welfare, social work, and other human service employees: What can we learn from past research? A review and metanalysis. *Social Service Review, 75*, 625-661.

National Institute for Health and Care Excellence. (2010). *Promoting the quality of life of looked-after children and young people.* Retrieved from http://www.nice.org.uk/PH28.

National Society for the Prevention of Cruelty to Children. (2014). *Statistics on looked after children.* Retrieved from http://www.nspcc.org.uk/Inform/resourcesforprofessionals/lookedafterchildren/statistics_wda88009.html.

Preston-Shoot, M., & Wigley, V. (2005). Mapping the needs of children in need. *British Journal of Social Work, 35*, 225-275.

Public Health Resource Unit (2006). *Critical Appraisal Skills Programme (CASP): Making sense of evidence.* England: Public Health Resource Unit. Retrieved from: http://www.casp-uk.net/#!casp-tools-checklists/c18f8

Scott, J. (2011). The impact of disrupted attachment on the emotional and interpersonal development of looked after children. *Educational and Child Psychology, 28*(3), 31-43.

Smith, J. A. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review, 5*, 9-27.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research.* London: Sage.

Sprince, J. (2000). Towards an integrated network. *Journal of Child Psychotherapy, 26*(3), 413-431.

Stainton-Rogers, W. (2003). *Social psychology: Experimental and critical approaches.* Berkshire: Open University Press.

Swann, R. C., & York, A. (2011). THINKSPACE - the creatiion of a multi-agency consultation group for Looked After Children. *Clinical Child Psychology and Psychiatry, 16*(1), 65-71.

Van Hook, M. P., & Rothenberg, M. (2009). Quality of life and compassion satisfation/fatigue and burnout in child welfare workers: A study of the child welfare workers in community based care organizations in central Florida. *Social Work & Christianity, 36*, 36-54.

Vygotsky, L. S. (1978). *Mind in society: The development of higher psychological processes.* Cambridge, MA: Harvard University Press.

Wallace, W. A., & Hall, D. L. (1995). *Psychological consultation: Perspectives and applications.* Pacific Grove, CA: Brooks/Cole Publishing Company.

Wass, R., Harland, T., & Mercer, A. (2011). Scaffolding critical thinkin in the zone of proximal development. *Higher Education Research & Development, 30*, 317-328.

Watson, D. (2003). Defining quality care for looked after children: frontline workers' perspectives on standards and all that? *Child & Family Social Work, 8*, 67-77.

Yardley, L. (2008). Demonstrating validity in qualitative psychology. In J. A. Smith (Ed.), *Qualitative psychology a practical guide to research methods* (2nd ed., pp. 234-251). London: Sage Publications Ltd.

Table 1

Total sample pool and number of participants from each team

	Team 1	Team 2	Team 3	Team 4	Team 5	Team 6	Total
Number of local authority social workers	15	6	3	8	2	5	39
Number of participants from team	6	1	0	1	0	0	8

Table 2

Super-ordinate and emergent themes grouped together to identify final themes

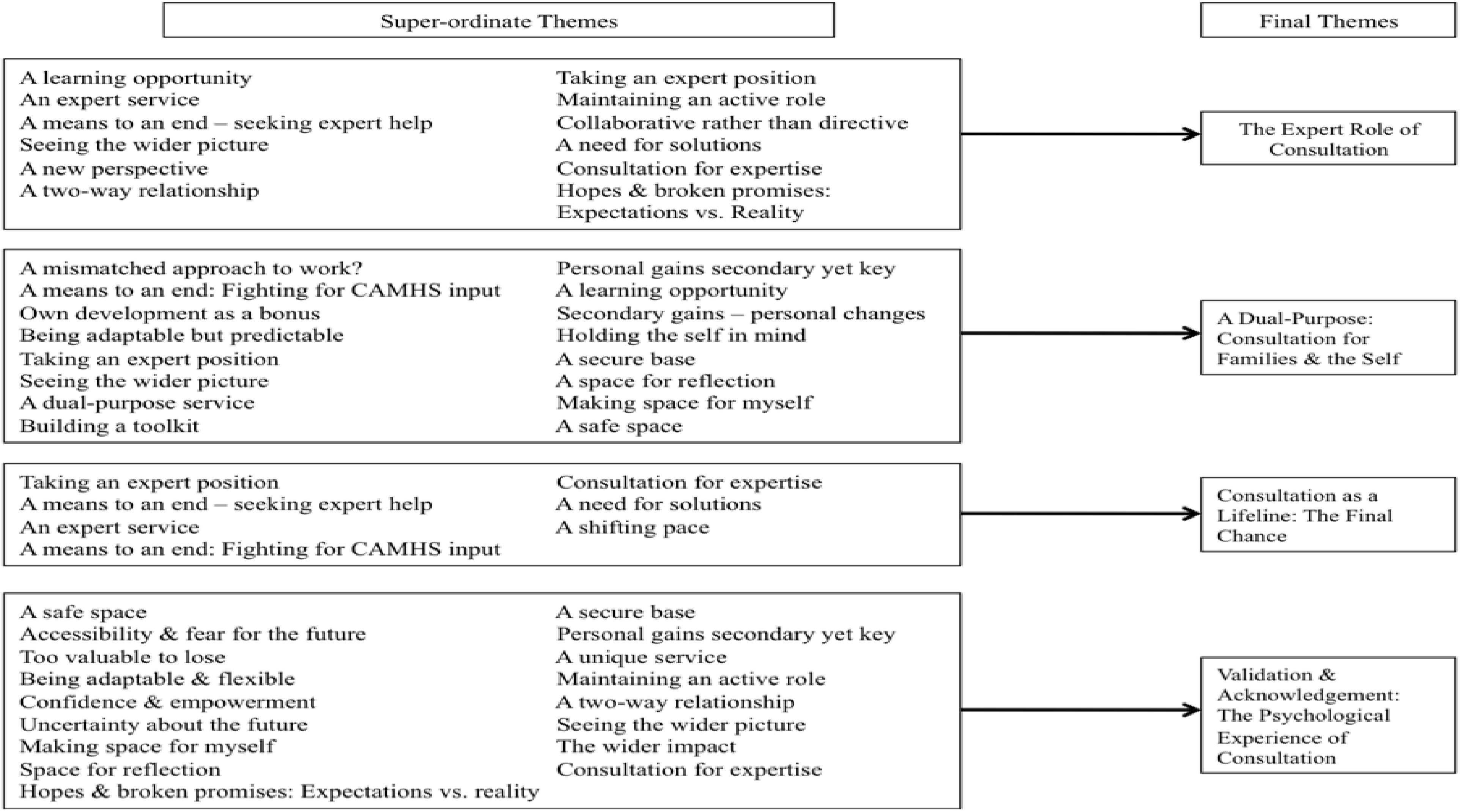
Final Theme	Superordinate Themes	Relevant Emergent Themes Within Superordinate Theme	Participant
The expert role of consultation	A learning opportunity	Wanting to be able to implement it herself; Taking an active role	Christine
	An expert service	Specialist advice; Experts; An outside view	Julia
	A means to an end – seeking expert help	Experts; Specific help	Jen
	Seeing the wider picture	An alternative perspective; Expert/supporting opinion	Gill
	A new perspective	Psychological understanding; Attachment theory as a key concept; Practical help; An outside view	Nicole
	A two-way relationship	Collaborative; Non-expert expert	Christine
	Taking an expert position	Experts; A definitive answer; Two-way experts	Helen
	Maintaining an active role	Wanting collaboration; Keeping a key role Both as experts,	Chris
	Collaborative rather than directive	Active; Discussion; A two-way process; Collaboration	Gill
	A need for solutions	Responses and explanations	Sarah
	Consultation for expertise	Expert knowledge; The holy grail	Sarah

Final Theme	Superordinate Themes	Relevant Emergent Themes Within Superordinate Theme	Participant
	Hopes & broken promises: Expectations vs. reality	Seeking expert help but not getting it; Seeking practical support; Seeking answers	Jen
A Dual-Purpose: Consultation for Families and the Self	A mismatched approach to work?	Conflict in way SW and CAMHS work around consent	Jen
	A means to an end: Fighting for CAMHS input	Fighting for service; Child-centred	Jen
	Own development as a bonus	For families not self; Benefits to self as a by-product, not a primary concern	Nicole
	Being adaptable but predictable	Reassurance and validation	Chris
	Taking an expert position	Develop own knowledge & skills	Helen
	Seeing the wider picture	Filling in the blanks; enhancing knowledge	Gill
	An expert service	Scaffolding – developing own knowledge	Julia
	A dual-purpose service	Expand own knowledge & skills; Support for families; Second to families; Increase confidence	Julia
	Building a toolkit	Increased confidence due to increased knowledge & skills	Sarah
	Personal gains secondary yet key	Supportive; Validating; Reassurance; Learning opportunity	Gill
	A learning opportunity	Develop own skills and knowledge	Christine

Final Theme	Superordinate Themes	Relevant Emergent Themes Within Superordinate Theme	Participant
	Secondary gains – personal changes	Own gains an afterthought; Learning opportunity; Increased psychological understanding; Transferable skills	Chris
	Holding the self in mind	Personal gains as secondary; Shift in thinking; Ways of changing SW approach	Jen
	A secure base	Reliable; Reassuring Back up – knowing not alone; Increased confidence and self-belief	Julia
	A space for reflection	Emotional support	Helen
	Making space for myself	Minimised own needs; Need reflection and practical help to be balanced	Sarah
	A safe space	Space for personal reflection	Christine
Consultation as a Lifeline: The Final Chance	Taking an expert position	Use when stuck	Helen
	A means to an end – seeking expert help	'End of the line'; Relief; Desperation	Chris
	An expert service	Use when stuck	Julia
	A shifting pace	Initial urgency & desperation; 'Get the job done'; Later shift toward reflection & thinking space	Nicole
	Consultation for expertise	Wanting to get it right	Sarah
	A need for solutions	Need quickly – time pressured; Complexity; Feeling stuck	Sarah

Final Theme	Superordinate Themes	Relevant Emergent Themes Within Superordinate Theme	Participant
	A means to an end: Fighting for CAMHS input	Fighting for service; Desperation for service; Persuading CAMHS to be involved	Jen
Validation and Acknowledgement: The Psychological Experience of Consultation	A safe space	Boundaried and containing; Therapeutic relationship	Christine
	Accessibility & fear for the future	Concerned re. potential service loss	Jen
	Too valuable to lose	Concerns re. cuts; Anger & fear re. losing only support	Helen
	Being adaptable & flexible	Predictability & structure; Reassurance & validation due to being predictable	Chris
	Confidence & empowerment	Undervalued & unappreciated; Consultation unique; Low confidence due to fear of negative consequences; Increased confidence & feeling empowered by consultation	Helen
	Uncertainty about the future	Wanting an increased service; Ongoing support; Desperation	Gill
	Making space for myself	Opportunity to be listened to and heard; Mirroring experience of LAC	Sarah
	A space for reflection	Emotional support; Only opportunity; Safe space; Thinking space; Therapeutic relationship; Parallel experience to LAC	Helen
	A secure base	Trusting relationship; Concern for potential loss	Julia
	Personal gains secondary yet key	Validating; Supporting; Reassurance	Gill

Final Theme	Superordinate Themes	Relevant Emergent Themes Within Superordinate Theme	Participant
	A unique service	Undervalued by system; Mirroring LAC experience; Consultation only place for support	Christine
	Maintaining an active role	Validation	Chris
	A two-way relationship	Respected and appreciated	Christine
	Seeing the wider picture	A sounding board	Gill
	The wider impact	Encouraging the wider system to show respect & appreciation; Psychology more acknowledged than SW	Christine
	Consultation for expertise	Undervalued	Sarah
	Hopes & broken promises: Expectation vs. reality	Let down; Unsupported	Jen



Super-ordinate Themes

Final Themes

A learning opportunity
An expert service
A means to an end – seeking expert help
Seeing the wider picture
A new perspective
A two-way relationship
Taking an expert position
Maintaining an active role
Collaborative rather than directive
A need for solutions
Consultation for expertise
Hopes & broken promises: Expectations vs. Reality

The Expert Role of Consultation

A mismatched approach to work?
A means to an end: Fighting for CAMHS input
Own development as a bonus
Being adaptable but predictable
Taking an expert position
Seeing the wider picture
A dual-purpose service
Building a toolkit
Personal gains secondary yet key
A learning opportunity
Secondary gains – personal changes
Holding the self in mind
A secure base
A space for reflection
Making space for myself
A safe space

A Dual-Purpose: Consultation for Families & the Self

Taking an expert position
A means to an end – seeking expert help
An expert service
A means to an end: Fighting for CAMHS input
Consultation for expertise
A need for solutions
A shifting pace

Consultation as a Lifeline: The Final Chance

A safe space
Accessibility & fear for the future
Too valuable to lose
Being adaptable & flexible
Confidence & empowerment
Uncertainty about the future
Making space for myself
Space for reflection
Hopes & broken promises: Expectations vs. reality
A secure base
Personal gains secondary yet key
A unique service
Maintaining an active role
A two-way relationship
Seeing the wider picture
The wider impact
Consultation for expertise

Validation & Acknowledgement: The Psychological Experience of Consultation

Figure 1. Super-ordinate themes for each participant as grouped together into the four final themes.

