

**Exploring Stakeholders' Perceptions of the Impact, Acceptability and
Feasibility of a Video-Feedback Intervention to Promote Positive Parenting in
Foster Care (VIPP-FC)**

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Thesis declaration form

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

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Overview

This thesis explores stakeholders' perceptions of the impact, feasibility and acceptability of the Video-Feedback intervention to Promote Positive Parenting for Foster Care (VIPP-FC). The first section of the paper involves a conceptual introduction to the literature on foster children and attachment difficulties. Specifically, this focuses upon the current context of foster care, outcomes of foster children, attachment and normal development, attachment patterns in foster children, reactive attachment disorder, treatments offered for attachment issues and the need to develop new foster carer interventions.

The second part of the thesis includes the empirical paper which presents findings from qualitative research involving key stakeholders on the VIPP-FC study. It explores their accounts of the impact, feasibility and acceptability of the VIPP-FC intervention. Thematic analysis allowed for similarities and differences amongst stakeholders to emerge relating to the barriers and facilitators of the study's design and implementation. The implications of the findings are discussed, ideas for improving implementation and sustainability are provided, as well as some of the methodological limitations of the research addressed.

The third and final section of this thesis includes a critical appraisal of the research process. The reflections and discussions included address the researcher's own perspective and its impact, challenges with recruitment, the process of developing and conducting interviews, issues with analysis, the strengths and weaknesses of the study, and clinical implications of the research.

Impact Statement

This study has several academic, research and clinical implications. It follows good practice guidelines for the development and evaluation of complex interventions as set by the Medical Research Council. Through the conducting of qualitative research with key stakeholders involved in the study's design and implementation we gain a better understanding of the successes and failures of the study and can utilise this information to improve large-scale future trials. To date many RCTs fail to routinely carry out this type of "research on the research" and when the research has been completed, rarely has it been documented for shared learning. The richness of the data gathered from this project relating to the barriers and facilitators to the study's acceptability and feasibility, reiterates the importance and potential usefulness of conducting this type of work prior to and during a study's implementation. The accounts of stakeholders also identified key areas for future research development which may improve the recruitment to and engagement in this RCT.

Clinically this is the first U.K. RCT to be conducted that specifically addresses attachment difficulties in foster children. Currently the NICE guidelines for looked after children (LAC), are based upon recommendations from research involving the general population. The literature highlights time and again that LAC have unique difficulties and characteristics given their unusual contexts and early adverse life experiences, and they emphasise the need for interventions to be tailored to address these. Therefore, if this study is shown to be feasible and acceptable, it can then be replicated on a larger scale and would go on to become the first evidence-based intervention to meet the attachment difficulties of foster children and can inform future NICE guidelines.

The preliminary findings of the research seem favourable for the VIPP-FC intervention, with many stakeholders reflecting that foster families have enjoyed it and the study has been well received. The challenges that this study identifies in the implementation of the program can guide the necessary adaptations and modifications that need to take place in order to ensure the intervention is feasible and sustainable within Local Authority contexts. If these recommendations can be adopted and the intervention is shown to be effective in supporting LAC with attachment difficulties, then it may reduce some of the potential negative future trajectories and psychopathology often predicted for foster children.

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PART ONE: Conceptual Introduction

An introduction to the literature on Attachment and Foster Care

Abstract

This introduction aims to outline the current foster care system within the U.K., drawing attention to some of the contextual issues it is facing, and the impact this can have upon looked after children (LAC). It focuses specifically on the prospective trajectory for many young people in care across several domains including education, crime, mental health and relationships. The prevalence of socioemotional difficulties is higher amongst these children compared to the general population and it is thought that this can be somewhat mediated through the development of positive attachments. Therefore, emphasis is placed upon examining the development of relationships within the care context. This is addressed by reviewing the literature on LAC's attachment and interpersonal difficulties, as well as the common types of attachment styles, with a specific focus on Reactive Attachment Disorder (RAD). Current recommended treatments offered to address such difficulties and gaps in the provision of interventions for LAC with RAD is discussed. A brief evaluation of the potential benefits and barriers to developing research to address these issues is conducted, with a specific focus placed upon stakeholders' perspectives as being a key mechanism for success.

1. Introduction

1.1 Foster Care System in the U.K.

In the U.K. children who have been in the care of their local authority for more than 24 hours are described as “looked after children” (LAC) or “children in care” (NSPCC, 2018). Once a child becomes “looked after” they are usually placed in one of three main care settings: with a foster carer, in a residential home/school or secure unit, or placed in kinship care i.e. with an appropriate relative.

Fostering can be defined as a care option for children who have been removed from the family home and placed with a foster carer who provides temporary care and support to the child. Durations of foster placements can vary from short to longer term.

In the U.K. the current process for removing a child from the home begins when the local authority (L.A.) has a significant concern about the safety or wellbeing of the child. They must then decide whether it is necessary to begin care proceedings and apply for a “care order” whereby, if granted, the council assumes parental responsibility for the child and can determine where a child should live.

At the beginning of proceedings, the L.A. may apply in family court for an interim care order lasting up to 8 weeks, which allows the local authority to take the child into care on a temporary basis. It can take up to 26 weeks, or longer, for the court to then decide what will happen. During this time a social worker, an officer from the Children and Family Court Advisory and Support Service and other professionals in the network will be trying to understand why a child may be at risk. Based on the information they gather they will then write a report to the court

detailing their findings. Once all information is gathered a court hearing is held and a decision made about the future of the child. (gov.uk)

In the U.K. when a child is first placed in care, an integral part of ensuring the child's needs are being met involves a named social worker creating a care plan which focuses upon assessing their physical, emotional and mental health needs and identifying ways in which to address and improve these (Department for Education, 2015).

1.2 Context around the child

In 2016-17, local authorities spent £1, 701 billion on their fostering services. Of that £1.7 billion, £102million was spent on children placed with family and friends carers. The remainder, around £1.60 billion, was spent on children placed with foster carers who the child does not know (Narey & Owers, 2018).

The introduction of the Every Child Matters agenda (2003) and the Children's Act (2004) provided a framework for services to support children's development. More recently the government has begun to recognise the importance of a child's early years as a key period for wellbeing and healthy development. They have started introducing policies and guidelines which focus more specifically on these crucial time points; one such example being the adaptation of the Children's Plan (2007).

The Children's Plan was developed by the Department for Children, Schools and Families as a ten-year strategic objective that aims to improve children and young people's lives. It sets six main goals for the Department to meet; safeguard children and young people, meet world-class standards, secure the health and wellbeing of children and young people, close the gap in educational achievement,

keep children and young people on the path to success, and ensure they are achieving their full potential (Department for Children, Schools & Families, 2007). However, despite this there is still significant uncertainty over the provision of services for LAC, namely what ought to be offered, when, and to whom.

Local authorities face several challenges in the current climate with regards to foster care. One of the major issues is that the number of children requiring a foster care placement is increasing at a much faster rate than the number of foster carers available. In 2015 the Fostering Network in the U.K. estimated that the shortfall of foster carers in England was approximately 5,900. Although research clearly highlights the need to match these vulnerable children with appropriate carers, it appears that placements are still supply- as opposed to needs- led (Narey & Owens, 2018).

There has also been increasing pressure placed on L.A.s to view foster caring as a profession, due to the high level of skill and time required. Whilst many view the professionalisation of the role as acknowledging the impact foster carers have on the development of the child or young person, the government issued a statement in July 2018 expressing that a change to the status of a foster carer would detract from the “family-centred nature” of fostering. They also emphasised that it would require significant changes in the care system structure and result in having yet another “professional” involved in the life of that child. However, if foster carers feel undervalued then this may impact upon their willingness to offer placements which leads to another pressing concern; difficulties with foster carer retention and placement stability.

Bronfenbrenner (1977) in his ecological model highlighted the importance of environmental experiences, and how the way in which a child (with their own individual characteristics) interacts with their environment can significantly impact their development. The removal of a child from their home and placement into foster care is considered a traumatic event, often with an impact that can be as great if not greater than the abuse that precipitated the removal (English, Thompson, & Roller White, 2015). There is a consensus amongst foster care researchers that placement stability promotes positive outcomes (i.e. resilience, secure attachment, better educational outcomes etc.), and that the quality of the relationship between the foster carer and child is a significant determinant of this (Dozier & Lindheim, 2006). However, placements frequently do not last as long as planned i.e. they “breakdown”. Minty (1999) estimated that between twenty and fifty percent of foster placements result in a breakdown and a new placement is required.

Despite placement instability contributing to poorer outcomes for LAC, L.A.s continue to adopt a more reactive response to difficulties in placements, often waiting until a crisis arises and then intervening, rather than taking a preventative approach, such as focusing upon training professionals and foster carers in specific skills to help support these young people. The Munro Report (2010) of Child Protection has called for social services to review and redesign how they deliver child and family social work. It emphasised that through the adoption of more evidence-based programs we could improve placement stability. The report also highlighted the need for social work systems to shift towards an early detection and prevention model. This echoes a recent systematic review conducted by Steenbakkers, Van Der Steen and Grietens (2018) who stressed that much of the

legislation, policies, and research around foster children appears to be focused upon problems they present with, instead of taking a more holistic, needs based approach.

Since the publication of the Munro Report (2010) social work systems in the U.K. are embarking upon a period of unprecedented change. This has led to a significant churn and turnover in staffing which in turn has created an overreliance on less experienced staff and increased caseload (Antonopoulou, Killian & Forrester, 2017). Instead of improving the situation, it is currently resulting in service disruptions (Travis & MorBarak, 2010), which may lead to foster carers feeling less supported, and potentially negatively impact upon placement stability.

1.3 Needs of Children in Foster Care

Extensive meta-analyses have found that foster children perform less well than children in the general population across multiple domains including, but not limited to, cognitive and adaptive functioning, behavioural functioning (particularly externalising behaviours), and report a higher frequency of behavioural problems overall (Goemans, van Geel, van Beem & Vedder, 2016).

1.3.1 Education

A recent systematic review of educational outcomes for children who grew up in foster care found that foster children had disproportionately lower educational outcomes than their peers (Gypen et al., 2017). Resonating with this, an earlier meta-analysis by Scherr (2007) demonstrated that foster children were unduly represented in special education, had high rates of grade retention and experienced exclusion at higher rates than their peers. In the U.K. foster children are four times more likely to have a special educational need than their peers, and almost ten times more likely to require an Educational Health Care Plan (Department of Education, 2017). Overall

their reported academic attainment is lower, whilst the rate of permanent school exclusion is higher.

Children who leave foster care as young adults experience higher levels of responsibilities when they live independently largely due to reduced social support, and increased dependence on themselves (Harris et al., 2009, Naccarato et al., 2010, Pecora et al., 2006). These care leavers have been consistently shown to have lower employment rates (Dworsky & Courtney, 2009), more unstable employment, and lower incomes (Hook & Courtney, 2011) than the general population.

The reasons for these poorer outcomes are less well documented, and the inconsistency and heterogeneity of findings is perhaps reflective of the complexity of the looked after population. Some researchers propose that possible negative predictors of success may include early life maltreatment and frequent placement changes associated with being in care (Gypen et al., 2017). However, many of these studies relied heavily upon self-report measures of maltreatment and smaller samples sizes.

Recently, O'Higgins, Sebba and Gardener (2017) tried to systematically explore potential factors which could be influencing academic achievement in fostered youth. There appeared to be a consensus amongst researchers that being male gender and from an ethnic minority were both predictors of poorer academic outcomes, and that having a supportive caregiver involved in the foster child's education was a positive predictor of higher academic attainments (O'Higgins et al, 2017). Interestingly, despite LAC having local authorities acting as corporate parents and being under the care of a large and fluctuating social care system, no studies

examined the relationship between wider policy or structural factors and educational outcomes.

Nonetheless, what remains consistent across the literature is that greater educational success is linked to better long-term outcomes (O'Higgins et al, 2017). Therefore, for LAC there is a need to develop strategies to interrupt these negative trajectories, and it would seem that the presence of a responsive caregiver who takes an interest in that child's education may be a cost-effective way for the government to raise the educational outcomes and future life trajectories for this group.

1.3.2 Offending

In 2017 looked after children in the U.K. were five times more likely to offend than other children (Ministry of Justice, 2017). Whilst most children in care do not commit offences, there appear to be multiple shared risk factors between looked after care and offending pathways (Darker, Ward, & Caulfield, 2008).

Corrado and Freedman (2011) theorised that there are five key risk factors for chronic youth offending, two of which, poor school performance and residential mobility, are often prevalent amongst looked after youth. As illustrated previously, LAC have been widely documented to have lower educational outcomes than their peers. This combined with the transitory nature of many of these children's lives may place them in a position of increased vulnerability and susceptibility to offending.

Placement instability and frequent changes in schooling can impact negatively upon LAC's opportunities for socialisation and development of positive peer relationships. This may mean that these youths are then at an enhanced risk of falling in with antisocial peers, as often these groups are generally more willing to

accept new members than their more prosocial peers (Haynie & South, 2005, Farrington et al., 2008).

The environment of LAC, not just in terms of placements and stability, but also in relation to their early home life, plays a significant role in mediating the risk for offending. Early adverse environments which have been neglectful or insensitive, particularly if coupled with violence, means that many of these children have developed an increased sense of hyper-vigilance to threat (Perry, 1997). In these cases, impulsivity can be viewed as an adaptive strategy for reacting to danger (British Psychological Society, 2017), and their fight or flight mechanism as an adaptive behaviour for coping with danger. These strategies, sometimes including the use of violence, are often functional in terms of survival or adaptation at the time (Rogers et al., 2015). However, it may also place them in a position of increased vulnerability to persistent hostile attribution biases (Dodge, 2006), difficulties in social relationships and future risk of violence.

Social Cognitive theory (Bandura, 1986) posits that learning is a dynamic and interactional process between the individual, their behaviour and the environment. It places an emphasis on the influence of an individual's past experiences on the likelihood of their engagement in a behaviour. An underdeveloped social cognition is frequently found in maltreated individuals as they may not have had the appropriate modelling or opportunity to develop their abilities in recognising, understanding and thinking about emotions in interpersonal and wider social contexts (Moskowitz, 2005). Social cognition has been suggested to be a mediating factor between abuse and later offending (Dodge, 2006).

For children in care many of these social cognition skills can only emerge in a context of trusting relationships in which anxiety is reduced and an emotional education becomes possible (Schofield, Biggart, Ward & Larsson, 2015). However, for some the shift between placements, and feeling unequipped to navigate social settings means that often they have reduced anchors to prevent them from engaging in antisocial behaviours (Corrado & Freedman, 2011).

1.3.3 Mental Health and Emotional Wellbeing

According to the Centre for Disease Control and Prevention (2017) children's mental health can be defined as "children's developmental, emotional and behavioural conditions, and social skills".

It has been widely documented that LAC have poorer mental health outcomes than their peers (Leslie et al., 2000; Sawyer, Carbone, Searle, & Robinson, 2007). In the developed world more than half the children in foster care will have a measurable need for mental health services (Tarren-Sweeney, 2014). A large national British study comparing LAC with children living in private households, found that LAC experienced higher levels of psychopathology, educational difficulties and neurodevelopmental disorders, and "looked after" status was independently associated with nearly all types of psychiatric disorder after educational and physical factors had been adjusted for (Ford, Vostanis, Meltzer, & Goodman, 2007).

The study demonstrated that specifically, fostered children had higher rates of attention deficit hyperactivity disorder, adjustment disorders and depression when compared with other children (Ford et al., 2007). These children have elevated risk for behavioural problems, which often stemmed from trauma or maltreatment and

were associated with placement disruptions, delinquency and substance abuse (Washington et al., 2018). They were also more likely to present with pervasive deficits in relationships (Green, 2003) and higher prevalence of post-traumatic stress disorder and conduct disorder (Ford et al., 2007). Not only have foster children been shown to have a higher prevalence for mental health difficulties, but these problems are also more likely to significantly impact upon their daily functioning (Vinnerljung & Hjern, 2011).

In the last decade researchers have become more interested in the role of placements and their potential impact upon LAC's mental health. Winokur and colleagues' (2014) meta-analysis demonstrated that children in non-kinship care were twice as likely to have a mental illness as those placed with relatives. Some researchers adopting an attachment perspective reason that perhaps the reduction in attachment disruptions through children being placed with adults where there are already established bonds may be an explanation for their better mental health outcomes (Shlonsky & Berrick, 2001). However, when an updated synthesis of the literature was conducted in 2018 as part of Xu, Bright and Ahn's systematic review, the results were less conclusive. For studies that used univariate and bivariate comparisons children in non-kinships placements displayed poorer mental health outcomes. Yet, when more statistically advanced regression analyses were conducted the results were mixed. This may be partly due to differences in design and the influence of confounding variables (Xu, Bright & Ahn, 2018).

Nonetheless, there is a belief amongst clinicians that mental health difficulties in LAC differ from those found in ordinary clinical practice (Minnis et al., 2009). Many of the mental health diagnoses for LAC are made based on standard mental health measures, however if we adopt an ecological approach and think about

the adverse environments many of these children grow up in, many of their behaviours become understandable as means for survival or responding normally to abnormal circumstances. Furthermore, many LAC have multiple co-morbidities and extensive impairments across multiple domains that whilst significant, may not meet diagnostic thresholds.

This is partly why it is widely cautioned (O'Connor & Rutter, 2000; Minnis et al., 2006; DeJong, 2013) against using ordinary standard mental health measures in clinical practice for LAC. Despite this there remains no universal, standard assessment measures for use with these children (Tarren-Sweeney, 2009). Many Local Authorities are still reliant upon the Strengths and Difficulties Questionnaire, which despite reasonable reliability and validity (Goodman, 2001), does not address the contextual influences which potentially affect looked after children's socioemotional wellbeing so significantly or capture accurately their varied social and emotional difficulties.

The current organisation of many Child and Adolescent Mental Health Services (CAMHS) around diagnostic-led criteria (DeJong, 2010) can therefore present significant difficulties for those working with these children trying to access appropriate services to meet their needs (Bellamy et al., 2010). The broader mental health difficulties of LAC are often poorly recognised and met (Golding, 2010). Child social workers and foster carers are the gatekeepers to children accessing mental health services (McHugh, 2015), yet they are often not provided with the necessary information and training to detect these mental health difficulties (Woodcock Ross, Hooper, Stenhouse & Sheaff, 2009). Perhaps the focus needs to shift from mental health being viewed as the mere absence of a diagnosable psychiatric disorder and instead focus upon psychological adjustment more broadly.

In addition, more rigorous research needs to be conducted on appropriate measures for this population.

1.3.4 Relationships

The Care Inquiry (2013) stressed the centrality of relationships for children in care, referring to relationships as the “golden thread” in these children’s lives and the lens which we should look through in care planning. Nevertheless, there is still little guidance and regulation for foster carers on appropriate means of displaying affection, resulting in many foster carers being fearful of expressing affectionate care due to potential retributions (Narey & Owers, 2018).

As much as half of the population of LAC will meet clinical threshold for interpersonal difficulties and possess behaviours indicative of attachments disorders (Tarren-Sweeney, 2014). There is collective agreement that the continuity and security found in close relationships is a protective factor for mental health and wellbeing (McHugh, 2015). An eight-year longitudinal study of 59 children in foster care in Australia found that the greater the length of time children in long term foster care spent with foster families, the better their ratings across adjustment, integration, academic attainments, behaviour and satisfaction (Fernandez, 2009). This links with research conducted by Tarren-Sweeney and Vetere (2014) which found that felt security in placements is important for healthy psychosocial development and is associated with more positive mental health outcomes for children in care.

Sensitive caregiving can lower the risk of depression in foster children (Guibord et al., 2011), reduce the risk of offending by providing a trusting relationship for them to develop their emotional education (Schofield et al., 2015), improve educational outcomes (Sebba et al., 2015) and help prevent mental health

difficulties (Steenbakkers et al., 2018). However, the importance of relationships goes beyond just the primary child and caregiver relationship.

Young people in the care system identified the need for continuity in relationships with professionals in their network and highlighted the impact multiple placements can have upon friendships and developing peer relationships (Mc Elvaney et al., 2013). Nonetheless, funding cuts and the subsequent strain placed on professional teams has led to what the government reports (2018) as a “churn” of children’s social workers. These children have experienced greater exposure to biological and social adversity (Tarren-Sweeney, Hazell, 2006) than most, and despite research emphasising the importance of reliable and stable relationships, children in foster care often struggle to find this within their own professional network.

2. Attachment and Development

In order to fully understand the potential interpersonal difficulties faced by many children in foster care, it is necessary to first turn our attention to their development, and experiences of early relationships. Through learning about how foster children form relationships we can gain an insight into why difficulties may arise and develop more effective interventions to ameliorate this process. Adopting an attachment-based perspective is crucial for guiding this discovery.

Attachment as proposed by Bowlby (1980) is an evolutionary and developmental phenomenon which begins in the first year of a child’s life. It refers to a child’s natural tendency to attempt to maintain proximity to their primary caregivers, and to selectively seeking comfort from them at times of distress. These early experiences with primary attachment figures lead to generalised expectations

and beliefs (“internal working models”) about self, the world, and relationships. In this way, the parent-child relationship can be viewed as a prototype for future patterns of relating (Bowlby, 1980).

A child’s attachment style is often viewed as being largely influenced by environmental factors and parental behaviours; however, attachment has also been shown to be impacted by genetic factors as illustrated by numerous twin studies (Sherlock & Zietsch, 2018). For example, Fearon and colleagues (2014) examined attachment in 551 pairs of teenage twins using the Child Attachment Interview and found that 40% of variance was explained genetic influences. Therefore, in thinking about attachment patterns and how these are shaped, one needs to hold in mind both nature and nurture, and the interaction these may have.