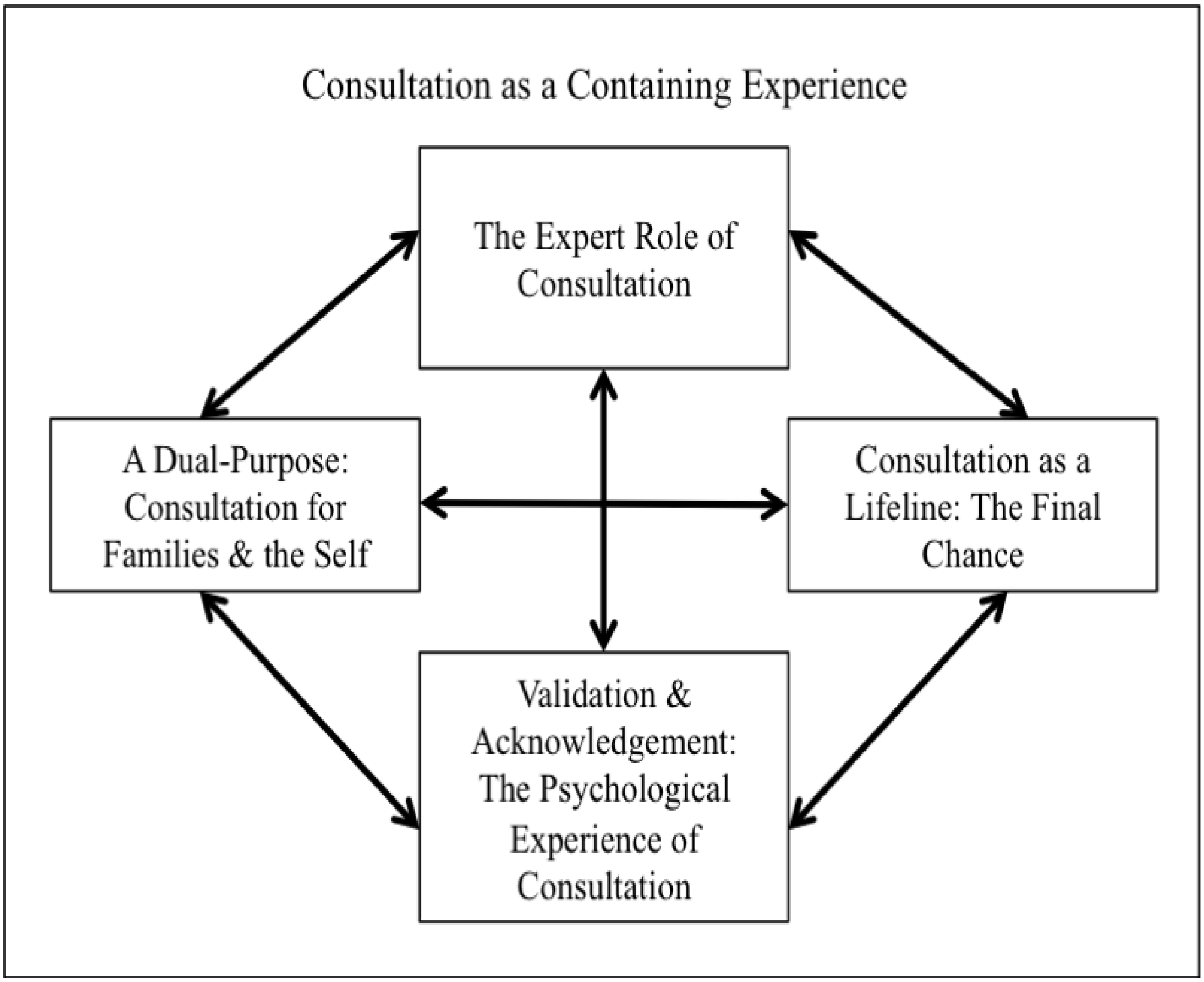


Figure 2. The relationship between the four final themes. The outer box represents the themes being connected by the concept of consultation being a containing experience for the participants.

Appendix 2-A

Example of Analysis Process: Jen's Transcript

Table A-1

Extract from participant transcript showing exploratory comments and emergent themes

Emergent themes	Transcript	Exploratory comments
	INT: So that sounds like they've missed the point that you and the other people in the meeting were trying to get across …	
	P3: Mhm.	
	INT: … how, what sense do you make of that? Sort of where do you think …	
Consultant lacking skill	**P3:** I think it was a very very poor consultation and I think the person that did the consultation did not have the skills I don't know I can't comment on	'Very, very poor consultation' on to talk in detail about shortcomings of CAMHS worker
	her can I but I don't think she had the skills to do what she was doing, she	Wanting explicit input from CAMHS, questions, advice etc.
Seeking answers	didn't contribute anything to the meeting, she did not say a thing at the	
Seeking feedback	consultation which was particularly unhelpful, she didn't ask questions, she	'Dump their concerns with no feedback' – expecting consultation to include feedback from CAMHS

Waste of time Communication is key Child-centred approach Self as a persuader	didn't ask anything erm so it was left to the people you know with the concerns to say to just basically dump their concerns with no feedback and it so I have been to a lot better consultations I mean that was just a, as far as I was concerned it was just a disaster, she did it on her own and I felt it was just the you know it was just a complete and utter waste of my time really especially as it took so long for the minutes to come out erm I did get apologies and she has gone now and I don't think that I was the only person that had problems but the difficulty was that I think the girl has lost out because of it and at the moment she's in a, she's, I've had to move her out of placement and go to another placement for a month to try and get, to, in order to get some help for her to bloody sort herself out.	'Disaster' Emphasising feeling that consultation was a waste of time Poor, delayed communication Feeling that the child lost out due to not being able to secure CAMHS input SW been unable to fulfil role of persuading CAMHS to help
	INT: Mmm and you said that in the consultation that the person who was running it didn't give any feedback to you …	
Communication is key	**P3:** No, nothing, didn't ask questions, literally did not say a word.	Poor communication during the consultation
	INT: But then you said that afterwards because the minutes took so long to come through you sort of had to step in and do some direct work. I just	

	wondered where erm what underpinned your direct work when you hadn't had any of this feedback from CAMHS at all?	
Uncertainty in work without consultation Relying on own experience in absence of CAMHS	**P3:** Just my gut instinct really, I mean just the fact, just to realise, trying to get her to realise that if she makes allegations that aren't true that about in those sort of situations she could ruin somebody else's life forever you know it's not a you know you can't go around making allegations and then withdraw them and say well actually no that isn't what happened you know when it's got too big for you to manage which is what happens and she, you know she's done it about three times now.	Using 'gut instinct' to drive direct work in the absence of feedback and input from CAMHS Re-emphasising own professional experience, perhaps to go against feeling belittled by CAMHS – stepping in when CAMHS not giving help
	INT: Okay.	
	P3: And I'm still not sure what the truth is.	Still unclear re. child's difficulties as consultation didn't meet expectations.
	INT: And you said that they've given her a different CAMHS worker …	
Time delay	**P3:** Well she never had a CAMHS, well no she's had the same CAMHS worker since she was allocated she didn't get allocated a CAMHS worker I think 'till April and then the CAMHS worker didn't start working with her 'till June because she was on holiday and various other things.	Time delay in getting ongoing help and input from CAMHS.

	INT: Okay. So now that that work has started have you had any follow up consultations …	
	P3: No.	
	INT: … with them?	
	P3: No only me talking to the worker.	
	INT: Okay.	
Feeling let down Unsupported Absence of psychologist Self and children let down	**P3:** She does come to meetings and she does, she does but we haven't had a, I think my concern is that *[name of CAMHS psychologist]* didn't get involved in that case I think I would've like it and it would've been helpful if *[name of CAMHS psychologist]* had got involved erm 'cause I think this girl's got problems and I'm not sure that, I think she could've benefitted from having a qualified psychologist look at the information and talk to us and I, I mean having been to a *[name of CAMHS psychologist]*, one that *[name of CAMHS psychologist]* done I think he's very good at getting information out of people and asking the right questions so he becomes clear in his head what the issues are erm and I think that, that didn't happen and I	Me making the effort to communicate – feeling let down? Also carrying a lot of responsibility despite accessing consultation for support. Absence of psychologist in the work – feeling that psychologist input would have been beneficial. Switch from talking about child to saying '..talk to us' – psychologist for SW as well as child. Contrast between psychologist & other CAMHS workers CAMHS not fulfilled their role. Positive re. psychologist but feeling job not done 'Not sure we're all working from a point of understanding' – mismatch

Absence of psychologist Feeling let down Expectations vs. reality Time delay	don't, I'm not sure that anyone, that, well that hasn't been done basically so we're all, I think, I'm not sure that we're all working from a point of understanding why it is she does what she does but I think, I think, to be fair I think the current therapist is probably getting to it but it's taken a long time because it's, she needs to get to it, and plus the girl hasn't been particularly good about engaging.	between expectations of SW & the actual consultation Time delay – it's taken a long time. Repetitive point – emphasis on this.

Table A-2

Development of super-ordinate themes from emergent themes for Jen's transcript

A means to an end: Fighting for CAMHS input	**Hopes and broken promises: Expectation vs. reality**	**Holding the self in mind**	**A mismatched approach to work?**	**Accessibility and fear for the future**	**A chance to be heard**
Prioritising children over self Child and carer centered Child-centered Child-centered approach Desperation for input Desperation for help Fighting on behalf of LAC Fighting for input Fighting for service Self as a persuader Consultation as a final option	Expectations vs. reality CAMHS as experts Psychology for complexity Psychology for high risk cases Mismatched aims Seeking strategies Seeking solutions not just reflection Practicalities and solutions Practical rather than theoretical Seeking answers Seeking directness Wanting to be told what to do Seeking knowledge and skills Consultation for knowledge Seeking explanation and understanding Seeking reassurance Seeking feedback Seeking support	Opportunity to be heard Value of psychologist Absence of a psychologist Indirect impact on work Impact on approach to work Feeling validated by long-term CAMHS input Consultation highlighting own downfalls Changed approach to role Shift in belief about carers Consultation prompting shift in thoughts Thinking about self	Conflicting aims and expectations Conflicting aims Conflicting approaches to working with children Approaching work from a different position Conflicting ways of working Conflicting standards Conflicting views on consent Conflicting theoretical views Theory vs. practice	Accessibility and availability Accessibility Shrouded in secrecy Unclear about service provision Seeking immediate access Time delay Communication as key Uncertainty and fear about the future Upset over potential loss Time of uncertainty Fear about the	Using interview as an opportunity to be heard Keenness to tell story Using interview to tell story Seeking validation in the interview

CAMHS as a last chance option Last resort Means to an end	Seeking informal contact Sharing of stories Gathering of professionals Consultation as collaborative Need for joined up working Broken promises Forced into an uncomfortable position Uncertainty without consultation Relying on own experience in absence of CAMHS Self as lacking skills Unequipped Feeling stuck Disappointment in process Frustration with the system Doubting explanations Missing the point Lack of collaboration Waste of time Early intervention Ongoing CAMHS input Need for follow-up Not listened to by carers Unheard and untrusted Unheard and invalidated by carers Hurt by carers Feeling excluded			future Fear about future	

	Excluded from therapeutic input Misinterpreted & misrepresented Feeling let down Out of the loop Feeling left out Not meeting expectations Unsupported Undervalued Invalidated Feeling alone and unsupported Isolated Feeling dismissed by CAMHS Disappointment in outcomes Self and children let down Falling through a gap Experience mirroring child's experience				

Summary of Super-Ordinate Themes for Jen's Transcript

A means to an end – fighting for CAMHS input.

Throughout her interview, this participant really emphasised taking a child-centred approach to her work and spoke about using the consultation service in the same way. For her, the outcomes of the consultations were focused upon outcomes for the LAC. Even when she did identify some outcomes for herself, she minimised them and brought the topic back to the impact that the consultations had upon the children and families. Linked to this, the participant described a real sense of having to fight to get CAMHS involvement, both in terms of accessing the consultations and in accessing any ongoing therapeutic input from CAMHS. The participant described herself as fighting on behalf of the LAC and there was a real sense of desperation for the service, which created frustration for the participant as she had found it to be quite difficult to reliably access. For this participant, the consultation and any CAMHS input appeared to be a last resort for cases where she did not know what else to do or try. She described feeling that her role was very much about trying to persuade CAMHS to become involved and would use the consultations to this end. The consultations appeared to be perceived as a means to an end, in the sense that, if she was able to do a good job of persuading CAMHS of the needs of the children, then they would then provide some further therapeutic input for the children. Given her loyalty to the children, I wondered whether the difficulties that she experienced in accessing the consultations may have resulted in her feeling that she had let the children down (unable to fulfill her role as persuader), which may have been displaced into frustration towards the service.

Hopes and broken promises: Expectation vs. reality.

Throughout her interview, this participant described a mismatch between her expectations of the consultation service and the reality of what she had experienced. She described accessing the consultation service in order to try to obtain an expert opinion from CAMHS and she was seeking solutions to the difficulties that the LAC may have been presenting with. For this participant, there was a focus upon practical advice and support from CAMHS, rather than using the consultations as an opportunity for reflection and thinking around a case. Whilst she did in some ways described the consultation as a collaborative process, she also had a strong focus on seeking answers and immediate responses from the CAMHS workers. She spoke about appreciating the opportunities for all professionals involved in a child's care to meet together and share their views and stories, though also said that she wished for the opportunity to contact the consultation team on an informal basis, rather than having to wait for these more formally arranged meetings.