The first few years of a child’s life have been emphasised as being the most crucial for development. The brain is at its most adaptable for the first two years after birth. It grows in volume, increases in grey matter, and maturation begins to occur allowing for behavioural developments and milestones to be met (Yin et al., 2019). Arguably the single most essential task an infant engages in during this period is creating a secure attachment bond of emotional communication with their primary carer (Schore & Schore, 2008).

The role of the primary caregiver during this period is to act an external psychobiological regulator i.e. the caregiver responds to arousal levels and changes in infant affective states (McHugh, 2015), and from this the infant learns to regulate their own emotions and tolerate stress (Schore, 1996). This ‘serve and return’ relationship is thought to be one of the key components for healthy attachments (National Scientific Council on the Developing Child, 2004; 2007). Caregivers who

are poor readers of these affective cues compromise the child's healthy psychosocial development (Fonagy et al., 2002), as it is these early experiences of co-regulation which go on to shape a child's personality and adaptive capacities, mentalization capacities, as well as vulnerabilities and resiliencies to future psychopathologies (Schoore, 1994).

Not only is the attachment relationship thought to be key for psychosocial functioning, but it has also been found to impact upon structural brain development (Zeanah & Gleason, 2015). Studies have found that there are reductions in grey and white matter in children who have experienced little to no caregiver involvement, having grown up in institutionalised settings (Eluvathingal et al., 2006; Mehta et al., 2009; Sheridan, Fox, Zeanah, McLaughlin, & Nelson, 2012). However, a positive caregiving environment has been shown to help remediate some of these deficiencies, as Vanderwert et al (2010) found that children who had been severely neglected showed normalisation of brain functioning by aged 8 when placed in foster care before 24 months.

2.1. Attachment Patterns across Normative, Maltreated and Foster Care Populations

As attachment can be viewed as an essential ingredient for healthy human development, it is therefore necessary that we focus upon learning about the types of suboptimal attachment patterns in foster children and why they may develop. Only then can we design interventions that are suitable and effective for supporting and improving the attachment difficulties many of these children experience.

Ainsworth in her later work began to identify variations in attachment patterns, suggesting that there are three main patterns of attachment – secure,

insecure avoidant and insecure ambivalent (Ainsworth, Blehar, Waters & Wall, 1978).

Secure attachment is expressed by children feeling protected and safe with their caregiver and having an appropriate balance of the attachment behaviours of proximity seeking and exploration. Gearity (2005) suggested that secure attachment has two main goals; to establish a basic sense of trust in the world, and for the allowance of emotional regulation. It is widely accepted that for a child to feel securely attached, the relationship with the caregiver must be predictable, which often comes from the caregiver's abilities to be sensitively attuned to the infant's needs, interpret these correctly and respond promptly and appropriately (Schore & Schore, 2008).

Children who are securely attached are likely to have better internal working models, which will help them to form secure, healthy relationships throughout the lifetime (Fearon et al., 2010). It is generally acknowledged amongst attachment researchers that having a secure attachment is protective against the development of psychopathology (Sroufe, 2005). A pivotal longitudinal study in U.S.A following children from 12 months to preschool examining their attachments and behaviours, found that secure children scored lower than insecure children on assessments of behaviour problems (Erickson, Sroufe, & Egeland, 1985).

In contrast to those who are securely attached; children with avoidant attachment styles do not readily seek comfort from their primary carer and often operate very independently of their caregiver. These children frequently have parents who discourage overt signs of affection (Karen, 1994), and who are absent or non-responsive at times of distress.

For the avoidant child, their early experiences promote a view that they are isolated and unworthy of care. This attachment subtype is one of the few to be associated with both externalising and internalising problems as shown in a recent meta-analytic review by Groh and colleagues (2017) on attachment in early life and its role in socioemotional development. These children may be wary of forming relationships and at times when they most need support from others, they may fail to seek comfort as healthy relationships are foreign to them (Sroufe, Carlson, Levy & Egeland, 1999).

Another similar style of insecure attachment is found in the ambivalent/resistant child. They receive inconsistent parenting, with the child never certain whether their distress will be suitably attended to (Malekpour, 2007). For these children exploration can feel too unsafe an option as they do not have predictable care or nurturance if anything were to go wrong.

Insecure attachments have been associated with a wide range of mental health difficulties throughout the lifespan (Mikulincer & Shaver, 2012). This is often thought to be somewhat influenced by needing to learn to develop defences for emotions which would have facilitated effective communication and exchange (Carlson & Sroufe, 1995). Consequently, when stressed or in distress these children are unable to appropriately signal or seek out support. These children are also more likely to struggle in peer relationships as demonstrated by Groh et al's (2014) meta-analysis exploring the significance of attachment security on peer competence. Their results suggested that an insecure attachment relationship in early childhood, regardless of subtype, is negatively associated with children's peer competence and this does not wane in magnitude from infancy to adolescence. These findings also

provide some support to claims that early attachment is associated with children's mental health in enduring ways (Groh et al., 2014).

It is estimated that among samples of children who have experienced abuse or neglect less than twenty percent will have a secure attachment pattern (Lang et al., 2016). Due to their adverse early life experiences, numerous children in foster care will exhibit attachment behaviours which reflect insecure histories. These internal working models may interfere with their abilities to form new secure attachments (Bovenschen et al., 2016), which in turn may also reduce their abilities to resolve and repair the sense of grief, anger and distress felt by the loss of the primary caregiver (Bowlby, 1969).

As these concepts of attachment began to be more commonly used in practice, it emerged that there were children whose attachment behaviours did not fit into any of the three proposed categories, and from this an additional style emerged, commonly referred to as "disorganised" attachment (Main & Solomon, 1986). These are children whose parents often have unresolved traumas and have little capacity to attend to their children's needs. Biologically the infant is impelled to seek proximity and nurturance from their caregiver; however, these caregivers are often a source of fear for the child, which may stem from their frightening behaviour or neglect (Malekpour, 2007).

Disorganised attachment or disorganised attachment disorder (DAD) has drawn significant attention over the decades for its perceived clinical relevance. Children with disorganised attachment styles are viewed as higher risk for maladaptive outcomes across numerous developmental domains, including but not

limited to, increase in externalising behaviours, psychopathology, interpersonal difficulties, and dysregulation (Facompré, Bernard & Waters, 2018).

A meta-analytic study examining attachment security and disorganization in maltreating and other high-risk families found that although only ten studies specifically focused upon maltreated children, they still demonstrated large effect sizes for being less secure ($d = 2.10$) and more disorganized ($d=2.19$) than other high-risk children (Cyr, Euser, Bakersman-Kranenburg & van Ijzendoorn, 2010). Approximately 90% of children in foster care have been abused or neglected (Minnis et al., 2001) which places them at higher risk for developing disorganized attachments. Their adverse early experiences of relationships may also mean that these children may exhibit behaviours which ostracise them from their new caregivers. However, if foster carers can continue to provide a healthy, secure base to these children it can act as a buffer against the impact of these harmful experiences. As Bovenschen et al's (2015) study of pre-school foster children's attachment behavior and neural circuit development after removal from adverse environments showed; it is the characteristics of foster carers rather than children's pre-placement experiences which can determine attachment security on a behavioural level.

Yet, whilst these findings are interesting, much of the research conducted on the impact of attachment difficulties on psychopathology have had inconsistent results. Furthermore, these studies focus on common patterns of attachment insecurity, rather than the more extreme deviations in attachment development that are often observed in children who have been raised in care.

2.2 Issues with Detecting Attachments Difficulties in Foster Children

Children in foster care often present with difficulties across several domains and less frequently do they meet specific thresholds for diagnoses, however, their impairment is often far greater (DeJong, 2010). Diagnostic categories are usually based upon data and research within a normal population; yet children in foster care often differ significantly from their peers. This is largely because they are subject to a very particular kind of adversity; ruptures to the primary caregiving relationship (DeJong, 2010), which is often further compounded by other forms of adversity, and highly atypical psychosocial experiences i.e. placement with multiple carers etc.

Contributing to the growing concern that the current attachment diagnostic criterion is inadequate to support clinicians working with the looked after population, Woolgar and Baldock (2015) conducted a case review of one hundred specialist and community referrals for adopted and foster children referred to specialist Tier 4 CAMHS service. They found that attachment disorders were identified four times more frequently than common disorders in these populations, however referrers rarely used the appropriate diagnostic terms of Reactive Attachment Disorder (RAD) or DAD, instead providing generic descriptions for their diagnoses. The authors suggest that perhaps the under-identification of more common disorders and an over-identification of attachment disorders in these children is partly due to confusion surrounding standard appropriate frameworks for assessment and diagnoses of attachment difficulties (Woolgar & Baldock, 2015).

2.3. The Emergence of RAD

The RAD diagnosis emerged from studies of children in institutionalised settings who were largely unable to form selective attachments to caregivers (Zeanah & Smyke, 2008). A key feature of the diagnosis was pathogenic or neglectful care.

In the original studies, they described two key subtypes of RAD; inhibited/emotionally withdrawn, and disinhibited/indiscriminate. For children with the inhibited type they display minimal attachment behaviour even at times when it would be appropriate. In contrast children with disinhibited RAD seek comfort and proximity from unfamiliar adults (Stineheart, Scott, Barfield, 2012).

However, in the latest version of the Diagnostic and Statistical Manual of Mental Health Disorders 5 (American Psychiatric Association, 2013), RAD has been reclassified and through this re-operationalisation, another distinct disorder known as Disinhibited Social Engagement Disorder (DSED) has emerged. DSED is characterized by a disinhibited display in social interactions and attachments with unfamiliar adults in a child of at least 9 months. It must include two of the following behaviors: reduced or absent reticence in approaching and interacting with unfamiliar adults, overly familiar verbal or physical behavior not consistent with culture or age-appropriate social boundaries, diminished or absent checking back with adult caregiver after venturing away, even in unfamiliar settings, or willingness to go off with an unfamiliar adult with minimal or no hesitation. These behaviors must not be limited to impulsivity that could be associated with attention deficit/hyperactivity disorder but rather include socially disinhibited behavior (American Psychiatric Association, 2013).

In contrast, RAD is described as a pervasive absence of attachment behaviour by young children towards their carers, combined with highly withdrawn and fearful behaviour, and emotional volatility (American Psychiatric Association, 2013). RAD affects social relationships and has the potential to impair a child's social, cognitive

and emotional development (Millward, Kennedy, Towlson & Minnis, 2006). RAD usually manifests before the age of 5 (American Psychological Association, 2000).

Whilst RAD can be seen as a tool to aid professionals and those in a child's network in their understanding of that child's needs, it also remains one of the least evidence-based areas of the DSM and International Statistical Classification of Diseases and Related Health Problems (Kay & Green, 2013). Part of this issue relates to the origins of RAD, as in Western societies it is unusual to see the classic post-institutionalisation picture that the disorder emerged from (DeJong, 2010). The second is connected to the difficulties encountered in trying to obtain an accurate clinical assessment of RAD. Many of the tools used are only applicable to children up to the age of five, and even those under five, as Minnis and colleagues (2009) highlighted in their study on foster children's attachment (based on a RAD questionnaire and the stranger situation); over a quarter of children who met criterion for RAD were rated as securely attached in the Strange Situation. Indicating that there are potentially major issues with the reliability and validity of measures, and indeed the operationalisation of RAD itself.