This participant conveyed a feeling of having been let down by the service, describing it as unreliable and difficult to access. This had left her in a position of being unable to obtain an expert opinion on some cases and having to complete some pieces of work with LAC herself due to being unable to access CAMHS. When she had been able to access the consultation service, the sessions had not met her expectations and she conveyed feelings of being left alone on cases when she felt out of her depth. The participant described feeling as though foster carers often did not seem to listen to her and that this was often why she sought consultation, in an attempt to gain some reassurance and validation in her thoughts around the child. However, her experience of the consultation was the same as with some foster carers as she described feeling as though she was not listened to. This resulted in feelings of invalidation and being unvalued by CAMHS. The participant seemed to portray a situation in which she felt that she and the LAC had fallen through a gap in services, feeling unsupported by the foster carers and now also by CAMHS. In this way, I wondered if her experience seemed to mirror the experiences of many looked after children in being excluded, undervalued and invalidated by those around them.

Holding the self in mind.

Although the participant focused upon outcomes for the LAC all the way through her interview, she did describe how the consultation had benefitted her own work but without explicitly labeling it as a personal benefit. She described the consultations as an opportunity to make her views known about the care of the children and described feeling validated at times when the consultation had lead to further involvement of CAMHS in the case. The participant described feeling that the consultation sessions could prompt a shift in her thought patterns, which may then have a knock on effect on her future work with LAC. Additionally, there seemed to be some times when the consultation had highlighted some ways in which she may not have been working in a way that best met the needs of the children and families. In this way, the consultation seemed to impact upon her own work in the sense of indicating ways in which she could change her approaches.

A mismatched approach to work?

Linked in with the second theme, the participant conveyed a mismatch between her aims and expectations for the consultation and what she believed to be the aims of CAMHS. This mismatch became particularly apparent when she spoke about CAMHS having ongoing involvement with some of the children she had sought consultation around. The participant held the view that this work had been agreed to and so it should have been followed through, regardless of whether or not the LAC expressed wanting the work. This conflicted with CAMHS seeking informed consent from the children before beginning work, and then not continuing any therapeutic work without this consent. Here, there appeared to be a mismatch in the ways in which the two professions worked. This may be rooted in the fact that the social worker holds parental responsibility for the children and is responsible for making decisions on their behalf, whereas psychologists and other CAMHS workers do not have this responsibility or power. The conflicting approaches appeared to contribute to the participant’s despondency about the service and about what CAMHS were able to offer.

Accessibility and fear for the future.

Despite having not had entirely positive experiences of the consultation service, the participant expressed wanting the service to continue but with a hope that it may become easier to access. The service that this participant was accessing was undergoing some restructure at the time of her interview and she described feeling excluded from this process and kept in the dark about what may be happening to the consultations. This seemed to mirror her experiences of accessing the service to date and added to her frustrations. However, she also expressed great concern over the prospect of losing the service and a fear of what may happen should the service change or be lost. This seemed to emphasise her desperation for a consultation service from CAMHS, linking into the first theme around accessing this service at times when she was at a loss as to what to do and seeking a psychological understanding around LAC.

A chance to be heard.

The participant was very keen to get her story across in her interview, at times cutting the interviewer off during a question or continuing with her story even if it did not fit with an interview question that had been asked. In light of her conveying feelings of being unheard and invalidated by carers and professionals, it seemed as though the participant was making use of the interview as a space to get her story heard. There were times during the interview when she asked questions of the interviewer and also times when she spoke in detail about specific cases, as though seeking validation for her thinking and approaches through the interview process.

Appendix 2-B
Author Guidelines for Journal

Child and Adolescent Mental Health Journal

Edited By: Tamsin Ford, Crispin Day, Jane Barlow and Kapil Sayal

Impact Factor: 0.635

ISI Journal Citation Reports © Ranking: 2012: 92/114 (Psychology Clinical); 103/121 (Psychiatry (Social Science)); 104/122 (Pediatrics); 112/135 (Psychiatry)

Online ISSN: 1475-3588

Associated Title(s): Journal of Child Psychology and Psychiatry

Author Guidelines

Why submit to *Child and Adolescent Mental Health*?

- An international journal with a growing reputation for publishing work of clinical relevance to multidisciplinary practitioners in child and adolescent mental health
- Over 4000 institutions with access to current content, and a further 5000 plus institutions in the developing world
- High international readership - accessed by institutions globally, including North America (40%), Europe (37%) and Asia-Pacific (15%)
- **Excellent service** provided by editorial and production offices
- Every manuscript is assigned to one of the Joint Editors as decision-making editor; acceptance rate is around 20%
- Acceptance to *EarlyView* publication within 2 - 4 months
- Simple and efficient **online submission** – visit http://mc.manuscriptcentral.com/camh_journal
- ***EarlyView*** – articles appear online before the paper version is published! Click here to see the articles currently available;
- Authors receive access to their article once published as well as 20% discount on Wiley-Blackwell publications.

The journal encourages pre-submission enquiries, which may be sent via the Managing Editor at camh@acamh.org.uk

1. Contributions from any discipline that further clinical knowledge of the mental life and behaviour of children are welcomed. Papers need to clearly draw out the clinical implications for mental health practitioners.Papers are published in English. As an international journal, submissions are welcomed from any country. Contributions should be of a standard that merits presentation before an international readership. Papers may assume any of the following forms: Original Articles; Review Articles; Measurement Issues; Innovations in Practice.

Original Articles: These papers should consist of original research findings.
Review Articles: These papers are usually commissioned; they should survey an important area of

interest within the general field.
Measurement Issues: These are commissioned review papers that aim to evaluate evidence-based measurement issues in child mental health disorders and services.
Innovations in Practice: Submission to this section should conform to the specific guidelines, given in full below.

2. Submission of a paper to *Child and Adolescent Mental Health* will be held to imply that it represents an original article, not previously published; that it is not being considered for publication elsewhere; and that if accepted for publication it will not be published elsewhere without the consent of the Editors.

3. Manuscripts should be submitted online. For detailed instructions please go to: http://mc.manuscriptcentral.com/camh_journalhttp://mc.manuscriptcentral.com/camh_journal and *Check for existing account* if you have submitted to or reviewed for the journal before, or have forgotten your details. If you are new to the journal *Create a new account.* Help with submitting online can be obtained from Piers Allen at ACAMH (e-mail Piers.Allen@acamh.org.uk)

4. Authors' professional and ethical responsibilities

Disclosure of Interest Form: All authors will be asked to download and sign a full Disclosure of Interests form and acknowledge this and sources of funding in the manuscript.

Ethics
Authors are reminded that the *Journal* adheres to the ethics of scientific publication as detailed in the *Ethical principles of psychologists and code of conduct* (American Psychological Association, 2010). These principles also imply that the piecemeal, or fragmented publication of small amounts of data from the same study is not acceptable. The Journal also generally conforms to the Uniform Requirements for Manuscripts of the International Committee of Medical Journal Editors (ICJME) and is also a member and subscribes to the principles of the Committee on Publication Ethics (COPE).

Informed consent and ethics approval
Authors must ensure that all research meets these ethical guidelines and affirm that the research has received permission from a stated Research Ethics Committee (REC) or Institutional Review Board (IRB) , including adherence to the legal requirements of the study county. Within the Methods section, authors should indicate that 'informed consent' has been appropriately obtained and state the name of the REC, IRB or other body that provided ethical approval. When submitting a manuscript, the manuscript page number where these statements appear should be given.

Recommended guidelines and standards
The Journal requires authors to conform to CONSORT 2010 (see CONSORT Statement) in relation to the reporting of randomised controlled clinical trials; also recommended is the Extensions of the CONSORT Statement with regard to cluster randomised controlled trials). In particular, authors must include in their paper a flow chart illustrating the progress of subjects through the trial (CONSORT diagram) and the CONSORT checklist. The flow diagram should appear in the main paper, the

checklist in the online Appendix. Trial registry name, registration identification number, and the URL for the registry should also be included at the end of the methods section of the Abstract and again in the Methods section of the main text, and in the online manuscript submission. Trials should be registered in one of the ICJME-recognised trial registries:

Australian New Zealand Clinical Trials Registry
Clinical Trials
Nederlands Trial Register
The ISRCTN Register
UMIN Clinical Trials Registry

Manuscripts reporting systematic reviews or meta-analyses should conform to the PRISMA Statement.

The Equator Network is recommended as a resource on the above and other reporting guidelines for which the editors will expect studies of all methodologies to follow. Of particular note are the guidelines on qualitative work http://www.equator-network.org/reporting-guidelines/evolving-guidelines-for-publication-of-qualitative-research-studies-in-psychology-and-related-fields and on quasi-experimental http://www.equator-network.org/reporting-guidelines/the-quality-of-mixed-methods-studies-in-health-services-research and mixed method designs http://www.equator-network-or/reporting-guidelines/guidelines-for-conducting-and-reporting-mixed-research-in-the-field-of-counseling-and-beyond

5. Exclusive License Form: Authors will be required to sign an Exclusive License Form (ELF) for all papers accepted for publication. Please note that signing of the ELF does not affect ownership of copyright in the material. Copies of the form can be downloaded here. Online Open is also available as a funded option for those authors requiring their article to be published Open Access: please see detailed guidance below.

6. Manuscripts should be double spaced and conform to the house style of *CAMH*. The first page of the manuscript should give the title, name(s) and address(es) of author(s), and an abbreviated title (running head) of up to 80 characters. Specify the author to whom correspondence should be addressed and provide their full mailing and email address.

Summary: Authors should include a structured **Abstract** not exceeding 250 words under the sub-headings: Background; Method; Results; Conclusions.

Keywords: Please provide 4-6 keywords (use MeSH Browser for suggestions).

Key Practitioner Message (in the form of 3-6 bullet points) should be given below the Abstract, highlighting what's known, what's new and the direct relevance of the reported work to clinical practice in child and adolescent mental health.

7. Papers submitted should be concise and written in English in a readily understandable style, avoiding sexist and racist language. **Original Articles should not exceed 5,500 words, including References and Tables. Occasionally, longer articles may be accepted after negotiation with the Editors. Authors should include a word count of their paper.**

8. Authors who do not have English as a first language may choose to have their manuscript professionally edited prior to submission; a list of independent suppliers of editing services can be found at http://authorservices.wiley.com/bauthor/english_language.asp. All services are paid for and arranged by the author, and use of one of these services does not guarantee acceptance or preference for publication.

9. **Headings:** Original articles should be set out in the conventional format: Methods, Results, Discussion and Conclusion. Descriptions of techniques and methods should only be given in detail when they are unfamiliar. There should be no more than three (clearly marked) levels of subheadings used in the text.

10. All manuscripts should have an **Acknowledgement** section at the end of the main text, before the References. This should include statements on the following:

Study funding: Please provide information on any external or grant funding of the work (or for any of the authors); where there is no external funding, please state this explicitly.

Conflicts of interest: Please disclose any conflicts of interest of potential relevance to the work reported for each of the authors. If no conflicts of interest exist, please include an explicit declaration of the form: "The author(s) have declared that they have no competing or potential conflicts of interest".

Contributorships: Please state any elements of authorship for which particular authors are responsible, where contributionships differ between the author group. (All authors must share responsibility for the final version of the work submitted and published; if the study includes original data, at least one author must confirm that he or she had full access to all the data in the study, and takes responsibility for the integrity of the data and the accuracy of the data analysis). Contributions from others outside the author group should also be acknowledged (e.g. study assistance or statistical advice) and collaborators and study participants may also be thanked.

11. For referencing, *CAMH* follows a slightly adapted version of APA Style http:www.apastyle.org/. References in running text should be quoted showing author(s) and date. For up to three authors, all surnames should be given on first citation; for subsequent citations or where there are more than three authors, 'et al.' should be used. A full reference list should be given at the end of the article, in alphabetical order.

References to journal articles should include the authors' surnames and initials, the year of publication, the full title of the paper, the full name of the journal, the volume number, and inclusive page numbers. Titles of journals must not be abbreviated. References to chapters in books should include authors’ surnames and initials, year of publication, full chapter title, editors' initials and surnames, full book title, page numbers, place of publication and publisher.

12. Tables: These should be kept to a minimum and not duplicate what is in the text; they should be clearly set out and numbered and should appear at the end of the main text, with their intended position clearly indicated in the manuscript.

13. Figures: Any figures, charts or diagrams should be originated in a drawing package and saved within the Word file or as an EPS or TIFF file. See http://authorservices.wiley.com/bauthor/illustration.asp for further guidelines on preparing and submitting artwork. Titles or captions should be clear and easy to read. These should appear at the end of the main text.

14. Footnotes should be avoided, but end notes may be used on a limited basis.

Review Articles

These papers are usually commissioned; they should survey an important area of interest within the general field of child and adolescent mental health disorders and services. Suggestions for topics and proposals (outline and/or draft abstract) may be sent to the CAMH Editorial Office camh@acamh.org

Measurement Issues

These are commissioned review papers that aim to evaluate evidence-based measurement issues in child mental health disorders and services: if you have a suggestion for a measurement-based overview article, please contact the CAMH Editorial Office camh@acamh.org with an outline proposal.

Manuscripts for Review Articles are Measurement Issues should follow the standard format for Original Articles but to a word limit agreed at the point of the proposal being agreed.

Innovations in Practice

Child and Adolescent Mental Health (CAMH) promotes evidence-based practice, intervention and service models. Innovations in practice, intervention and service provision may arise through careful and systematic planning, while others are responsive to need, evolution of existing services, or simply arise because of changing circumstances or technology. In this rapidly evolving field, the Editors of *CAMH* warmly welcome short *Innovations in Practice* papers which aim to allow authors to share with our wide international multidisciplinary readership knowledge and initial impact of new and interesting developments.

Manuscripts submitted as *Innovations in Practice* submissions should follow the standard format for *Original Articles* but be no more than 2500 words, including references and tables. They should briefly set out the aims and detail fo the innovation, including relevant mental health, service, social and cultural contextual factors; the evaluation methods used; relevant supporting evidence and data; and conclusions and implications. Submissions may describe formal pilot and feasibility studies or present findings based on other evaluative methods. Contributions outlining important innovations with potential significant impact may be considered even in the absence of evaluative data. Close attention should be paid in all submissions to a critical analysis of the innovation.

Manuscript Processing

Peer Review Process: All material submitted to CAMH is only accepted for publication after being subjected to external scholarly peer review, following initial evaluation by one of the Editors. Both original and review-type articles will usually be single-blind reviewed by a minimum of two external referees and only accepted by the decision Editor after satisfactory revision. Any appeal of an editorial decision will first be considered by the initial decision Editor, in consultation with other Editors. Editorials and commissioned editorial opinion articles will usually be subject to internal review only, but this will be clarified in the published Acknowledgement section. Editorial practices and decision making will conform to COPE http://publicationethics.org/resources/guidelines and ICMJE http://icmje.org/ best practice.

Proofs: Proofs will be sent to the designated author only. These will be sent via e-mail as a PDF file and therefore a current e-mail address must always be given to the journal office. Only typographical or factual errors may be changed at proof stage, and the publisher reserves the right to charge authors for correction of non-typographical errors.

The designated author of a published paper will receive a PDF file of their final published article. The designated author should undertake to forward copies of the PDF file to their co-authors.

CrossCheck

An initiative started by *CrossRef* to help its members actively engage in efforts to prevent scholarly and professional plagiarism. The journal to which you are submitting your manuscript employs a plagiarism detection system. By submitting your manuscript to this journal you accept that your manuscript may be screened for plagiarism against previously published works.

Advice for NIH authors and other grant-funded authors

CAMH and *Wiley-Blackwell* will support NIH funded authors by posting the accepted version of articles by NIH grant-holders to PubMed Central upon acceptance by the journal. The accepted version is the version that incorporates all amendments made during peer review, but prior to the publisher's copy-editing and typesetting. The accepted version will be made publicly available 12 months after publication. The NIH mandate applies to all articles based on research that has been wholly or partially funded by the NIH and that the accepted for publication on or after 7th April 2008.

Arrangements are also in place to comply with the mandates of other funders - please see further details here.

Please let the editorial office know that you are a funded author when you submit your article.

Online Open

OnlineOpen is available to authors of primary research articles who wish to make their article available to non-subscribers on publication, or whose funding agency requires grantees to archive the final version of their article. With OnlineOpen, the author, the author's funding agency, or the author's institution pays a fee to ensure that the article is made available to non-subscribers upon publication via Wiley Online Library, as well as deposited in the funding agency's preferred archive. For the full list of terms and conditions, see http://wileyonlinelibrary.com/onlineopen#OnlineOpen_Terms

Any authors wishing to send their paper OnlineOpen will be required to complete the payment form available from our website at http://authorservices.wiley.com/bauthor/onlineopen_order.asp

Prior to acceptance there is no requirement to inform an Editorial Office that you intend to publish your paper OnlineOpen if you do not wish to. All OnlineOpen articles are treated in the same way as any other article. They go through the journal's standard peer-review process and will be accepted or rejected based on their own merit.

Liability

Whilst every effort is made by the publishers and editorial board to see that no inaccurate or misleading data, opinion or statement appears in this journal, they wish to make it clear that the data and opinions appearing in the articles and advertisements herein are the sole responsibility of the contributor or advertiser concerned. Accordingly, the publishers, the editorial board and editors, and their respective employees, officers and agents accept no responsibility or liability whatsoever for the consequences of any such inaccurate or misleading data, opinion or statement.

Section Three: Critical Appraisal

Word Count: 3,762 words

Kate Houlihan

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

All correspondence should be sent to:

Kate Houlihan
Doctorate in Clinical Psychology
Furness College
Lancaster University
Lancaster
LA1 4YT
k.houlihan@lancaster.ac.uk

The aim of this paper is to critically appraise the research that has been presented earlier in this thesis. The first paper that was presented was a systematic literature review of research into the psychological needs of foster carers. Secondly, a research project was presented, exploring the experiences of social workers who had accessed psychological consultation services in relation to their work with looked after children (LAC). In this research paper, interpretative phenomenological analysis (IPA; Smith et al., 2009) was used to gather and subsequently analyse data from eight participants in order to develop a detailed understanding of their experiences of psychological consultation. Four key themes were identified in the data: An alternative perspective: Seeking expertise; A dual-purpose: consultation for families and the self; Consultation as a lifeline: The final chance; and Validation and acknowledgement: The psychological experience of consultation.

Throughout this research, a range of methodological considerations and decisions were made. Whilst some were addressed as part of the discussion in the research paper, the format of the paper does not allow for an in-depth consideration of these issues. As such, this critical appraisal will explore these issues further. Reflective practice is emphasised in qualitative research and I will use this appraisal to discuss the reflective processes that I went through during the research process. This paper will be split into four sections: issues around recruitment of participants; the use of IPA; confidentiality and anonymity in qualitative research; and finally, a section on separating the role of a researcher from the role of a therapist as a trainee clinical psychologist.

Recruiting Social Workers as Participants

For this research, I approached six social care teams in order to recruit social workers working with LAC. Whilst I contacted and provided study information packs to all teams, those who participated in the research were recruited from across only three teams. Although I did not experience difficulties in recruiting a sufficient number of participants, I felt that it was important to reflect upon possible reasons as to why the final sample came from a small section of the total sample pool. This seems particularly important when I consider that all of the teams expressed an initial interest in participating in the project.

Social workers who were employed by social work agencies were excluded from the study, with only those who were employed by the local authorities being approached. Whilst I initially wondered whether this would impact upon recruitment, several of the teams that I approached were comprised mainly of local authority social workers and so this exclusion criterion did not appear to influence recruitment. However, despite initial enthusiasm, many of the potential participants simply did not have enough spare time during their working hours to be able to commit to participating in an interview. Indeed, this issue of being able to set time aside for an interview was also apparent for those social workers who did participate. For several social workers, it was difficult to arrange a mutually suitable time for their interview, and I rearranged several interviews due to participants having urgent work commitments arise unexpectedly. This issue of social workers being extremely time pressured fits in with previous research outlining that social workers often report high levels of stress in relation to carrying large workloads and high levels of responsibility (Collins, 2007; Guerin, Devitt, & Redmond, 2010; Leeson, 2010). If potential participants were experiencing stress and pressure at the time of my recruiting, it is perhaps unsurprising that the initial enthusiasm was not followed up with opting into the research. The limitations of the final participants having been recruited from only three teams have been discussed as part of the main research paper. I made every effort to be flexible in arranging interviews, arranging them at a time that was convenient for the participants and at their usual place of work so as to avoid any travel inconveniences. However, reflecting upon this issue since the completion of the study, I have wondered whether the short timescale that I had available in which to complete recruitment and interviews influenced the response rate. Perhaps if I had been able to be more flexible in terms of timescales, social workers from other teams would have opted to participate.

I also considered whether there could have been something inherent in the research process that may have reduced social workers' willingness to participate. Fontes (2004) suggests that having an opportunity to discuss experiences through research could be perceived differently across different cultures, depending upon the value placed upon emotional expression. During the interviews for my research, I noticed that participants tended to focus on the needs of LAC and families, with reflection on their own needs often secondary to this. In light of the suggestions by Fontes, I have wondered whether anticipating this level of reflection may have felt uncomfortable for some individuals, perhaps impacting upon their willingness to participate. This issue would be something that I would consider in future research in terms of the potential impact upon recruitment and engagement with the research process.

Using Interpretative Phenomenological Analysis

Interpretative phenomenological analysis (IPA) is grounded in three philosophical concepts: phenomenology, hermeneutics and idiography. Phenomenology is the study of experience, and is based upon the notion that individuals construct their experiences through their interactions with the world (Baker, Wuest & Stern, 1992; Smith et al., 2009). Phenomenological approaches to research, therefore, aim to understand participants' lived experiences (Smith et al., 2009). Hermeneutics concerns the theoretical approach to interpretation (Smith et al., 2009). In IPA, it is acknowledged that research is a dynamic process between participants and the researcher and that interpretation of data is a key part of this process. This has been described as the 'double hermeneutic', meaning that qualitative research involves the researcher attempting to make sense of the participant's attempts to make sense of an experience (Smith, 2011). Finally, the third key concept upon which IPA is based is idiography, which refers to being focused on "the particular" (Smith et al., 2009; p. 29). In terms of IPA, this refers to research being focused on obtaining detailed accounts of a specific experience from a specific group of participants. It also refers to maintaining a focus on individuals, rather than on large groups and so, in IPA research, small samples tend to be used. Even where several participants are involved, as opposed to single case studies, IPA aims to ensure that each person's experiences are not lost within the wider group (Smith et al., 2009).

The current study was exploratory as, although government and professional guidelines outline the importance of multi-agency working around LAC (Department for Education, 2003; Department of Health, 2004), there has been little research to date into professionals' experiences of this model of working. Whilst the possible emotional impact of working with LAC has been widely recognised (e.g. – DePanfilis, 2006; Grady & Cantor, 2012; Leeson, 2010; Van Hook & Rothenberg, 2009), there has been very little research into how support for professionals in this area has been experienced. Biggerstaff and Thompson (2008) outline the value of understanding services from the perspective of individuals using them. They highlight that, if only the perspective of the service is accounted for, key reasons why people may be accessing the service are likely to be overlooked. The potential emotional impact of working with LAC represents a significant experience for social workers, and, as a key support service, psychological consultation could be viewed as a key part of that experience. As such, the aim of the current project was to explore social workers' experiences of psychological consultation services around LAC. Due to a key aim of IPA being to understand how people make sense of their experiences, this was judged to be an appropriate method to use for my research. Additionally, IPA provides an opportunity to obtain a rich and detailed account of participant experiences, which fit with the exploratory aims of this project.

Whilst IPA acknowledges the role of researcher interpretation, it is suggested that a researcher's existing knowledge and assumptions about a topic should be 'bracketed' off (Baker, Wuest & Stern, 1992) so as to ensure that interpretations remain grounded in the research data. I kept a reflective diary throughout the research process, which I found greatly increased my awareness of my assumptions and allowed me to make a conscious effort to separate my beliefs from the research data. For example, during one interview I noticed that I had begun to repeat some questions in order to try to encourage further reflection. However, I also noticed that the participant began to say phrases such as "like I've said…" and I realised that perhaps I was asking these questions due to my beliefs about reflective practice in social work, rather than to further understand the participant's experiences. Taking the time to reflect upon this following the interview helped me to notice these patterns and to separate my assumptions about reflective practice from the data during future interviews. This is evidenced in the following excerpt from my reflective diary after completing the fifth interview:

> There has been a tendency for participants to revert to talking about the consultation in relation to children/families, rather than upon how it's helped them to make sense of their work – I wonder how this links to the value of reflective practice in social work? During this interview, I noticed I kept returning to questions to try to encourage reflection as then the participant said a couple of times '….like I've said'. I realised this during the interview, and think that I was returning to questions (as I might do during clinical work around assessment or formulation) due to wanting to find out more about social workers' reflective practice. I changed questioning when I noticed so as to avoid losing the participant and to make sure I was keeping to the research questions – to think about this for further interviews.

Alternative Qualitative Approaches

Although an IPA approach seemed to fit my research project, I recognise that other qualitative methods may have also been appropriate to research this topic area. For example, thematic analysis (Braun & Clarke, 2006) could have been used as this approach would allow for the identification of themes within a data set. However, although thematic analysis is flexible (Braun & Clarke, 2006), it does not emphasise phenomenology or allow for detailed interpretation of data. As my research aimed to obtain a detailed understanding of social workers' experiences, IPA appeared to be more appropriate than thematic analysis.

Grounded theory approaches developed from the work of Glaser and Strauss (1967), who aimed to develop a qualitative method that held onto the scientific rigour of quantitative research methods. The grounded theory method focuses upon how individuals make meanings out of situations through their social interactions (Baker, Wuest, & Stern, 1992). The approach uses the researcher's interpretations of data to develop a theory to explain the processes involved in the phenomena being studied (Charmaz, 2008). Having reflected upon the choice of research method for the current study, I recognise that a grounded theory approach could be useful in order to gain a deeper understanding of the social processes involved within psychological consultations. Many of the participants in the current study spoke about their social relationships, including their interactions with the psychologists and other professionals who provided the consultations. The participants' experiences appeared to vary in terms of the professionals who had provided their consultations, something that may be useful to explore further using a grounded theory approach. Additionally, many participants described finding the consultation services to be beneficial due to the level of flexibility offered. In this sense, developing a more standardised model of consultation may not be appropriate but using grounded theory to develop an understanding of the processes of consultation could be beneficial.

Confidentiality and Anonymity

Thompson and Russo (2012) identify potential difficulties in being able to provide complete confidentiality and anonymity to individuals who provide detailed accounts of their experiences as part of research with small numbers of participants. They suggest that, even when pseudonyms are used, findings may be attributable to individual participants due to the accounts being so detailed. Additionally, Thompson and Russo suggest that this can be particularly true when research is conducted with professionals due to the potential for participants to discuss relationships with other professionals and specific organisational issues.