3. Treatments

3.1. Current Recommended Treatments for Attachment Difficulties

Bakermans-Kranenburg and colleagues (2005) conducted a narrative review and quantitative meta-analysis of 15 preventative interventions for disorganised attachment. They found that interventions with the most positive effects occurred after the child was six months, suggesting that there is an optimal time point in a child's development to intervene and aid the formation of child-caregiver attachment. Their research also emphasised the importance of sensitivity-based

approaches as opposed to broader focused interventions, for reducing attachment disorganization.

More recently Mountain, Cahill and Thorpe (2017) undertook a systematic review and meta-analysis to explore sensitivity and attachment-based interventions for infants, and like Bakermans-Kranenburg et al (2005), they found that early interventions which focus on the importance of parental behaviour during the first few years of a child's life, improved attachment security and maternal sensitivity.

Wright and Edington (2016) also conducted a systematic review and meta-analysis of evidence-based interventions to promote secure attachment. They focused upon randomized control trials (RCTs) of parenting interventions and found that those which centred on maternal sensitivity were clinically effective in promoting secure attachment in children. Anisfield and colleagues (1990) illustrated that for infants under 12 months, who were carried daily by mothers in a bid to promote physical closeness and maternal sensitivity, had more secure attachment at 12 months than controls. In addition, Preventive Psychotherapeutic Intervention Program by Brisch and colleagues (2003) was found to protect neurologically unhealthy children from forming insecure attachments.

An RCT of a Home Visiting Intervention (van Doesum, Riksen-Walraven, Hosman & Hoefnagels, 2008) aimed at the prevention of relationship difficulties between mothers with depression and child, involving video feedback (VF), was shown to have positive impacts upon the quality of mother-infant interaction. These improvements were maintained at 6 months follow-up and infants receiving the intervention also had higher levels of attachment security post intervention (van Doesum et al., 2008).

For toddlers above 12 but below 60 months, Toddler-Parent Psychotherapy (Cicchetti, Toth & Rogosch, 1999) for mothers with post-natal depression was found to produce higher security of attachment than their two control groups. There were no statistically significant interventions found to improve secure attachment beyond 60 months (Wright & Edington, 2016), reiterating the suggested importance of intervening early and how crucial the first few years of development are.

A recent meta-analysis conducted by Juffer and colleagues (2017) found that the most effective interventions for increasingly maternal sensitivity and improving attachment were those with a focused behavioural approach aimed at parental sensitivity. The use of interventions which had video feedback (VF) components were highlighted as potentially effective non-invasive ways to improve parental sensitivity. These ideas are in keeping with Bakermans-Kranenberg et al's (2003) extensive meta-analysis of attachment-based interventions which found that interventions involving video-feedback were more successful in improving sensitive parenting than those without. This was later demonstrated again by Fuk-kink (2008) whose meta-analysis illustrated that VF produced statistically significant improvement in parenting sensitivity, parenting behaviour and attitudes and child development for children aged 0–8 years.

Therefore, largely considering the evidence described above, NICE guidelines (2016) recommend that for children and young people who may have attachment difficulties, VF interventions should be the first port of call.

3.2. Video-feedback Interventions

The general aim of VF is to increase parents' confidence and competence in their parental abilities by providing constructive feedback (Wirtberg et al., 2013).

One of the core proposed mechanisms for change is in the watching of one's self on video as it is thought to engage parents in reflecting upon their internalized view of their child and their own attachments, and by doing so become more sensitive and attuned to their child (Dowrick, 1999; Fuk-kink, 2008; Juffer & Steele, 2014; Steele et al., 2014).

Video Interactive Guidance (VIG) is a VF intervention based upon the concepts of intersubjectivity, attunement and mediated learning (Kennedy, Ball & Barlow, 2017). In VIG the client is encouraged and supported to reflect on video clips of their own successful interactions. The approach takes the view that change can be achieved more effectively in the context of a collaborative, empowering relationship than a didactic 'teaching' relationship. It focuses upon strengths and skills rather than areas of deficit.

In a non-randomised pre-post study Kennedy, Landor & Todd (2010) examined the outcomes of VIG as an intervention to promote early attachments in families who were considered hard-to-reach. They found that at baseline 25% of the VIG intervention group were scoring in the 'good enough' range on the Care-Index (Crittenden, 2005), a measure of parental sensitivity, whereas post intervention 87.5% were considered 'good enough'. Of course, without a control group it is difficult to know whether these changes were a result of the intervention per se, but the substantial change suggests that this may be a promising intervention for improving parental sensitivity.

Like VIG, Video-Feedback to Promote Positive Parenting (VIPP) which hails from the Netherlands, is one of the best known and most validated evidence-based VF programs, designed for at-risk parents and vulnerable children under the age of 5

(Juffer et al., 2017). VIPP draws inspiration from attachment theory, whilst also interweaving work conducted by Stern (1985) about “speaking for the child”, as well as Carter, Osofsky and Hann’s (1999) concepts on enhancing parental empathy for infant’s distress signals. It focuses upon emphasising parents’ strengths, improving sensitivity, emotional availability and therefore increasing the likelihood of positive parent-child attachments.

Studies using the VIPP approach have shown positive effects on parental sensitivity both in nonclinical (Juffer, Bakermans-Kranenburg, & Van IJzendoorn, 2005) and at-risk, clinical groups (Klein Velderman, Bakermans-Kranenburg, Juffer, & Van IJzendoorn, 2006). There were also improvements in infant’s security of attachment and a reduction in externalising behaviours (Juffer et al. 2008).

3.3. Current Treatments Offered for Foster Children

It has been suggested that the negative consequences of traumatic early life experiences often seen in children in foster care are possible to reduce or reverse through appropriate and timely interventions (McHugh, 2015). Current interventions in foster and kinship care broadly fall into one of five categories; wraparound services, relational interventions, non-relational interventions, carer training and individual interventions for the foster child.

A systematic review conducted by Kinsey and Schlosser (2012) reviewing foster and kinship care interventions found that few pure carer training programmes were well supported. There was generally good support for relational interventions and all the wraparound services included in the study showed positive findings. It is worth noting though that many of these did not include controls groups or random allocation to treatments.

Wrap around services referred to interventions that targeted various areas of the system within which the child resided. The Early Intervention Foster Care (EIFC) programme which involved foster care training, support groups, 24 hour on-call crisis interventions, and weekly home visits, showed a significant difference in carers but not children's behaviours (Kinsey & Schlosser, 2012). For preschool children the Multidimensional Treatment Foster Care Program (MTFC-P) with foster carers and birth parents, involving very similar content to the EIFC but also including weekly children's play sessions with clinicians, found improvements in attachment-related behaviours, fewer behaviour problems, and improved cortisol rhythms (National Scientific Council on the Developing Child, 2012).

The relational studies shown to be effective with children in foster care included the Attachment and Biobehavioural Catch-Up Intervention, which was found to significantly improve avoidance behaviour but not levels of attachment security (Dozier et al., 2009). Parent Child Interaction Therapy (PCIT) (Timmer et al., 2006) is also a promising intervention as it has been found to be as effective at improving behaviour in fostering population as biological families.

There have also been several mental health interventions for children in foster care such as Fostering Healthy Futures (FHF), Incredible Years (IY), Keeping Foster Parents Trained and Supported (KEEP), Short Enhanced Cognitive Behavioural Parent Training (CEBPT). However, very few of these follow the gold standard for research and use an RCT design. It is important to focus not only upon developing a greater understanding of how these mainstream interventions can be adapted to meet the mental health needs of children in foster care (Hambrick, Oppenheim-Weller & Taussig, 2016), but further research also needs to be

conducted on interventions which are specifically designed to meet the attachment needs of these children.

3.4. Current Interventions Offered for Treating RAD

RAD has been shown to be more prevalent amongst children (aged 6-8) from deprived backgrounds (Minnis et al., 2013). As many foster children originate from such environments, is it vital that current treatments for RAD are considered when thinking about attachment interventions for children in care.

Research has indicated that the most effective interventions for RAD focused upon identifying and improving issues within the child caregiver relationship (Ontario Centre of Excellence for Child and Youth Mental Health, 2012).

Some dyadic developmental therapists adopting Adlers's "early recollections" process which focuses upon the reintegration of trauma experiences using an attachment framework (Becker-Weidman & Hughes, 2010) has shown some success in working with families who have a child with RAD (Becker-Weidman, 2008; Stineheart et al, 2012).

Other treatments offered include PCIT aimed at improving the relationship between carer and child using play techniques and discipline skills (Kinsey & Schlosser, 2012). Circle of Security Intervention which tries to prevent insecure attachment and development of psychopathology by instilling awareness and understanding of unconscious responses to their children (Wright et al., 2015), is another treatment mainly provided in the U.S and Canada.

Yet the dilemma remains that the evidence supporting these interventions is limited in general, and particularly in relation to RAD. They are often not

specifically tailored to the attachment needs of children with RAD and instead focus upon improving attachment more generally. We are yet to develop a “gold standard” treatment for supporting children with RAD and their caregivers.

4. Issues with Current Interventions for Foster Carers and Foster Children

As documented by the Wright et al (2015) review, there is currently a universal lack of evidence-based treatments for children in foster care, an even greater shortage for those with general attachment difficulties, and no U.K. evidence-based interventions for foster children with specific disorders such as RAD.

The experience of parenting a child in foster care involves several elements which differ from parenting birth children. These include, but are not limited to, understanding the child’s background, their previous parenting experiences, managing challenging behaviours, and developing attachments, whilst often maintaining links to the birth family (Lipscombe, Farmer & Moyers, 2003).

Many studies have noted that foster children may not respond to traditional treatments offered in CAMHS, which may be partly because these children’s difficulties are found in their early attachment relationships as opposed to some of the more common mental health problems usually presenting at CAMHS (Rushton & Minnis, 2002). However, it is worth noting that perhaps it is not solely the presentation which may mean that accessing CAMHS can pose difficulties. A recent qualitative review of foster carers’ experiences of CAMHS in a single geographical area highlighted that, whilst the initial referral and assessment can be quite quick, the long waiting times and long-term treatments often generated feelings of anxiety and powerlessness in foster carers (York & Jones, 2017). Particularly in times of crisis,

foster carers shared that they often felt excluded or undervalued by professionals (York et al., 2017).

It is commonly accepted that foster carers play a pivotal role in supporting and addressing the emotional and behavioural needs of looked after children. Unsurprisingly when foster carers feel unsupported and are experiencing high levels of stress, their parenting capacities reduce, which can negatively impact upon placement stability (Farmer et al., 2005). This is particularly important to hold in mind when thinking about foster care for children with RAD. Many of these children may struggle to form the kinds of attachments foster carers have come to expect from their foster children. This in turn may lead to foster carers feeling deskilled or overwhelmed and pose challenges for foster carers in maintaining a nurturing and compassionate, secure base for these children.