I used pseudonyms throughout all transcripts during the writing up of the project and removed any information that could have identified particular services. However, I remained aware that some of the detailed accounts of experiences of the consultation services could have been attributed to individual participants. As such, I tried to ensure that I included excerpts from transcripts which avoided these difficulties. Additionally, due to the participants having been recruited from a small number of services, I provided minimal contextual information so as to reduce the likelihood of participants being identifiable. Thompson and Russo (2012) highlight the importance of making participants aware of how the results of research will be used at the time of their consenting to taking part. In accordance with this, in the participant information sheet I explained the purpose of the research and how the results will be used. I also clarified that participants understood this prior to completing their interviews. Additionally Thompson and Russo suggest involving participants in decisions around the level of detail that is reported in the research results. Time constraints in terms of completing this research as part of my thesis meant that this process was not possible. However, involving participants in the process of writing a project report would be something that I would consider in future research as a potential strategy for avoiding difficulties around confidentiality in small-scale qualitative research.

Researcher vs. Therapist

In a discussion of the ethics that are associated with conducting research, Seider, Davis, and Gardner (2007) suggest that psychologists need to be aware of the range of roles that they may take as part of their profession. They discuss in detail an issue of wearing "too many 'hats' simultaneously" (Seider et al., 2007; p. 673), referring to the potential for psychologists to try to take on multiple roles at one time, such as being a researcher as well as taking a therapeutic role. Whilst it has been suggested that being both a clinician and a researcher has several benefits, such as bridging the gap between theory and practice, this dual role also has the potential to create confusion for both the researcher and participants in terms of what can be expected from the process (Haverkamp, 2005; Yanos & Ziedonis, 2006). I was acutely aware of the potential for this role confusion throughout my research project, taking on the role of researcher whilst also spending my time in the role of therapist during my time on clinical placements. Throughout the research process, I made use of regular supervision so that I was able to reflect upon the impact of these multiple roles following completing the interviews.

There are clear differences between the role of a clinical psychologist as a researcher and as a therapist. When in a therapeutic role, the aim tends to be to facilitate change over a sustained period of time working with a client, whereas a researcher may often only have one meeting with an individual with the aim of gathering information in line with the research being carried out (Brinkmann & Kvale, 2008; Thompson & Russo, 2012). However, this distinction may not always be so clear when conducting qualitative research. The nature of qualitative research means that the researcher will be attempting to gain an in-depth understanding of a participant's experience, which tends to involve the researcher attentively listening to and engaging with the participant's story (Moyle, 2002; Thompson & Russo, 2012). Indeed, some researchers have referred to research interviews as conversations, implying a collaborative and engaging process (Biggerstaff & Thompson, 2008; Haverkamp, 2005). Moyle (2002) suggests that this lack of distinction between research and therapy may be particularly true for research that is focused upon emotional experiences of participants, as they may be seeking opportunities to discuss these experiences in a therapeutic environment. In this sense, it seems almost inevitable that qualitative research could be a therapeutic process for participants (Moyle, 2002). Although the current study was not focused on emotional distress, I recognised the potential for this to happen from the outset due to the nature of social work with LAC.

The engagement between a researcher and participants has been described as a "quasi-therapeutic" relationship (Brinkmann & Kvale, 2008). It is important for researchers to develop rapport with participants in order to enhance engagement in the research and allow for the gathering of detailed information (Brinkmann & Kvale, 2008). The training that clinical psychologists receive in communication and therapeutic skills suggests that the profession is well-placed for being able to develop rapport and trusting relationships with research participants (Drabick & Goldfried, 2000; Haverkamp, 2005; Thompson & Russo, 2012). However, Haverkamp (2005) suggests that there is an inherent power imbalance between researchers and participants due to the involvement of the researcher in every stage of the process, from developing the research idea to conducting the data collection and analysis. Whilst the training received by clinical psychologists may place the profession in a strong position to be able to engage participants so as to elicit rich, detailed data, this also raises the power of the researcher. Furthermore, if a practitioner was to allow the two roles to overlap too extensively, even unintentionally, there is the possibility for therapeutic skills to be misused in order to gather detailed information that a participant may not have wished to disclose (Brinkmann & Kvale, 2008; Haverkamp, 2005). Additionally, this position of having a dual role as a clinician and a researcher has the potential to create participant expectations for therapy (Brinkmann & Kvale, 2008; Haverkamp, 2005; Thompson & Russo, 2012). An awareness of this power difference is required throughout any qualitative research to ensure a balance between developing rapport and stepping away from research into a more therapeutic relationship (Haverkamp, 2005).

During my research, I initially struggled in interviews to strike a balance between offering an empathic response to participants when they were discussing their experiences and yet keeping my responses to a minimum in order to limit the potential for my responses to influence the interview. Thompson and Russo (2012) acknowledge this dilemma of listening to personal and sometimes sensitive information without being able to provide a therapeutic response. Yanos and Ziedonis (2006) describe this dilemma as "internal role confusion" (p. 252), with the clinical and research roles involving very different tasks. This conflict in roles may result in a practitioner defaulting to the position that they feel most comfortable with (Yanos & Ziedonis, 2006). Having had the opportunity to reflect upon this, I recognise that I experienced this conflict at the beginning of the interview process and that I showed a clear preference for therapeutic responses due to being more familiar with this approach. Throughout my research, I ensured that I sought regular supervision in order to discuss this balancing of clinician and researcher roles. Additionally, I made use of a reflective diary, keeping notes after each interview in order to help with reducing the potential negative impact of this role conflict upon my research. This also helped me to be more mindful of the issue during subsequent interviews.

I felt this struggle particularly during my interview with Jen, which was the third interview that I conducted. During this interview, I recognised that Jen had several negative experiences of the consultation service and I felt as though she used the interview process as an opportunity to have her story heard. This seemed to be particularly true as she spoke about feeling that she had frequently not been listened to in her role, both by professionals and carers. During this interview, I struggled with balancing an empathic response whilst also ensuring that the interview remained focused on the research question. Due to these conflicting feelings, I sought feedback from my academic supervisor on the approach that I had taken in the interview and then held this feedback in mind during further interviews. I felt that this was an important process for me to go through as it helped me to reflect upon how I could develop my research skills and try to integrate these skills with my therapeutic role. Additionally, this reflection helped me to understand that this can be an issue for many clinical psychologists, which normalised my experiences and increased my confidence in being able to continue the research process.

This conflict also reflects Yanos and Ziedonis' (2006) concept of "external role confusion" (p. 251); the idea that participants may experience some confusion as to the role of the researcher. The challenge of clarifying my role as being a trainee clinical psychologist conducting research arose during my project, with some participants expecting that I was part of the consultation services that they had accessed. This occurred despite having clearly outlined my role as part of the participant information sheets and so I further clarified my role at the beginning of the interviews to ensure that participants knew what to expect from the process. This fits with recommendations that have been made in terms of ensuring that participants are clear on the purpose of the research and the role of the researcher (Thompson & Russo, 2012; Brinkmann & Kvale, 2008). Additionally, Yanos & Ziedonis (2006) suggest that clinician-researchers should try to conduct research away from their usual clinical environment in order to reinforce this change in their role. In addition to clarifying that I was not part of the consultation services, I arranged the interviews at the place of work of the participants. This was beneficial to recruitment as it made the process more flexible for participants. It also ensured that the interviews were held in a different environment to where they would usually access consultation, aiming to reinforce the concept of the research being a separate process.

Conclusion

This critical appraisal has discussed the process of recruiting social workers for this research project and highlighted some considerations for future research. Additionally, it has provided further discussion of the use of IPA, along with considerations of alternative qualitative methodologies. Issues around confidentiality in small-scale, qualitative research were also discussed, along with details of how these issues were managed in this project. Finally, I have also reflected upon the challenges of taking on multiple roles as a trainee clinical psychologist and have drawn upon the existing literature when considering how to manage these challenges.

References

Baker, C., Wuest, J., & Stern, P. N. (1992). Method slurring: The grounded theory/phenomenology example. *Journal of Advanced Nursing, 17,* 1355-1360. doi: 10.1111/j.1365-2648.1992.tb01859.x

Biggerstaff, D., & Thompson, A. R. (2008). Interpretative phenomenological analysis (IPA): A qualitative methodology of choice in healthcare research. *Qualitative Research in Psychology, 5,* 214-224. doi: 10.1080/14780880802314304

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3,* 77-101. doi: 10.1191/1478088706qp063oa

Brinkmann, S., & Kvale, S. (2008). Ethics in qualitative psychological research. In C. Willig & W. Stainton Rogers (Eds.), *The Sage Handbook of Qualitative Research in Psychology* (pp. 263-280). London: Sage Publications.

Charmaz, K. (2008). Grounded theory. In J. A. Smith (Ed.), *Qualitative Psychology: A practical guide to research methods* (Vol. 2nd, pp. 81-110). London: Sage.

Collins, S. (2007). Social workers, resilience, positive emotions and optimism. *Practice, 19,* 256-269. doi: 10.1080/09503150701728186

DePanfilis, D. (2006). Compassion fatigue, burnout, and compassion satisfaction: Implications for retention of workers. *Child Abuse & Neglect, 30,* 1067-1069. doi: 10.1016/j.chiabu.2006.08.002

Department for Education. (2003). *Every child matters.* London: The Stationery Office Retrieved from https://www.gov.uk/government/publications/every-child-matters.

Department of Health. (2004). *Children Act 2004.* London: The Stationery Office Retrieved from http://www.legislation.gov.uk/ukpga/2004/31/contents.

Drabick, D. A. G., & Goldfried, M. R. (2000). Training the scientist-practitioner for the 21st century: Putting the bloom back on the rose. *Journal of Clinical Psychology, 56,* 327-

340. doi: 10.1002/(SICI)1097-4679(200003)56:3%3C327::AID-JCLP9%3E3.0.CO;2-Y

Fontes, L. A. (2004). Ethics in violence against women research: The sensitive, the dangerous, and the overlooked. *Ethics & Behavior, 14*, 141-174. doi: 10.1207/s15327019eb1402_4

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory*. Chicago Aldine.

Grady, M. D., & Cantor, M. (2012). Strengthening the professional selves of social workers through the lens of self psychology. *Smith College Studies in Social Work, 82*, 401-417. doi: 10.1080/00377317.2012.717027

Guerin, S., Devitt, C., & Redmond, B. (2010). Experiences of early-career social workers in Ireland. *British Journal of Social Work, 40*, 2467-2484. doi: 10.1093/bjsw/bcq020

Haverkamp, B. E. (2005). Ethical perspectives on qualitative research in applied psychology. *Journal of Counseling Psychology, 52*, 146-155. doi: 10.1037/0022-0167.52.2.146

Leeson, C. (2010). The emotional labour of caring about looked-after children. *Child & Family Social Work, 15*(4), 483-491. doi: 10.1111/j.1365-2206.2010.00704.x

Moyle, W. (2002). Unstructured interviews: Challenges when participants have a major depressive illness. *Journal of Advanced Nursing, 39*, 266-273. doi: 10.1046/j.1365-2648.2000.02274.x

Seider, S., Davis, K., & Gardner, H. (2007). Good work in psychology. *The Psychologist, 20*, 672-676.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London: Sage.

Thompson, A. R., & Russo, K. (2012). Ethical dilemmas for clinical psychologists in conducting qualitative research. *Qualitative Research in Psychology, 9*, 32-46. doi: 10.1080/14780887.2012.630636

Van Hook, M. P., & Rothenberg, M. (2009). Quality of life and compassion satisfation/fatigue and burnout in child welfare workers: A study of the child welfare workers in community based care organizations in central Florida. *Social Work & Christianity, 36*, 36-54.

Yanos, P. T., & Ziedonis, D. M. (2006). The patient-oriented clinician-researcher: Advantages and challenges of being a double agent. *Psychiatric Services, 57*, 249-253. doi: 10.1176/appi.ps.57.2.249

Section Four: Ethics Section

Word Count: 3,208

Kate Houlihan

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

All correspondence should be sent to:

Kate Houlihan
Doctorate in Clinical Psychology
Furness College
Lancaster University
Lancaster
LA1 4YT
k.houlihan@lancaster.ac.uk

Faculty of Health and Medicine Research Ethics Committee (FHMREC)

Lancaster University

Application for Ethical Approval for Research

Instructions

1. Apply to the committee by submitting
   - ✓ The University's Stage 1 Self-Assessment Form (standard form or student form) ***and*** the Project Information & Ethics questionnaire. These are available on the Research Support Office website: LU Ethics
   - ✓ The completed FHMREC application form
   - ✓ Your full research proposal (background, literature review, methodology/methods, ethical considerations)
   - ✓ All accompanying research materials such as, but not limited to,
     1) Advertising materials (posters, e-mails)
     2) Letters of invitation to participate
     3) Participant information sheets
     4) Consent forms
     5) Questionnaires, surveys, demographic sheets
     6) Interview schedules, interview question guides, focus group scripts
     7) Debriefing sheets, resource lists
2. Submit all the materials electronically as a **SINGLE** email attachment in PDF format. Instructions for creating such a document are available on the FHMREC website (http://www.lancs.ac.uk/shm/research/ethics/).
3. Submit one collated and signed paper copy of the full application materials. If the applicant is a student, the paper copy of the application form must be signed by the Academic Supervisor.
4. Committee meeting dates and application submission dates are listed on the research ethics committee website http://www.lancs.ac.uk/shm/research/ethics. Applications must be submitted by the deadline stated on the website, to:

   Diane Hopkins
   Faculty of Health & Medicine
   B03, Furness College
   Lancaster University, LA1 4YG
   d.hopkins@lancaster.ac.uk
5. Attend the committee meeting on the day that the application is considered.

1. Title of Project:

An exploration of the role of psychological consultation for social workers who work with looked after children

2. If this is a student project, please indicate what type of project by ticking the relevant box:

☐ PG Diploma ☐Masters dissertation ☐MRes ☐MSc ☐ DClinPsy SRP

☐ PhD Thesis ☐PhD Pall. Care/Pub. Hlth/Org. Hlth & Well Being ☐MD ☐✓**DClinPsy Thesis**

☐ Special Study Module (3rd year medical student)

3. Type of study

☐✓**Involves direct involvement by human subjects**

☐ Involves existing documents/data only. Contact the Chair of FHMREC before continuing.

Applicant information

4. Name of applicant/researcher:

Kate Houlihan

5. Appointment/position held by applicant and Division within FHM

Trainee Clinical Psychologist (DClinPsy)

6. Contact information for applicant:

E-mail: [redacted] Telephone: [redacted]

Address: Clinical Psychology, Furness College, Lancaster University, LA1 4YG

7. Project supervisor(s), if different from applicant:

Name(s): [redacted]

E-mail(s): [redacted]

8. Appointment held by supervisor(s) and institution(s) where based (if applicable):

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

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

Kate Houlihan – Trainee Clinical Psychologist, Doctorate in Clinical Psychology, Lancaster University

The Project

NOTE: In addition to completing this form you must submit a detailed research protocol and all supporting materials.

10. Summary of research protocol in lay terms (maximum length 150 words).

Research suggests that, although social workers tend to report enthusiasm for their work, they often become "disenchanted" (Garrett, 2010) with their roles due to issues such as high workloads and feeling that the services being offered are of poor quality (Garrett, 2010; Leeson, 2010). Additionally, research suggests that social workers experience a significant emotional impact as a result of these issues, including feeling frustrated with their role and feeling that they have failed the children they work with (Leeson, 2010).

Child and Adolescent Mental Health Services (CAMHS) have begun to offer consultation services which aim to support carers and professionals who work with looked after children (Hibbert & Frankl, 2011; Swann & York, 2011). However, research into this consultation is limited (Hibbert & Frankl, 2011; Swann & York, 2011). As such, this project aims to explore the role of psychological consultation in the work of social workers who work with looked after children. Semi-structured interviews will be used to allow for detailed exploration of social workers' experiences and to encompass all aspects of the consultation, both professional (impact on their direct work with children and families) and personal (how they cope with the work that they do).

11. Anticipated project dates

Start date: August 2013 End date: May 2014

12. Please describe the sample of participants to be studied (including number, age, gender):

The aim is to recruit 8-12 social workers who work with looked after children. To be included in the study, participants will need to have taken part in at least one consultation session with a Looked After Children (LAC) CAMHS during the six months preceding the start of the study. This has been chosen in order to maximise the opportunity of obtaining detailed accounts of their experiences of the consultation. However, should this result in not being able to recruit enough participants, recruitment will be extended to include social workers who took part in the consultation during the year prior to recruitment. Social workers who work for agencies, rather than being employed by the local authority, will not be recruited. This is because there may not be the same continuity of experience with agency social workers as with local authority social workers. Additionally, due to the potential for agency social workers to move between teams quite frequently, it is anticipated that there may be practical difficulties in recruiting them. Recruitment will be restricted to English speaking social workers due to limited resources (time and funding) for using interpreters for interviews and then translating the interviews. Potential participants will not be excluded on the basis of age or gender.

13. How will participants be recruited and from where? Be as specific as possible.

Participants will be recruited from two local authorities – [redacted]. Although the social care teams are from different local authorities, they both receive input from LAC CAMHS teams in the [redacted] NHS Trust. The clinical psychologists working in the LAC CAMHS will pass the contact details for the team managers of the social care teams that they work with to the researcher. The researcher will then contact the teams directly to arrange initial meetings to explain and gather interest in the project. Each CAMHS team provides consultation to six social care teams, with several social workers based within each team. It is thought, from previous experience of conducting research with this group, that interest in participating in the study might be quite high. Thus, the recruitment for this study will be done in three stages, in order to avoid potential over-recruitment. Initially, three social care teams from each locality will be contacted directly by the researcher to arrange initial meetings in order to explain the project and answer any questions about it. Following these meetings, information packs outlining the study will be distributed to the social workers within these teams.

Additionally, the researcher will send electronic copies of the information packs to the social care team managers and ask them to distribute them to social workers who may have been unable to attend the initial meetings. At this stage, participants will be asked to opt-in to the study by contacting the researcher directly. The researcher will send a reminder of the project to the social care teams two weeks after the initial meeting. After six weeks, if a sufficient number of participants have not opted in, the recruitment will be extended to the remaining social care teams in each locality. The same procedure as the first stage of recruitment will then be followed in order to recruit more participants. If this does not result in a sufficient number of participants, the criterion of having taken part in a consultation session during the six months preceding the study will be extended to include social workers who have taken part in consultation up to 12 months prior to the study. If this stage is reached, the researcher will contact all six social care teams by emailing the social care team managers to recruit participants who meet this extended time criterion.

14. What procedure is proposed for obtaining consent?

Participants will be provided with information sheets outlining the research project prior to opting into the study. They will be asked to opt-in to the study by completing and returning the opt-in form to the researcher. The researcher will then contact participants directly by telephone in order to arrange a date, time and location for the interviews. By contacting the researcher directly, this will ensure that clinicians working in the CAMHS will remain unaware of participant details. Before beginning the interview, the researcher will outline the information in the participant information sheet and clarify any questions or queries that the participants may have. All participants will then be asked to complete a consent form outlining their agreement to taking part in the study. A copy of the opt-in form and the consent form can be found in the appendices to the research protocol.

15. What discomfort (including psychological), inconvenience or danger could be caused by participation in the project? Please indicate plans to address these potential risks.

Interviews will be arranged directly with participants to ensure that they are at a time that is convenient to them. In order to fit in with participants' busy work schedules, the interviews will be carried out at the social care offices in which they work. Interviews will be arranged as much as possible to meet the needs of the participants and so inconvenience and danger are not anticipated. In order to maintain anonymity when interviews are conducted in the participants' place of work, the researcher will arrange the interview directly with the participant, including arranging a room. Rooms will be arranged to be outside of the social care office but within the same building, allowing participants to take part in the research in a place that is convenient to them but also maintaining anonymity by ensuring that other members of their social care team are not aware of the interview taking place. If participants express concerns about anonymity, the researcher will discuss the option of a telephone interview with them which can be carried out at a time that is suitable to them.

Following being given the information packs, social workers may choose not to participate in the study by not completing and returning the opt-in form. For those who do choose to take part, participants may withdraw their information from the study during their interview or up to two weeks after their interview. After this time, the interviews will have been transcribed and anonymised and will be collated with the data from other interviews in the study. At this point, it may not be possible to identify individual information. This information is outlined on the participant information sheet and on the consent form and participants will be made aware that they can contact the researcher directly should they wish to withdraw from the study.

16. What potential risks may exist for the researcher(s)? Please indicate plans to address such risks (for example, details of a lone worker plan).

No risks to the researcher are foreseen. The University Lone Worker guidelines will be followed when conducting face-to-face interviews. In accordance with these guidelines, the researcher will contact their research supervisor by email on the day of carrying out an interview to inform them about the planned interview, including time and location. They will email them again following the interview having taken place. If the research supervisor is unavailable, the researcher will establish a 'buddy' system with a peer on the DClinPsy course, again contacting them before and after each interview. If the researcher requires any further support, they will contact their research supervisor.

17. 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 will be no direct benefit to participation in this study.

18. Details of any incentives/payments (including out-of-pocket expenses) made to participants:

Incentives are not being offered to participants. Where applicable, any travel costs for participants will be reimbursed following the Lancaster University Doctorate in Clinical Psychology policy for reimbursing participant travel costs.

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

In order to allow for detailed exploration of participants' experiences of psychological consultation, semi-structured interviews will be used to collect the data for this study. The data collected from the interviews will be analysed using interpretative phenomenological analysis (IPA). This approach focuses upon the ways in which individuals make sense of their experiences (Smith et al., 2009), which fits with the aims of this project.

The interviews will last for approximately 45 minutes to 1 hour, though the duration will not be restricted by the researcher, and all interviews will be recorded using a digital voice recorder with consent. Following completion of the interviews, the researcher will transcribe the interview data. At this point, all data will be anonymised so that it cannot be associated with individual participants. Any other names or potentially identifying information, such as details of where the participants work or names of specific CAMHS clinicians, will also be changed.

20. Describe the involvement of users/service users in the design and conduct of your research. If you have not involved users/service users in developing your research protocol, please indicate this and provide a brief rationale/explanation.

Service users (LUPIN) were involved in the initial stages of developing the project and provided feedback on the design and also on the implications of the study for participants and ongoing development of the consultation services.

21. What plan is in place for the storage of data (electronic, digital, paper, etc.)? Please ensure that your plans comply with the Data Protection Act 1998.

At the point of transcription, all interviews will be anonymised and pseudonyms will be used for each participant. The electronic copies of the transcripts will be stored as password protected files, and the computers will also be password protected. Upon completion of the study, electronic copies of the transcripts, the opt-in forms and consent forms (which will include participant details) will be stored securely at Lancaster University for 10 years, at which point they will be destroyed.

22. Will audio or video recording take place? ☐ no ☐ ✓ **audio** ☐video

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

Once interviews have been conducted, the audio recordings will be transferred to the Lancaster University shared computer drive and stored securely as password protected files. The recordings will then be deleted from the digital voice recorder. Once the project has been written up as part of the researcher's thesis for their DClinPsy course, and the thesis has been examined, the audio files will be destroyed. The electronic copies of the transcripts, opt-in forms and consent forms will be password protected and stored on a memory stick. This will be given to the DClinPsy research administrator, along with password instructions, who will be responsible for storing the data securely until the end of the storage period, at which point it will be destroyed.

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

Dissemination of the findings from this study will firstly be done by meeting with the LAC CAMHS that assisted with recruitment, as these will be the services that provided the consultation sessions to participants. The researcher will also arrange to meet with the social care teams that take part in the study to feedback on the findings. Both of these plans will include providing the teams with a summary/information sheet outlining the findings and recommendations from the study. Participants will not be identified at any stage of the feedback.

The project will be written up as part of a thesis to meet the requirements of the researcher's DClinPsy course. This will be written in accordance with the publication guidelines of an academic/professional journal that is relevant to this subject area and may be submitted for publication in this journal at a later date.

Any direct quotes that are used in the reporting of findings will be selected in a way to minimise that chance that participants can be identified. Quotes will not be linked to a particular recruitment site and the professional details of participants will not be disclosed. Pseudonyms will be allocated to all participants and used in all write-ups of the project.

24. What particular ethical problems, not previously noted on this application, do you think there are in the proposed study?

One potential ethical concern is that there is the possibility that participants could disclose information about the looked after children with whom they work when asked about the experiences of the consultation process. In order to try to minimise the chance of this happening, the researcher will explain to participants that the details of the individual cases are not required for the research and will also ask participants to use pseudonyms if they do wish to highlight specific aspects of a case that are relevant to the questions being asked.

There is the possibility for participants to disclose information regarding risk, whether it be in relation to their practice, another professional's practice or risk in relation to a looked after child. If this were to happen, then I would need to breach confidentiality and would pass this information on to the manager of the social care team in which they are based. I would inform the participant of this before breaching confidentiality and also discuss the information to be passed on with them. Participants will be aware of these procedures before the study begins as they are outlined on the participant information sheet. Additionally, participants are asked to agree to these procedures when completing and signing the consent form prior to beginning their interview.

There is the potential for participants to experience distress or become upset when asked about the impact of the LAC CAMHS consultation upon their work as this may invite participants to speak about any personal effects of the consultation e.g.- how it may have affected the ways in which they coped with working with looked after children. Should this happen, the interviews will be stopped at the point of the distress and the researcher will discuss with the participant whether they wish to continue with their interview or to withdraw their participation from the study. Additionally, participants will be provided with details of organisations where they can seek further support (e.g. – their team manager, G.P., organisations such as Samaritans).

A further concern is that the project could potentially become an evaluation of the practice of the LAC CAMHS clinicians who run the consultation sessions. In order to avoid the project becoming a critique of the practice of these services, the interview questions will be focused upon the experiences of the participants and the impact that the consultation had upon their work, rather than questions which evaluate the consultation service that is offered.

Signatures: Applicant: ……………………………………………………………………

Date: ……………………………………………………………………

Project Supervisor* (if applicable): ……………………………………………

Date: ……………………………………………………………………

*I have reviewed this application, and discussed it with the applicant. I confirm that the project methodology is appropriate. I am happy for this application to proceed to ethical review.