Research illustrates that caregivers' own attitudes to attachment issues influence their abilities to detect, recognize and seek help for children with these kinds of difficulties (Dozier, Fisher & Sepulveda, 2002). Therefore, it is necessary to create evidence-based interventions that not only involve foster carers but also address foster children's relational difficulties, as it is likely that this will have a knock-on positive effect on their wellbeing and mental health.

Regulation theory proposes that external development and therapeutic attachment experiences can be transformed to internal regulatory capacities (Schore & Schore, 2007). Therefore, focusing on building a positive relationship between child and foster parent through therapeutic intervention, can help to repair and create new structures and models which are better able to cope with life's demands. Cornell and Hamrin (2008) suggest that for LAC a key component in the work is developing

attachment interventions which help caregivers “repair” the child’s internal working models. Yet, to date this area has been largely under researched, with very few interventions involving foster carers, and those that do suffer from numerous methodological issues – lack of randomization, small to moderate samples, limited follow-up, overreliance on caregiver reporting and overreliance on symptom reduction to name a few (Luke, Sinclair, Woolgar & Sebba, 2014).

In the U.K. there have been four major interventions that focused upon foster carers. The first was an RCT involving both foster children and foster carers. Participants were either allocated standard services or standard services with additional foster care training focusing on communication and attachment; however, the results proved non-significant, with the training not having a measurable impact on child psychopathology (Minnis et al., 2001). Following this a foster carer only study, offering 53 foster carers Cognitive Behavioural based strategies for managing challenging behaviours, was conducted. The training had limited impact on children’s behaviours and foster carers’ capacities and lacked a control group. Despite this, the participants involved felt the training had been useful (Pithouse, Hill-Tout & Lowe, 2002). Another, similar study involved Cognitive Behavioural training for foster carers and a comparative wait-list control. The findings showed no statistically significant differences between the groups regarding behaviour management skills, the frequency and/or severity of behavioural problems, and placement stability (MacDonald & Turner, 2005).

Lastly an “Incredible Years” program for foster carers in Wales was developed and ran as a multi-centre feasibility study (Bywater et al., 2010). It used comparison with wait-list controls, and the program comprised of group discussion,

videotape modelling and rehearsal of intervention strategies, with a focus upon developing parental skills in managing difficult behaviours. The results at 6-month follow-up showed promise, with a 40% decrease in foster carer depression levels, as measured by Beck's (1961) BDI, as well as a significant decrease in the foster children's challenging behaviours, however, this was rated by foster carers.

Despite foster care being a potentially cost-effective intervention for foster children, services are not equipping foster carers with the necessary tools to address the emotional and behavioural needs of these children. Most of the studies conducted to date focus upon managing challenging behaviours and whilst their findings can be instructive, they do not address the attachment needs of foster children. In addition, the interventions offered lack the methodological rigor and reporting quality to be viewed as replicable and reliable enough to be offered as a NICE recommended treatment. The limited and poor quality of the research conducted is perhaps reflective of potential challenges faced in carrying out research in the foster care context, where there are numerous barriers to implementation such as consent (Heptinstall, 2000), lack of infrastructure (Mezey et al., 2015) etc. This emphasizes the need to conduct more feasibility trials to understand the barriers and facilitators to these processes in order to develop treatments which better support these foster carers and children.

4.1 Developing a Foster Carer Intervention for RAD

A feasibility RCT has been commissioned in the U.K, with the hopes that the findings will improve interventions and attachment outcomes for children in care with RAD. NICE (2015) currently recommends that interventions for children on the edge of care, and in care systems should begin at pre-school age, involve carer

video-feedback, with primary focus on themes such as parental sensitivity, responsiveness and communication, acknowledging positive behavioural changes etc. However, these guidelines are based upon evidence gathered from non-LAC populations and there are currently no evidence-based U.K. interventions specifically designed for LAC with attachment difficulties.

This new RCT is designed to test the acceptability and suitability of Video Feedback Intervention to Promote Positive Parenting in Foster Care (VIPP-FC), a specially modified version of the VIPP program. It pays particular attention to the need to help carers recognise signals that are specific to foster children--that may be quite challenging and difficult to understand - so that they are better equipped to respond sensitively, and to support the child's secure attachment to them as their carer (Fearon, 2018).

Delivering and testing such an intervention is a large-scale, complex process which requires consistency across sites and amongst practitioners, as well as liaison with several key agencies and authorities to ensure all services involved in a child's care are working cohesively. For the RCT implementation to be a success there is a need for synergy amongst internal and external stakeholders (Rapp, Etzel-Wise, Marty et al., 2010).

The Medical Research Council (2006) has emphasized the importance of including stakeholder in complex intervention planning. They state that involving relevant "users" should occur at all stages of design as it is more likely to result in more relevant science and higher chance of producing implementable data. Alongside this, they note that by focusing upon the process as well as outcome, we gain useful insights into why an intervention may succeed or fail (MRC, 2006).

One of the key ways in which stakeholders can be utilized is by providing researchers with information relating to the intervention-setting fit (Hickey, McGilloway, O'Brien, Leckey, Devlin & Donnelly, 2018) i.e. how appropriate and compatible is the intervention and the implementation setting (Proctor et al., 2011). Hickey and colleagues' (2018) Irish case study of an area-wide evidence-based prevention and early intervention strategy with children and young people, highlighted several interesting factors which may influence stakeholder buy-in and engagement. These included having a "shared vision", understanding stakeholders' priorities and preferences, fostering collaboration, respecting existing work practices and values, and having inclusive structures which facilitate communication and feedback processes (Hickey et al., 2018).

Palinkas et al. (2017) interviewed 75 agency leaders of CAMHS services to gain a better insight into potential barriers to new evidence-based practices. They found that financial costs, capacity and acceptability were viewed as the greatest barriers to implementation. Building upon this, a recent quantitative study of barriers to trauma focused evidence-based treatments in community mental health discovered that there was only one significant barrier, which was endorsed by more than 70% of their 263 participants (clinicians, clinical supervisors, agency leaders etc.); competing demands for time (Oliver & Lang, 2018). Similarly, a Cochrane review addressing barriers and facilitators to implementation of lay health worker programs to improve access to maternal and child health highlighted the importance of programme acceptability, appropriateness and health system constraints as major factors (Glenton, Colvin, Carlsen, Swartz, Lewin, Noyes & Rashidian, 2013).

Stakeholders in research trials are often asked to operate within structural arrangements which may differ from their usual practice and this requires clear communication, understandings of power and responsibilities and how these may shift, as well as comprehension planning (Butterfoss, 2007). Whilst focusing on stakeholder interaction can increase researchers' understanding of the practical context, increase stakeholders' interests in the project and strengthen the application of the research (Slunge, Drakenberg, Ekbom, Gothberg, Knaagard & Sahlin, 2017), very few studies include it as part of their implementation design.

It is anticipated that this RCT will be influenced by the engagement and perceptions of key stakeholders. Therefore, it is deemed necessary to investigate the processes and challenges involved in the implementation of the VIPP-FC intervention to further understand the facilitators of change, gather information regarding good practice and the barriers to delivery both from the point of view of individual clinical practice and service-level implementation. If this intervention is effective in enhancing the sensitivity of the foster parents and their sensitive disciplining towards the child, this would support its implementation more widely in foster care. The VIPP-FC intervention could thereby improve the mental wellbeing of the foster parents as well as their foster child.

This study, as detailed in Chapter two, aims to understand the impact, acceptability and feasibility of VIPP-FC in a L.A. context as perceived by key stakeholders. Primarily the hope is to further understandings of the intervention-setting fit (Hickey et al., 2018), the perceived usefulness and effectiveness of the intervention, facilitators and barriers to implementation, as well as identify concerns and key areas for future study development.

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PART TWO: Empirical Paper

Exploring Stakeholders' Perceptions of the Impact, Acceptability and Feasibility of a
Video-Feedback Intervention to Promote Positive Parenting in Foster Care (VIPP-
FC)

Abstract

Aims: Looked after children (LAC) have a higher prevalence for mental health problems, lower academic attainments, and greater interpersonal difficulties than their peers. Many of these difficulties are thought to be rooted in early attachment relationships yet currently there are no evidence-based treatments in the U.K. to support children with these difficulties. This study is part of a Randomised Control Trial (RCT) of a modified video-feedback intervention, VIPP-FC, designed to improve sensitive caregiving and relations between foster carers and LAC with attachment difficulties. Conducting such a trial is a complex and challenging process and in order to fully understand whether the intervention is acceptable and feasible, it is necessary to seek key stakeholders' qualitative perceptions of the study as they undergo the development, implementation and conduct of the RCT to ensure that a larger-scale future trial is feasible.

Method: 10 semi-structured interviews were conducted with key stakeholders involved in the study. Thematic analysis was applied to the data using NVivo12 software.

Results: Three overarching themes developed; Challenges of Implementation, Benefits and Impact of VIPP-FC and Key Learnings. These were further broken down into eight subthemes.

Conclusions: Conducting an RCT with LAC in a Local Authority (L.A.) context is a multi-layered, complex process. Whilst VIPP-FC holds promise as a useful intervention for this population, adaptations need to occur for the intervention-context fit to improve. These include the intervention being more flexible, adopting a relational approach to study management and infrastructure, developing a research

infrastructure in L.A.s and improved communication and dialogue between researchers and L.A.s.

Introduction

About 50% of Looked after Children (LAC) in care are likely to meet clinical thresholds for a mental health disorder, compared to one in ten children from the general population (Department of Education, 2018). As documented in Chapter One, there is extensive evidence that LAC are more at risk of developing childhood mental, emotional and behavioural problems, including sub-optimal attachment patterns (Ford, Vostanis, Meltzer, & Goodman, 2007; Rutter, 2009 Tarren-Sweeney & Hazell, 2006). Despite this there are surprisingly few evidence-based interventions for these children, let alone more preventive approaches to try and reduce these poorer outcomes.

One of the ways to address these issues would be by developing interventions which could improve LAC's attachments with caregivers, as children with secure attachments are less likely to develop psychopathology in later life (Fearon et al., 2010; Fearon et al., 2016; Groh, Roisman, van IJzendoorn, Bakermans-Kranenburg, & Fearon, 2012). As the first few years of life are most crucial for attachment development (Bowlby, 1952), interventions ought to be targeted at this group.

More recently there has been a significant number of studies focused upon improving children's attachment relationships (see Chapter One for more details). Those which have been shown to be most effective at reducing disorganised attachment patterns and other attachment difficulties focus largely on caregiver sensitivity (Wright et al., 2015). One of the main techniques used to achieve this is the use of video-feedback (VF) as it allows parents to notice children's cues and sensitively respond to these. Studies which have a VF element in their intervention have reported positive, significant and sizeable treatment effects (Bernard $d = .72$;

Moss $d = .90$; Juffer $d = .80$) in reducing attachment difficulties and improving caregiver sensitivity. NICE (2015) currently recommends the use of VF interventions to treat attachment difficulties in pre-school children who are adopted, looked after or are on the edge of care, due to their efficacy and cost-effectiveness. However, there is currently little evidence for the clinical effectiveness of such an intervention for children in foster care in a UK context.

LAC are at a significantly higher risk of developing attachment disorders due to the prevalence of early adverse life events (Bakermans-Kranenburg & van Ijzendoorn, 2007). Often these children struggle to access and respond to traditional treatments offered in CAMHS, as many of their difficulties are found in their early attachment relationships as opposed to the more common mental health problems usually presenting at CAMHS (Rushton & Minnis, 2002). There is some evidence that parenting work with foster carers of children with attachment disorders is helpful (Minnis, Pelosi, Knapp & Dunn, 1999).

There is clearly an unmet need in services to deliver good quality, evidenced interventions to ameliorate attachment difficulties and hopefully improve the future trajectories for LAC. Providing attachment interventions like video feedback for foster carers within the context of local authority care is an obvious way to support children in foster care with attachment difficulties, but currently no trials have tested whether such an approach is effective or indeed feasible.

A feasibility RCT of video-feedback has been commissioned in the U.K, with the hopes that the findings will improve interventions and attachment outcomes for children in care. The study uses a specifically modified version of the Video Feedback Intervention to Promote Positive Parenting (VIPPP), which has good

efficacy with families (Juffer, Bakermans-Kranenburg & van IJzendoorn, 2008), and has recently been developed for foster carers (VIPP-FC). This programme pays attention to helping carers understand and recognise that LAC may not seek support or demonstrate attachment signals in the same way as other children, and to encourage foster carers to become more sensitively attuned to their needs. The effects of the experience of watching oneself on video-film can evoke multiple sensations, emotions, beliefs and representations, often in unsettling ways (Steele et al, 2014) which may impact upon the therapeutic alliance and thus effect retention in the study. Therefore, supervision in VIPP-FC will be essential in order to support clinicians to manage some of these complexities and challenges to implementation. Supervision can also be viewed as a means of quality control; ensuring adherence to the intervention protocol, and optimising clinician competencies.

If this intervention is effective in enhancing the sensitivity of the foster carers and their sensitive disciplining towards the child, this would support its implementation more widely in foster care. The VIPP-FC intervention could thereby improve the mental wellbeing of the carers as well as their foster child. Conducting such an RCT with this population, however, will not be without some significant challenges.

Implementation science suggests that barriers to Evidence Based Practice (EBP) are multi-level e.g. individual, organisational, intervention and systems levels (Beidas et al., 2016). As the proposed trial would be working with children involved in the social welfare system, we envision the process of recruitment and engagement will be more complex than a trial based in the health care environment as more people are involved, there are complex regulatory constraints, resources are very tight and this setting is less used to being involved in research (Bogolub & Thomas,

2005). Accessing LAC and their foster carers will likely be significantly dependent upon their social workers, who act as gatekeepers in these children's care (Dale & Watson, 2010). Social workers view their roles as needing to protect these vulnerable children and therefore their beliefs about the child's vulnerability, the potential benefits of the study and the timing i.e. engaging in research after a recent placement transition (Dixon et al., 2014), may all impact upon their willingness to recruit families.

The process of consent with LAC also poses numerous challenges as it can be particularly difficult with these children to determine who consent must be obtained from, and how this should be done (Bogolub & Thomas, 2005). Beyond this there may be a reluctance amongst social workers to consent to engage in EBP, as many social workers do not identify their profession as a scientific discipline (Murphy & McDonald, 2005) and therefore they may be unaware of the methodological processes of an RCT.

Dixon and colleagues' (2014) attempt at conducting an RCT of Multi-dimensional Treatment Foster Care for adolescents highlighted that social workers' understandings of randomisation impacted upon recruitment, with many social workers adopting their own clinical judgement when selecting children. Later research by Mezey et al (2015) involving implementing a peer mentoring intervention to reduce teenage pregnancy in LAC in the U.K. also highlighted misconceptions amongst stakeholders about recruitment criteria and the purpose of randomisation as key barriers to implementation. Although there was often a theoretical acceptance of the need for randomisation, in practice this rarely occurred (MacDonald, 2000). Similarly, Dale and Watson (2005) noted that if key stakeholder do not fully believe that an intervention is of tangible benefit, their engagement and

acceptance of the research project can be compromised. Whilst these studies highlight interesting dilemmas around conducting an RCT with LAC, their populations largely focused upon adolescents. There has been little research to date on the potential barriers and their impact on implementing an RCT with younger LAC.

We perceive that the current climate of financial constraints and changes in organisational policy and structure within L.A.s may impact our study. As many others have found in their research with LAC, social workers often have very large caseloads which effect their abilities to engage in research tasks (Gilbertson & Barber,2002). Those who have tried to engage organisations in EBP research have encountered challenges with competing demands, and financial strains (Beidas et al., 2016). Other studies specifically involved with L.A.s found that the re-organisation of services (Dale & Watson, 2010), and general lack of research infrastructure (Mezey et al. 2015) impacted upon services' abilities to engage in scientific studies.

Many of the studies that documented challenges with implementing EBP and working with L.A.s also discussed potential facilitators to the process, these included: access and support from the development team (Beidas et al, 2016); face-to-face meetings, having a research “champion” within a team (Dale & Watson, 2010); continual dialogue to address divergent perspectives (Goodkind et al., 2017); social workers acknowledging the importance of strong links between research and practice (Gray et al., 2014); contractual agreements, incentives and greater acknowledgement of ethical dilemmas (Dixon et al., 2014).

Studies which attempt to implement new EBP often focus upon knowledge development, with little information about strategies to prepare people and

organisations for this new knowledge (Flynn & Brown, 2011). However, without this it is likely that progress will be stagnant or slow at best. The Medical Research Council (2006) has emphasized the importance of including stakeholders in complex intervention planning, as it allows you to gain insights into the process which may contribute to positive or negative study outcomes.

Qualitative approaches position themselves as useful methodologies for achieving these insights, as they provide the ability to explore and understand in detail how well different implementation components work together (Gale et al., 2019). They can be used concurrently with a pilot trial (as is the case with this study) to optimise recruitment and informed consent strategies, to identify acceptability of the intervention, to provide insights into processes of change and to help interpret findings (Pons-Vigues et al., 2019). Thematic analysis is often the first port of call for qualitative researchers studying implementation as it can help to illuminate patterns of results and why and how results were obtained for various outcomes, including unintended effects (Holtrop, Rabin & Glasgow, 2018).

Pons-Vigues and colleagues (2019) in their recent qualitative evaluation of a complex intervention to implement health promotion activities found that utilizing thematic content analysis provided them with crucial information regarding the feasibility and acceptability of their intervention. For instance, they discovered that whilst the intervention was viewed as “acceptable” by many stakeholders, they also perceived it as “overly ambitious” and too long in duration. They learnt that their recruitment processes were deemed as adding to the workload of stakeholders in a greater way than anticipated. The use of this approach emphasized to the researchers the importance of seeking stakeholders’ perspectives for the successful, setting-

specific implementation of adequate, acceptable, equitable and sustainable strategies aimed at health promotion and well-being (Pons-Vigues et al., 2019).

Similarly, another recent study aiming to understand the implementation of complex interventions in primary care teams (Luig et al., 2018) also utilised thematic analysis alongside other qualitative techniques. Through the adoption of a qualitative approach the researchers learnt of the overall importance of being flexible and despite the challenges this posed to their trial's protocol they found that the intervention depended upon having a dynamic and adaptable design (Luig et al., 2018). Key information such as this, which improves the study's likelihood of success, would not have been discovered had the researchers not sought qualitative data to understand the implementation process, going beyond merely evaluating whether the intervention is effective (Pons-Vigues et al., 2019). In this way the use of thematic analysis and other qualitative methodologies has transcended what we may gain from a purely quantitative approach (Pons-Vigues et al., 2019).

Aims of the current study

This study aims to understand the impact, acceptability and feasibility of VIPP-FC in a L.A. context. Delivering and testing such an intervention is a large-scale, complex process which requires consistency across sites and amongst practitioners, as well as liaison with several key agencies and authorities to ensure all services involved in a child's care are working cohesively. It is anticipated that this process will be heavily influenced by the engagement and perceptions of key stakeholders in the study. Therefore, in order to fully understand the facilitators and barriers to the implementation of VIPP-FC, the current study adopts a qualitative approach to exploring stakeholders' experiences and views about the general and

specific research challenges posed by a clinical trial of an attachment intervention in young children in foster care. Primarily we hope to further our understanding of the intervention-setting fit (Hickey et al., 2018), the perceived usefulness and effectiveness of the intervention for this population, facilitators and barriers to implementation particularly within a L.A. context, identify stakeholders' main concerns, and key areas for future study development. The qualitative data gathered from stakeholders can then be utilised to establish optimal systems, procedures and feasibility for a larger-scale trial of VIPP-FC.

Method

This project is part of a multi-site pilot feasibility RCT evaluating the effectiveness of the VIPP-FC programme in improving foster carer sensitivity. The study is being conducted across several NHS trusts in London, Hertfordshire, Peterborough, Leeds and York, and is being delivered through local authorities within these areas.

The RCT is a two-phase design. In the first phase input is sought from experts and clinicians in the field in order to develop the VIPP-FC manual. The second phase involves the manual being tested with a small number of children and their foster carers. During this phase, a small scoping study (this research project) of the organizational, ethical and practical landscape within which a trial of VIPP for foster care will need to operate.

Ethical Approval

This project obtained ethical approval from the HRA Harrow NHS Research Ethics Committee (Reference number 17/LO/0978) (Appendix A).

VIPP-FC Program

For this study the VIPP-FC intervention was delivered by trained VIPP practitioners. It consisted of six home-based sessions, over 16 weeks, during which time foster carers were video recorded whilst carrying out their daily routines and interactions with their foster child. The VIPP-FC intervener then provided feedback on the interaction. During this feedback the practitioner also speaks to the foster carer from the child's perspective.

Each VIPP-FC practitioner received regular supervision, involving supervisor and supervisee discussing the video recordings, and the "script" written when "speaking for the child" (Stern, 1985). Supervisors are also expected to model key elements of the program in their supervisory style.

Participants

Stakeholders involved in the organisation and implementation of VIPP-FC project in the London and Kent sites were invited to take part in the study. This equated to a total number of 26 stakeholders. Of the 26 invited to interview, 15 responded and 13 agreed to be interviewed. One dropped out due to poor health, another had left their post, and one had yet to begin work on the VIPP-FC. Consequently, ten stakeholders were interviewed.

Participants included six child social workers, three of whom were either service managers or deputy managers, two clinical psychologists, both of whom were service leads, one commissioner and one researcher trained in VIPP. One participant worked in a CAMHS service, four worked in LAC services, and the remaining participants were employed by L.A.s. In terms of their roles on the VIPP-FC study, three participants held a strategic role i.e. involvement in study design,

five participants were involved in service delivery i.e. offering VIPP-FC in their service or being a trained VIPP-FC practitioner, and two participants were involved in both aspects. There were two males and eight females interviewed, with clinical experience ranging from approximately three to twenty years.