Appendix 4-A
Thesis Research Protocol

Thesis Research Protocol (Version 2)

Thesis title: An exploration of the role of psychological consultation for social workers who work with looked after children

Primary Researcher:

Kate Houlihan, Trainee Clinical Psychologist

Division of Health Research, Doctorate in Clinical Psychology, Furness College, Lancaster University, LA1 4YG

Email: k.houlihan@lancaster.ac.uk

Supervisors:

[redacted]

Email: [redacted]

Telephone: [redacted]

[redacted]

Email: [redacted]

Telephone: [redacted]

Introduction

The National Society for the Prevention of Cruelty to Children (NSPCC, 2012) suggest that there were more than 89,000 looked after children across the UK during 2011, though outline that it is difficult to establish exact numbers as the four countries differ in the ways in which they collect and collate their data. Although the exact numbers may be unclear, it is apparent that the numbers of looked after children in the UK are rising. Every child who is looked after by the state in the UK is allocated a local authority social worker (Garrett, 2010). The Children's Act (Department of Health, 1989) outlines that social workers are responsible for assessing, monitoring and evaluating a looked after child's development. Additionally, social workers also have the role of helping children who are looked after by the state to achieve their potential and to help them to progress following the situations that have resulted in them being taken into care (Leeson, 2010).

Research suggests that, although social workers tend to report enthusiasm for their work, they often become "disenchanted" (Garrett, 2010, p.96) with their roles due to issues such as high work loads, changes to the definition of their roles, feeling that the services being offered are of poor quality, and spending time carrying out administrative tasks rather than having direct contact with young people and their families (Fulcher & McGladdery, 2011; Garrett, 2010; Leeson, 2010; McLeod, 2007; Sprince, 2000; Watson, 2002). Leeson (2010) conducted a qualitative study which involved interviewing seven social workers in order to find out about their experiences of working with looked after children. The participants reported frustration with their working conditions, their level of training and with services seeming to be cost-driven rather than driven by the needs of the children, suggesting that their work had a significant emotional impact. These concerns with their work had led to participants feeling that they were compromising building relationships and working directly with looked after children in favour of more administrative tasks (Leeson, 2010). As well as the previously mentioned frustrations, participants reported often feeling as though they had failed the children or were not adequate or capable of working with this population. Many of those interviewed as part of this study stated that they did not have any specific training in working with looked after children and young people and they had to learn through experience as they progressed through their jobs. Additionally, participants attributed their feelings of failure or inadequacy to the financial constraints within services, which meant that they regularly felt unable to work as they would wish (Leeson, 2010).

Further to this, the nature of working with looked after children, many of whom have complex presentations as a result of their experiences, can have an emotional impact upon professionals. Taking a psychodynamic psychotherapy approach, Emanuel (2002) describes a concept of ‘triple deprivation’ in relation to looked after children. The author outlines that children who are taken into care can experience three levels of deprivation: the first level comes from the child’s external circumstances which result in their being taken into care; the second level results from the children’s defence mechanisms which can prevent them from accepting further support (such as from carers or professionals); and the third level of deprivation arises when these defence mechanisms are projected onto, and subsequently re-enacted by, the professionals working with the children. Emanuel (2002) suggests that this transference of defence mechanisms can result in professionals, such as social workers, being unable to think clearly about their work and can also affect their own ability to seek support with their work. This can result in professionals experiencing difficulties in coping in their roles, but also may result in the services replicating the children’s original experiences of neglect: the third level of deprivation (Emanuel, 2002).

In light of these issues, the rising number of looked after children may be expected to exacerbate the impact that working with this population can have upon social workers. In recent years, clinical psychologists and other professionals working in child and adolescent mental health services (CAMHS) have begun to offer consultation services that provide support to carers and other professionals who work with looked after children (Hibbert & Frankl, 2011; Swann & York, 2011). This is in accordance with national policies and guidelines, which outline the importance of multi-agency working in services for looked after children (Department for Children, Schools & Families, 2003; Department of Health & Department for Education and Skills, 2004; National Institute of Clinical Excellence, 2010). Research evaluating such consultation services suggests that social workers have found them to be supportive in terms of developing their skills in working with this population and also in the sense of feeling that the consultation has strengthened the systems of support provided by professionals and carers surrounding the children (Hibbert & Frankl, 2011; Swann & York, 2011).

Despite this, research into the impact of such consultation services is limited. Additionally, the existing research has tended to focus upon how the consultation has impacted upon the work of social workers and has given little insight into whether the consultation has had any impact upon their personal coping and wellbeing. Given the research outlined above that suggests that social work with looked after children can have both a personal and professional impact upon social workers, this study aims to explore the role of psychological consultation across both of these domains. As such, the main research question for this project is to explore the role of psychological consultation in the work of social workers who work with looked after children. This question is broad so as to allow for detailed exploration of social workers' experiences of consultation and encompass all aspects of this, rather than focussing purely on personal or professional issues.

Method

Design

This will be a qualitative study using interpretative phenomenological analysis (IPA). This design is used to explore how people make sense of their experiences (Smith, Flowers & Larkin, 2009), which fits with the aims of this project. A semi-structured interview schedule will be used to carry out individual interviews with social workers.

Participants

The study aims to recruit 8-12 social workers who work with looked after children. To be included in the study, social workers will need to have taken part in at least one consultation session with a Looked After Children (LAC) CAMHS during the six months preceding the start of the study. This cut off has been chosen in order to maximise the opportunity to obtain detailed accounts of their experiences of the consultation. However, should this result in not being able to recruit enough participants, recruitment will be extended to include social workers who took part in the consultation during the year prior to recruitment.

Recruitment will take place in the [redacted] area. Participants will be recruited from social work teams who have taken part in consultation sessions with one of two LAC CAMHS operating in the area. Demographic details, including the participant's name, age and gender, will be collected. Details of the participant's experience of consultation, including the CAMHS team that provided the consultation and the date of the session will also be collected.

Materials

Participants will be provided with information sheets outlining the research project prior to opting into the study. They will be asked to complete an opt-in form to express their interest in taking part and all participants will be asked to complete a consent form outlining their agreement to taking part in the study. In order to collect the data for this project, individual, semi-structured interviews will be carried out with all participants. An interview topic guide, based upon the aims of this project, has been devised as part of this protocol. All interviews will be recorded using a digital voice recorder.

Procedure

The clinical psychologists working in the LAC CAMHS will pass the contact details for the team managers of the social work teams that they work with to the researcher. The researcher will then contact the teams directly to arrange initial meetings to explain and gather interest in the project. Each CAMHS team provides consultation to six social care teams, with several social workers based within each team. It is thought, from previous experience of conducting research with this population, that interest in participating in the study might be quite high. Thus, the recruitment for this study will be done in three stages. Initially, three social care teams from each locality will be contacted directly by the researcher to arrange initial meetings in order to explain the project and answer any questions about it. Following these meetings, information packs outlining the study will be distributed to the social workers within these teams. Additionally, the researcher will send electronic copies of the information packs to the team managers and ask them to distribute them to social workers who may have been unable to attend the initial meetings. At this stage, participants will be asked to opt-in to the study by contacting the researcher directly. The researcher will send a reminder of the project to the teams two weeks after the initial meeting. After six weeks, if a sufficient number of participants have not opted in, the recruitment will be extended to the remaining social care teams in each locality. The same procedure as the first stage of recruitment will then be followed in order to recruit more participants. If this does not result in a sufficient number of participants, the criterion of having taken part in a consultation session during the six months preceding the study will be extended to include social workers who have taken part in consultation up to 12 months prior to the study. If this stage is reached, the researcher will contact all six social care teams by emailing the team managers to recruit participants who meet this extended time criterion.

The study information packs will consist of the participant information sheet, the opt-in form and the participant consent form. The social workers will be asked to opt-in to the study by completing and returning the opt-in form to the researcher. The researcher will then contact participants directly by telephone in order to arrange a date, time and location for the interviews. By contacting the researcher directly, this will ensure that clinicians working in the CAMHS will remain unaware of participant details. Additionally, the completed opt-in forms and consent forms will not be stored with the data so as to ensure that the data remain anonymous.

At the beginning of the interviews, the researcher will fully explain the project and ask the participants to complete a consent form. Individual interviews will be conducted with all participants in order to explore their experiences of taking part in consultation sessions with professionals from the LAC CAMHS. The interviews will be arranged at the social care offices where the participants are based. In order to maintain anonymity when interviews are conducted in the participants' place of work, the researcher will arrange the interview directly with the participant, including arranging a room. Rooms will be arranged to be outside of the social care office but within the same building, allowing participants to take part in the research in a place that is convenient to them but also maintaining anonymity by ensuring that other members of their social care team are not aware of the interview taking place. If participants express concerns about anonymity, the researcher will discuss the option of a telephone interview with them that can be carried out at a time that is suitable to them.

The interviews will last for approximately 45 minutes to 1 hour, though the duration will not be restricted by the researcher, and all interviews will be recorded using a digital voice recorder. Following completion of the interviews, the researcher will transcribe the interview data. At this point, all data will be anonymised so that it cannot be associated with individual participants. Any other names or potentially identifying information, such as details of where the participants work or names of specific CAMHS clinicians, will also be changed.

Proposed Analysis

The data collected from the interviews will be analysed using interpretative phenomenological analysis (IPA). This approach focuses upon the ways in which individuals make sense of their experiences (Smith et al., 2009), which fits with the aims of this project. The analysis for this study will follow the structure that is outlined by Smith et al. (2009). This begins with transcribing each interview verbatim and then, as a researcher, becoming familiar with each transcript by reading them all several times. Following this, the next stage of analysis involves making initial notes on each transcript to identify the various ways in which participants spoke about their experiences. These notes are then drawn together to develop themes that have emerged in each transcript. Ones these initial themes have been identified, the next stage of analysis involves identifying connections between these themes and bringing them together within each transcript. Finally, once these stages have been done for each transcript, the themes in individual interviews are brought together to identify patterns in these initial themes. It is these overarching themes that are then focused upon when writing up the project.

Practical Issues

The nature of the work carried out by social workers means that they are often incredibly busy and so it could be difficult to arrange meetings and interviews with participants. This could make it difficult to recruit enough participants to be able to carry out the analysis. In order to overcome this, the researcher will be flexible in terms of arranging meetings and interviews, contacting participants directly (once they have completed and returned opt-in forms) in order to arrange to meet at a time and place that is suitable for them. In terms of recruiting enough participants, the proposed method of analysis (IPA) is designed to be carried out on small groups of participants (Smith et al., 2009) and so recruiting fewer participants than hoped for should not mean that the analysis cannot be carried out.

Copies of the participant information sheets, opt-in forms, consent forms, the interview schedule and the transcribed interviews will be printed or photocopied at Lancaster University. Once interviews have been conducted, the audio recordings will be transferred to the Lancaster University shared computer drive and stored securely as password protected files. The recordings will then be deleted from the digital voice recorder. Once the project has been written up as part of the researcher's thesis for their DClinPsy course, and the thesis has been examined, the audio files will be destroyed. At the point of transcription, all interviews will be anonymised and pseudonyms will be used for each participant. The electronic copies of the transcripts will be stored as password protected files, and the computers will also be password protected. Upon completion of the study, electronic copies of the transcripts, the opt-in forms and consent forms (which will include participant details) will be stored securely at Lancaster University for 10 years, at which point they will be destroyed. The electronic copies of the transcripts, opt-in forms and consent forms will be password protected and stored on a memory stick. This will be given to the DClinPsy research administrator, along with password instructions, who will be responsible for storing the data securely until the end of the storage period, at which point it will be destroyed.

Ethical Concerns

One potential ethical concern is that there is the possibility that participants could disclose information about the looked after children with whom they work when asked about the experiences of the consultation process. In order to try to minimise the chance of this happening, the researcher will explain to participants that the details of the individual cases are not required for the research and will also ask participants to use pseudonyms if they do wish to highlight specific aspects of a case that are relevant to the questions being asked.

There is the possibility for participants to disclose any information regarding risk, whether it be in relation to their practice, another professionals' practice or risk in relation to a looked after child. If this were to happen, then I would need to breach confidentiality and would pass this information on to the manager of the social care team in which they are based. I would inform the participant of this before breaching confidentiality and also discuss the information to be passed on with them. Participants will be aware of these procedures before the study begins as they are outlined on the participant information sheet. Additionally, participants are asked to agree to these procedures when completing and signing the consent form prior to beginning their interview.

There is the potential for participants to experience distress or become upset when asked about the impact of the LAC CAMHS consultation upon their work as this may invite participants to speak about any personal effects of the consultation e.g.- how it may have affected the ways in which they coped with working with looked after children. Should this happen, the interviews will be stopped at the point of the distress and the researcher will discuss with the participant whether they wish to continue with their interview or to withdraw their participation from the study. Additionally, participants will be provided with details of organisations where they can seek further support

A further concern is that the project could potentially become an evaluation of the practice of the LAC CAMHS clinicians who run the consultation sessions. In order to avoid the project becoming a critique of the practice of these services, the interview questions will be focused upon the experiences of the participants and the impact that the consultation had upon their work, rather than questions which evaluate the consultation service that is offered.

Timescale

January 2013 – April 2013:

Continue discussions with thesis supervisors in order to develop idea further.

Continue literature search for research relevant to project.

May 2013 – July/August 2013:

Complete and submit ethics (Lancaster University) & R&D applications

August 2013 – November 2013:

Recruitment of participants and data collection.

Write up literature review section.

November 2013 – December 2013:

Data analysis & draft write up.

December 2013 – April 2014:

Submit drafts, making changes to drafts.

May 2014:

Submit thesis.