Procedure

In order to capture the facilitators and barriers which may be impacting on the acceptability and feasibility of the intervention, stakeholders who were involved in the set-up and conduct of VIPP-FC in local authorities were invited to interview. An initial email was sent by the VIPP-FC research team to eligible stakeholders, introducing the researcher and informing them that they would be getting in contact.

Participants who expressed initial interest were then contacted by the researcher and were sent information about the study (Appendix B), as well as consent forms (Appendix C).

The interviews were conducted at a time and place that was convenient for the participants, namely in local authorities or NHS sites. Two of the interviews were carried out via telephone due to lack of availability for face-to-face meetings.

Prior to interview, practitioners were given an additional copy of the information sheet to read and time was allocated for answering questions about the research. Practitioners were then asked to complete the consent form which they had been sent previously. Participants were assured that the researcher was independent of the NHS and Local Authority and that their data and information would be stored in accordance with the Data Protection Act (2018). Participants were also given a brief debriefing after the interview so they could ask further questions or share any concerns they may have had. Furthermore, participants were informed that should

any concerns arise post interview they could contact the researcher on the email provided.

Interviews

A semi-structured interview schedule was developed based upon Smith's (1995) established guidelines. The researcher sought consultation from a qualitative specialist as well as senior researchers on the study when establishing the aims of the research and drafting the schedules. An initial interview schedule was then piloted with a colleague who had experience of working with looked after children, and further edited and refined.

As the research involved stakeholders from various roles and professional backgrounds, four different interview schedules were drafted to suit individuals' positions within the study. All schedules began broadly asking the participant for a brief overview of their part on the study, then becoming more tailored to their specific involvement and role. (Appendix D).

The interview schedules addressed themes such as (1) engagement (2) supervision and training (3) obstacles and challenges of implementation and (4) acceptability of VIPP-FC. The interview schedules were applied flexibly and the order in which these topics were explored was dependent on the material the participants brought. This helped to ensure the interview flowed naturally and spontaneous information could emerge (Breakwell, Smith & Wright, 2012).

Throughout the interview participants were encouraged to elaborate on their answers by giving specific examples. The interviews lasted between 50-70 minutes and were audio-recorded. Participants were invited to add additional comments or

discuss topics the interview schedule may not have captured at the end of the interview.

Qualitative Analysis

Each semi-structured interview was transcribed verbatim, with 8 of the interviews (P1-8) transcribed by the researcher and 2 interviews (P9-10) transcribed by the online transcription service TRINT. Thematic analysis was applied to the interview transcriptions to understand the key patterns arising from within the data. This approach was deemed appropriate as it allowed the researcher to capture both similarities and differences amongst participants' perspectives (Breakwell et al.,2006). Through its theoretical freedom, thematic analysis is considered a flexible and useful tool for the inductive process of mining the data to come to a coherent, rich and detailed account of the challenges and facilitators of engagement in, and implementation of the program (Braun & Clarke, 2006).

This approach is an active, iterative process, whereby the researcher is selecting themes of interest. The process followed protocol outlined by Braun and Clarke (2006) and involved five phases to the analysis. NVivo 12 software was used for data management. For the first phase the researcher began to read through the transcripts and familiarise themselves with their depth and breadth. Once read through in its entirety, the researcher began to read the transcripts in a more active manner and started to take notes of ideas or phrases of interest. Phase two involved the initial generation of codes. This involved the researcher semantically identifying different features of the data and working systematically through the transcripts (Braun & Clarke, 2006). The researcher also took note of data that did not fit the more dominant narratives during this process. Following from this, in stage three,

the researcher began to analyse the codes they created and started to think about how these could be combined to form themes. During this phase the researcher began to look at how these themes could also be organised hierarchically i.e. overarching theme, sub-themes. Illustrative quotes which captured the themes were also selected for each theme. In phase four each of the extracts that were coded for a theme were reviewed and examined to see whether there is a coherent thematic framework developing. Themes were refined and divided into sub-themes or merged together to form a larger theme. Once completed these themes were then placed in the context of the entire data set to examine whether they reflect the meanings that were evident in the data (Braun & Clarke, 2006). The fifth phase involved the researcher trying to capture the essence of each theme and its application to the narrative that came from the data. This involved a final examination of each transcript allowing for theme refinement, and ensuring that all nuances, contradictions and exceptions had been captured. An illustration of the main stages of analysis is included in Appendix E.

Credibility Checks

Whilst thematic analysis in its classic form has in-built quality procedures through the checking of themes against coded data and then the reviewing of themes against the entire data set (Braun & Clarke, 2006), the researcher also undertook several credibility checks following good practice guidelines developed by Barker and Pistrang (2005), as well as those set forth by Elliot, Fischer and Rennie (1999), in order to enhance the quality and validity of their analysis and subsequent conclusions.

In the initial stages of analysis, the researcher involved an external qualitative researcher and provided them with two transcripts to code. They then checked their

coding of the two interviews against those coded externally to identify overstatements, discrepancies and potential errors (Elliot et al., 1999). Following this a consensus approach was adopted to the development of a thematic framework. The researcher involved a member of the research team to review a selection of the data, compare ideas and discuss the best ways to represent the data. Similarly, the researcher had multiple discussions with their supervisor to again develop a consensus and agreed final thematic framework. Throughout the analytic process interpretations were grounded in participant data by illustrative excerpts.

Researcher's Perspective

Prior to commencing analysis, I engaged in a bracketing interview in order to highlight any preconceived ideas I may have held (Tufford & Newman, 2010), and to mitigate the potential impact these may have on the analytic process. Whilst I had no experience of working with looked after children or offering VIPP as an intervention before engaging in this research, I had undergone a clinical placement within a Local Authority. This gave me an insight into the structures and pressures of that system, which may have increased my awareness of how potentially difficult implementation of a study such as VIPP-FC may be in this setting. Experiences of working with children and families also has increased my beliefs about the importance of collaborative working in order to ensure clients receive best quality care. Through teachings on the doctorate course on early relationships and the potential usefulness of video-feedback interventions, this knowledge may have led me to have some preconceived ideas about the importance of an intervention such as VIPP-FC.

As a trainee clinical psychologist my professional background may have also influenced the way I made inquiries and how participants engaged with me. My epistemological approach to the research was one of critical realism, meaning that I acknowledge that there is a “reality” and the ways individuals make sense of their experience, and, in turn, the ways the broader social context impinges on those meanings impacts upon this reality.

Results

The analysis generated three overarching themes which comprised of eight subthemes. The first overarching theme “Challenges of Implementation” addresses the difficulties and barriers perceived by participants in setting up and delivering the study. The second main theme addresses “Benefits and Impact of VIPP-FC” which discusses what participants feel has and can be gained from engaging in the study. The final overarching theme is focused upon “Key Learnings” and discusses ideas that were generated to overcome some of the barriers identified in implementation. The number of references made in the data set to each theme is illustrated in Appendix F.

Overarching theme 1: Challenges of implementation

Throughout the interviewing process participants reflected upon the barriers to implementing the study both from their direct experience of having been involved in the early stages of the project and their wider knowledge of the system. It was evident that there were three main areas that posed challenges; “Chaos in the System”, “Conducting an RCT in a L.A context” and “Elements of VIPP-FC”. These subthemes operated on varying levels from a more macro systems, cultural level to the specificities of the intervention itself.

Table 1.

Overarching theme and subthemes in: Challenges of Implementation

| Overarching Theme | Subthemes |
|---------------------------------|---|
| 1. Challenges of Implementation | 1.1. Chaos in the System 1.1.1. Priorities 1.1.1.1. Additional 1.1.1.2. Capacity 1.1.2. System Structures 1.1.2.1. Structural Issues 1.1.2.2. Implementing Change 1.1.3. Conducting an RCT in a LAC context 1.1.3.1. Consent 1.1.3.2. Ethical Dilemmas of an RCT 1.1.3.3. Information Sharing 1.1.4. Elements of VIPP-FC 1.1.4.1. Manualisation 1.1.4.2. Logistics |

1.1. Chaos in the system

The participants in the study all spoke about the struggles of implementing an RCT in a setting that feels quite disordered, where there is a lot of disruption. They mentioned the difficulties with managing multiple priorities and the ever-changing structures within L.A.s as key barriers to successful study implementation.

1.1.1 Priorities

1.1.1.1. Additional

Considerable emphasis was placed upon the idea that being involved in the VIPP-FC study was something “*additional*” to their everyday work. There was a sense amongst participants specifically in reflecting on why social workers were not

consistently engaging, that the study was not a mandatory activity and therefore placed on the “backburner”.

“...because social workers are so busy and so stressed and have such a high demand to deal with whatever is the most crisis situation, that research, however much they kind of support it, it’s kind of on the bottom of their list.”

One of the social workers mentioned that perhaps as the study was more of a “mental health” intervention rather than a social care construct, this may have also contributed to the VIPP-FC work being viewed as an add-on, and not wholly relevant to their work. Several participants echoed this sentiment questioning where the “incentive” for social workers to engage in the research was, as it involves extra work with relatively little information getting through to them about potential gains for them as social care professionals.

Although the “Key Learnings” overarching theme focuses in greater detail upon solutions to difficulties, a few of the participants whilst discussing the subtheme “Additional”, generated ideas about how to overcome the specific challenges within the system around juggling and managing the priorities of the local authority, as well as those of the VIPP-FC study. Three of the participants felt making VIPP an intrinsic part of one’s role i.e. outlining it as “part of their job description” would be helpful in allowing them boundary their time and prioritise VIPP-FC work also. This implies the need for buy-in at a relatively high level within the local authority.

1.1.1.2 Capacity

Linking to the previous sub-theme, capacity and lack of resources in the local authority was endorsed as a challenge by all participants. One of the key challenges

identified in relation to priorities was that Local Authorities lacked adequate resources and thus social workers had limited capacity to engage in the kind of research requirements VIPP-FC set forth.

Many of the participants, whether social worker by profession or not, were able to empathise with how “*incredibly busy*” social workers were and understood perhaps why VIPP-FC was not a priority for them.

The difficulties with capacity were located largely on a service level. There was a sense in the data that perhaps what the study team were asking of stakeholders in the trial was unrealistic as the hectic environment of the Local Authority does not make for a “*research friendly environment*”. Several participants expressed feelings of frustration with the system not supporting the research processes more, whilst also showing awareness of why this may be the case.

“...they have got no man-power, they’ve got no spare capacity to support our process...”

1.1.2 System Structures

1.1.2.1 Structural issues

Participants spoke of the structural changes and organisational issues which Local Authorities are currently facing as a significant hinderance to the smooth running of the VIPP-FC study. There was a distinct feeling amongst stakeholders that trying to conduct research in L.A.C. services is a uniquely “*complex*” and trying process. One of the reasons some of the participants identified for this was the lack of standardised organisational structures across L.As.

“There’s so many layers, and every local authority is different, every local authority has a different structure and a different attitude...corporate structure and management structure about who you need to speak to you cannot generalise information”

Not only was the lack of systematic organisation a challenge, but many of the participants also spoke of the struggles within the network to bring people together. They shared that specifically in L.A.C services there was a “*fragmentation*” within the network, and perhaps if this could be overcome then L.A.s would provide a more “*benign environment*” for research to take place.