References

Emanuel, L. (2002). Deprivation x 3: The contribution of organizational dynamics to the ‘triple deprivation’ of looked-after children. *Journal of Child Psychotherapy, 28*(2), 163-179. doi: 10.1080/00754170210142771

Fulcher, L., & McGladdery, S. (2011). Re-examining social work roles and tasks with foster care. *Child & Youth Services, 32*(1), 19-38. doi: 10.1080/0145935x.2011.553579

Garrett, P. M. (2010). Creating Happier Children and More Fulfilled Social Workers: Neoliberalism, Privatization and the Reframing of Leftist Critiques in Britain. *Journal of Progressive Human Services, 21*(1), 83-101. doi: 10.1080/10428230903301386

Hibbert, G., & Frankl, J. (2011). A psychology consulation service for social workers and foster carers in a child and adolescent mental health service. *Educational and Child Psychology, 28*(3), 63-72.

Leeson, C. (2010). The emotional labour of caring about looked-after children. *Child &*

Family Social Work, 15(4), 483-491. doi: 10.1111/j.1365-2206.2010.00704.x

National Society for the Prevention of Cruelty to Children (2012). Statistics on looked after children. Accessed from: http://www.nspcc.org.uk/Inform/resourcesforprofessionals/lookedafterchildren/statistics_wda88009.html

McLeod, A. (2007). Whose agenda? Issues of power and relationship when listening to looked-after young people. *Child & Family Social Work*, *12*, 278-286.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research.* London: Sage.

Sprince, J. (2000). Towards an integrated network. *Journal of Child Psychotherapy, 26*(3), 413-431. doi: 10.1080/00754170010003606

Swann, R. C., & York, A. (2011). THINKSPACE – the creation of a multi-agency consultation group for Looked After Children. *Clinical Child Psychology and Psychiatry,* 16, 65-71. doi: 10.1177/1359104509355018

Watson, D. (2003). Defining quality care for looked after children: frontline workers' perspectives on standards and all that? *Child & Family Social Work, 8*, 67-77

Appendix 4-B
Participant Information Sheet

DIVISION OF HEALTH RESEARCH
Doctorate In Clinical Psychology

Participant Information Sheet (Version 1)

Study title: An exploration of the role of psychological consultation for social workers who work with looked after children

My name is Kate Houlihan and I am conducting this research as a student on the Clinical Psychology Doctorate programme at Lancaster University, Lancaster. I have put this information together to explain my research so that you can decide whether you would like to take part.

What is this study about?

The purpose of this study is to speak to social workers who work with looked after children to find out about their experiences of psychological consultation provided by Child and Adolescent Mental Health Services (CAMHS). The study aims to find out about the role that psychological consultation may have in the work of social workers who work with looked after children.

Why have I been approached?

You have been approached because the study is seeking information from social workers who have experienced psychological consultation during the last six months [*This will be amended to 12 months should stage 2 of the recruitment process need to be implemented]*. The study is being carried out in the [redacted] area and you are based in a social care team that receives psychological consultation input from CAMHS services in these areas.

Do I have to take part?

No, you do not have to take part. It is completely up to you whether or not you take part in the study. Taking part or not taking part will not affect any future work that you may do with the CAMHS team.

Should you wish to, you can withdraw from the study before taking part, during your interview or up to two weeks after your interview. After this time, your interview will have been transcribed and anonymised and will be collated with the data from other interviews in the study. At this point, it may not be possible to identify and remove your information. If you would like to withdraw from the study, please contact the researcher directly.

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

If you do decide that you wish to take part, you will be asked to complete an opt-in form and return this to the researcher. Alternatively, you can contact the researcher by telephone to confirm that you would like to take part. Following this, the researcher will contact you by telephone to arrange to meet and carry out an interview to find out about your experiences of psychological consultation. This interview will last approximately 1 hour and will take place at the social work offices where you are based. With your consent, the interviews will be recorded on a small digital recorder so that I can listen back and transcribe them following the interview.

Will my information be confidential?
The information you provide will be confidential. However, there are some limits to this: if what is said in the interview makes me concerned that you, or someone else, is at significant risk of harm, then I would have to breach confidentiality. If this were to happen, I would discuss this with you first and would have to speak to your team manager to explain what you had told me and why I was concerned. This would then mean that what you had told me would no longer be confidential. At this point, you would be able to decide whether you would like the information to be used in the study or whether you would like to completely withdraw your information.

The data collected for this study will be stored securely and only the researcher conducting this study will have access to this data:

- Audio recordings will be stored securely as password protected computer files. Once the interviews have been transcribed and the transcripts checked, the audio files will be destroyed.
- During the study, hard copies of the opt-in forms and consent forms will be stored securely at Lancaster University.
- All computer files, including the anonymised transcripts, will be encrypted (that is no-one other than the researcher will be able to access them) and the computer itself will be password protected.
- The typed version of your interview will be made anonymous by removing any identifying information. This includes your name, the social care team you work in and the CAMHS team you had the consultation with. 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.
- At the end of the study, electronic copies of the transcripts, the opt-in forms and consent forms will be password protected and stored securely in a locked cabinet at Lancaster University for 10 years. At the end of this period, they will be destroyed.

What will happen to the results of the study?
The results of the study will be summarised and reported in a thesis as part of my Doctorate in Clinical Psychology. The report may be submitted for publication in an academic or professional journal. Once the report has been written up it will be shared with CAMHS so that they can get a better understanding of what social workers think about the psychological consultation that they offer.

Are there any risks if I take part in the study?
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, who can put you in touch with sources of support.

Are there any benefits to taking part in the study?
Although you may find participating interesting, there are no direct benefits to taking part.

Who has reviewed the project?
The study has been reviewed by the Faculty of Health and Medicine Research Ethics Committee, and approved by the University 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, then please contact the main researcher:

Kate Houlihan
Email address: [redacted]
Telephone number: [redacted]

You can also contact my supervisor for this project:

[redacted]
Email: [redacted]
Telephone: [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:

[redacted]

Email: [redacted]
Telephone: [redacted]

If you wish to speak to someone outside of the Clinical Psychology Doctorate Programme, you may also contact:

[redacted]

Email: [redacted]
Telephone: [redacted]

Sources of support

Should your interview bring up anything that causes you concern, you may find it helpful to speak to your supervisor about these issues. Alternatively, if you wish to speak to somebody outside of your organisation, you may find it helpful to contact your G.P. or a voluntary organisation such as the Samaritans (Tel: 08457 909 090, Website: www.samaritans.org, Email: jo@samaritans.org).

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

Appendix 4-C
Study Opt-In Form

LANCASTER
UNIVERSITY

DIVISION OF HEALTH RESEARCH
Doctorate In Clinical Psychology

Opt-In Form (Version 1)

Study title: An exploration of the role of psychological consultation for social workers who work with looked after children

Thank you for taking the time to read the information in this pack and for deciding that you would like to take part in my research project.

Please complete the information below and return it to me in the stamped addressed envelope enclosed in the pack. Once you have sent this back, I will contact you by telephone within two weeks to arrange your interview. Otherwise, my contact telephone number is on the information sheet and you can let me know by telephone that you would like to take part.

Name:

....

Social Care Team:

....

Contact Telephone Number *(I will use this to contact you to arrange your interview):*

....

Approximate time (number of months) since I accessed CAMHS consultation:

....

I confirm that I have read the information sheet and agree to taking part in the research study.

Signed:

....

Appendix 4-D
Consent Form

LANCASTER
UNIVERSITY
DIVISION OF HEALTH RESEARCH
Doctorate In Clinical Psychology

Consent Form (Version 1)

Study Title: An exploration of the role of psychological consultation for social workers who work with looked after children

I am asking if you would like to take part in a research project to find out about social workers' experiences of psychological consultation in relation to looked after children. Before you consent to participating in the study I 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, Kate Houlihan. I confirm that I have read the information sheet and fully understand what is expected of me within this study

1	I confirm that I have had the opportunity to ask any questions and to have them answered.	
2	I understand that my interview will be audio recorded and then made into an anonymised written transcript.	
3	I understand that audio recordings will be kept until the research project has been examined.	
4	I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.	
5	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.	
6	I understand that the information from my interview will be pooled with other participants' responses, anonymised and may be published	
7	I consent to information and quotations from my interview being used in reports, conferences and training events.	
8	I understand that any information I give will remain strictly confidential and anonymous unless it is thought that there is a risk of harm to myself or others. If this happens, the principal investigator will need to share this information with her research supervisor and my team manager.	
9	I consent to Lancaster University keeping written transcriptions of the interview for 10 years after the study has finished.	
10	I consent to take part in the above study.	

Name of Participant: Signature: Date:
Name of Researcher: Signature: Date:

Appendix 4-E
Semi-Structured Interview Topic Guide

Semi-structured interview – topic guide (Version 1)

Title of study: An exploration of the role of psychological consultation for social workers who work with looked after children

Opening:

Introduce the project to participant.

Please can you tell me a little bit about your role in this social care team?

(Prompts may include: What team are you part of? How long have you worked in this team? How long have you been qualified as a social worker? Without giving any specific details, could you tell me a bit about the work that you do with looked after children and their families?).

Experience of psychological consultation – broad questions/prompts:

Could you tell me about what prompted you to seek the consultation session?

(Prompts may include: When did you have the consultation session? How many consultation sessions have you had? How did you find out about the consultation service? How did the consultation session come about?)

Before the session, what thoughts did you have about psychological consultation?

- *Could you tell me about your hopes for the consultation?*
- *Could you tell me about your expectations of the consultation?*
- *Did you have any fears/concerns about the consultation session?*
- *How did you feel about using psychological consultation?*

Before the session, how did you make sense of your own feelings around the types of issues that you may come across in your work with looked after children?

- *Could you tell me about how you coped/managed the work that you were doing?*

Could you tell me about the consultation session(s) that you had with a CAMHS practitioner?

- *Can you remember the role of the CAMHS practitioner who offered the consultation (psychologist?)?*
- *Without giving specific details of a case, what did you use the consultation session to discuss?*
- *How did you make use of the time during the session?*
- *Can you tell me about how you felt during the consultation session?*

Could you tell me about how the consultation session fit with your hopes/expectations for it? How did you feel about the case following having the consultation session?

- *What was your thinking about the case following the consultation session?*
- *How do you make sense of the case now?*
- *Did this differ from how you thought about it before the consultation?*
- *What changed?*
- *If your thoughts about the case didn't change, why do you think that might have been?*

Earlier, you spoke about how you used to make sense of your own feelings around the work that you do with looked after children. Did you use the consultation session to think about your own feelings/coping? If so, could you tell me about your experience of having done this?

- *How do you make sense of your own feelings/how you cope with your work now?*
- *What changed?*

How did you use the information or advice following the consultation session?

- *Could you tell me about how you used the discussions from the consultation in your subsequent work with that child/family?*
- *Did it change how you worked with that child/family? How?*
- *Do you think that the child/family noticed any changes?*

Having had some time since the consultation session, how do you feel about it now?

- *Could you tell me about how you have used the content of the consultation session since?*
- *How do you make sense of your work with looked after children following having the consultation?*

Do you know if other members of your team have used the consultation service?

- *Have you spoken about the consultation to other social workers?*

Appendix 4-F
Ethics Application Approval Letter

LANCASTER
UNIVERSITY

Applicant: Kate Houlihan
Supervisors: Dr Suzanne Hodge
Department: DClinPsy

01 August 2013

Dear Kate and Suzanne,

Re: An exploration of the role of psychological consultation for social workers who work with looked after children

Thank you for submitting your research ethics 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 University Research Ethics Committee (UREC), I can confirm that approval has been granted for 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 (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 the Research Ethics Officer, Debbie Knight (01542 592605 ethics@lancaster.ac.uk) if you have any queries or require further information.

Yours sincerely,

Sarah Taylor
Secretary, University Research Ethics Committee

Cc Professor T McMillan (Chair, UREC); Professor Paul Bates (Chair, FHMREC)

Research Support Office
Research and Enterprise Services

Lancaster University
Bowland Main
Lancaster LA1 4YT
United Kingdom

Tel: +44 (0) 1524 592002
Fax: +44 (0) 1524 593229
Web: http://www.lancs.ac.uk

Appendix 4-G
Research Governance Approval Letters

[redacted]

[redacted]
Tel: [redacted]
Textphone: [redacted]
Web: [redacted]

Kate Houlihan
Division of Health Research
Doctorate in Clinical Psychology
Furness College
Lancaster University
LA1 4 YG

Reference number:	Please ask for:	Date:
[redacted]	[redacted]	22nd August 2013

Dear Kate

Re: An exploration of the role of psychological consultation for social workers who work with looked after children.

Thank you for contacting [redacted] Council about the above project.

We have looked through your research protocol and supporting documents and are pleased to confirm that we are happy for you to proceed with your project.

We hope the project goes well.

Yours faithfully

[redacted]

[redacted]

[redacted]

Children and Young People's
Department
[redacted]

Telephone: [redacted]
Direct Line : [redacted]
Fax: [redacted]
Email: [redacted]

To: Kate Houlihan
Please ask for: [redacted]
Tel ext: [redacted]

Dear Kate,

Re: Research Governance Approval

I am pleased to inform you that [redacted] Children and Young People's Department have approved your research project '*An exploration of the role of psychological consultation for Social Workers who work with looked after children*'.

The approval is subject to the following:

1. You inform us if you plan to make changes to the research methodology or extend the research to areas that you have not informed us about.
2. You provide a final report to [redacted] Council on completion of the research.

If you need any more information or advice please do not hesitate in contacting [redacted] on [redacted] or [redacted] who will be happy to assist.

Yours sincerely

[redacted]