Within these structures participants spoke of the regularity of change and impact this can have on study momentum. They discussed difficulties encountered in the setting-up of the study as key stakeholders had moved positions, “*lost jobs*” or became invested in something else. Alongside these issues, participants identified the “*churn within social care*” as a major barrier to engagement in the study.

“We have a huge problem with turnover and I think all of these things make a kind of perfect storm really and set up a context where it’s really easy to disengage with anything else other than the basic work that you’re meant to do.”

A few of the social workers spoke directly about the “*internal politics*” that went alongside these structural obstacles. They voiced their frustrations at the system being unwilling to create a place for research within its organisational structures despite agreeing to take part in the study. They felt this created unnecessary pressure for staff who had to try implement VIPP-FC without feeling fully supported by those that had signed the L.A. up to the study in the first place.

An additional structural challenge that participants referred to regularly related to positioning; both in terms of who to target in the system to gain support for the VIPP-FC study, but also with regards to being an external body coming into the L.A. A few participants spoke of how difficult it can be to work in such a chaotic system, let alone try to ‘infiltrate’ it as an outsider.

“...it’s quite hard for you to know where to press on the system to get things to happen...”

1.1.2.2 Implementing Change

Another interesting subtheme which was largely endorsed by the social workers interviewed, was around the idea of change, and the introduction of something new being difficult within L.A.s. Some participants spoke of how L.A.s almost adopted a defensive position to the prospect of change and new studies/interventions. They reasoned that this may have be due to the system undergoing so much structural change already.

“There’s been so much change in terms of policy and direction and government interference and regulatory bodies, you know, in the last ten years it’s really ridiculous the amount of change. “

Many of the participants were able to empathise with this scepticism of change, describing L.A.s as being under significant pressure and constantly having things *“coming at you from all directions”*. One participant highlighted that change in general is difficult on an individual level but trying to mobilise change in a system that is used to and *“comfortable with”* doing things in a specific manner is *“almost impossible”*.

Numerous participants spoke specifically about how this reluctance to engage in something new and innovative is perhaps reflective of a wider cultural issue within the system. They recognised that working in the L.A. can be quite “*a hostile place*” as employees are often having to deal with difficult dynamics and criticisms from external sources. They hypothesised that perhaps external researchers coming and wanting to work within their organisation is being branded as another external actor judging, without understanding their struggles.

“Of course, I mean from the social workers point of view you know, these are ivory tower people...you need to get down a bit.”

1.1.3 Conducting an RCT in a LAC context

1.1.3.1 Consent

Thinking about offering an intervention such as VIPP-FC evoked a few concerns in stakeholders; one of the key worries centred on the process of consent. Several of the participants highlighted that the LAC population poses additional challenges to the usual consenting process. Questions emerged over who to obtain consent from, legalities around parental responsibilities, and queries over “*best interest decisions*”.

Like earlier themes, a few of the participants reflected that the chaos of the system meant that obtaining consent for this population was not as straightforward a process as perhaps it would be for another population of children.

“...there’s layers of consent, it’s just...they’re there to protect children but they’re horrendous to navigate.”

They explained that for this population consent is not only multi-faceted but also distributed throughout the network, with different people holding more or less influential roles in the process.

Linking with this, several of the participants spoke about the dilemma of whether consent needed to be obtained from birth parents. Some participants felt dubious over whether this may be harmful to the child and their relationships, as they felt the child had been removed from the family home “*for a reason*”, and as social workers they needed to protect the child. Whilst other participants felt that perhaps asking the parents would complicate things as parents may be irritated that foster carers were being offered support to bond with their child, whilst they were not being offered anything to help their attachments. One participant role-played how they envisioned some parents to respond to this:

“Well why does the foster carer get offered that intervention? Why didn’t I get offered it as part of the package to support me in my parenting, so I could become a better parent and keep my child?”

Participants also provided several examples of how shared parental responsibility and whether court proceedings were ongoing or not could make consenting to research difficult and be a possible reason why recruitment rates are low.

1.1.3.2 Ethical dilemmas of an RCT

Participants highlighted a number of different causes for concern in conducting an RCT with LAC that left them pondering whether it felt ethical to do so. A significant proportion of the stakeholders felt there was a “*diagnostic*” element to the inclusion criteria of the RCT. They raised issues around the potential

pathologizing impact a “*diagnosis*” can have upon such a young child, as well as fears that if the “*diagnostic report*” was available to non-research staff what that may mean for that child’s prospects.

“Yeh you don’t want to thwart their chances of being seen as a child, an adoptable child...”

It was mainly participants with hands-on clinical experience with this population who felt the greatest sense of discomfort with the report.

Participants also expressed discomfort with specific elements of the exclusion criteria and with some children not receiving the intervention which is expected within an RCT model. Specifically, several participants felt that the age range and Reactive Attachment Disorder (RAD) diagnosis meant that children who they felt could have benefited from being involved in the study did not meet inclusion thresholds.

Likewise, participants described concerns that if a child was randomised to treatment as usual with this population that “*could mean nothing*”. All the participants who thought that this was an issue also felt that perhaps this was a barrier to people’s engagement with the study, as they reasoned:

“...it would be easier to get families to put themselves forward if they know that they would get something, whereas with this they may get something, or they may not”.

In this way participants began noticing that perhaps there is a conflict between their aims as clinicians and those of the research study. Whilst the majority of the participants who noted this dilemma were able to appreciate that the study needed to have certain guidelines to ensure “*fidelity*” and “*study efficacy*”, they

found it difficult sometimes to switch from their clinical mindset and step into that of a partner in a research study.

1.1.3.3 Information sharing

Participants provided many examples of how information sharing with this population, particularly in a research study, can be challenging to manage. Most participants felt concerned about how and what information would be shared. They emphasised the need for researchers and those involved in the study to ensure they took necessary precautions to safeguard these “*vulnerable children*”. The social workers interviewed felt particularly strongly that their role is to protect these children and so they expressed the most concern about how the team as an external body would manage the data and the videoing element of the intervention.

“...you are you know, a third party to these children’s lives, not directly involved in their care or offering day to day therapy, so for me, there’s a little bit of that sharing information and then you step out, so I think it’s about the confidentiality...”

However, a number of participants then also wanted information gathered in the study to be shared within their network. They felt that it was a shame for the potential learnings and information collected about both the child’s needs and foster carers’ skills to be lost as it could benefit future placements and planning. This they recognised posed a dilemma as to how much, when, and to whom this information should be shared, as similarly to the concerns over diagnoses, participants feared that a report that was less positive could be shared with people who could misconstrue it.

1.1.4 Elements of VIPP-FC

1.1.4.1. Manualisation

Opinion was somewhat divided on the benefits and drawbacks of VIPP-FC being a manualised intervention. Many of the VIPP-FC interveners felt that having to follow a more “*rigid*” protocol for sessions meant that often they found themselves having to say things which did not feel fully applicable to the families that they were working with. This left some practitioners feeling “*stuck*” and unsatisfied.

A few participants shared that whilst the manual was thorough, it would have been helpful if there had been more guidance around how to manage these types of situations, more flexibility in application and greater use of “*clinical judgement*”.

“...it would just be really helpful to have the flexibility to adapt the message...certain messages you really, very strongly felt didn't apply to that family you didn't have to read them out.”

Some of the participants reflected that perhaps VIPP-FC is just a “*different way of working*” which may not suit everyone's style, including that of foster carers as different foster carers may hold beliefs about “*how to discipline their child*”.

Whilst many of the participants felt VIPP-FC could be improved through allowing some deviations from the manual, a few participants praised the manual for being mindful of these children and their contexts. Specifically, they felt the “*language*” was appropriate and helpful in reflecting the “*experience of children who perhaps are in transition*”.

1.1.4.2. Logistics

Participants with experience of offering VIPP-FC or working with LAC provided an abundance of examples of practical and logistical obstacles faced in trying to deliver the intervention according to protocol. One of the most significant

difficulties faced was the available time of the foster carers. They detailed struggles in getting foster carers to commit to the program, trying to manage clinician's time whilst fitting in amongst birth parent visits, court dates and various appointments.

"...so, there were 4 children in the placement of different ages with different contact arrangements and different needs, and a single carer."

Another key struggle was centred on both the practical, but also the ethical issues of other children being in the home. Nearly all the participants who mentioned logistics, highlighted this dilemma, detailing how sometimes it felt as though foster carers' attention was divided by other children *"running around"* which made the feedback process difficult.

"It would be easier if the child wasn't there during the feedback so yourself and the parent could have a proper conversation, without the parent being distracted by trying to manage the child's behaviour all the time..."

Others felt their visits were quite time consuming as they did not want other children to feel left out so felt they had to spend time interacting with them also.

A few of the participants questioned the timings of VIPP-FC and spoke of concerns relating to placement timings. They explained that it can sometimes feel uncomfortable offering an intervention that may increase attachment when there was uncertainty over whether the child would remain with that foster carer for a while.

2. Overarching theme 2: Benefits and Impact of VIPP-FC

The benefits and impact of being involved in the VIPP-FC study were separated into three distinct sub-themes, each representing a different layer within the ecological system (Bronfenbrenner, 1979). The first "Creating an Evidence

Base” explores the wider level benefits VIPP-FC can have upon the world of psychological research for Looked after Children. The second examines service level benefits to those engaging in the research and the impact the study has upon their practices. Lastly the positive potential and gains on an individual and family system level are explored.

Table 2.

Overarching theme and subthemes in: Benefits and Impact of VIPP-FC

| Overarching Theme | Subthemes |
|-----------------------------------|--|
| 2. Benefits and Impact of VIPP-FC | 2.1. Creating an Evidence Base 2.2. Benefits to Services 2.3. Benefits to Families |

2.1. Creating an Evidence Base

There was a unanimous feeling amongst stakeholders that creating an evidence base for LAC was hugely important. The current “*lack of evidence*” was highlighted as being “*problematic*”. Several of the participants mentioned their “*excitement*” and eagerness to be involved in research which could potentially ameliorate this issue. Many participants elaborated on this by explaining that even when services are following good practice guidelines, they still lack high quality, scientific evidence to support their recommendations, therefore they were keen to work to change this.

“I think the SDQ is poor, which is nationally what is used for foster children for outcome measures. It is not the most sophisticated tool. It doesn’t really work for some children because it doesn’t really pick up any of the nuances...it doesn’t capture exactly what they go through.”

Stakeholders who held more structural roles such as managers, identified the building of an evidence base as an essential component for being granted commissioning for services. They spoke of how this research can hopefully aid future decision making, contributing to developing NICE guidelines for this population and allow LAC services to “*negotiate money differently*”.

2.2. Benefits to services

Generally, participants felt positive about the VIPP-FC from a service level perspective. Many of them referenced the benefits of being able to offer something additional, that was “*free*” to vulnerable children and families who receive very “*little support*”. A few participants held the realistic standpoint that whilst VIPP-FC is not the “*panacea that means all placements are great*”, they felt hopeful that it would add to the repertoire of interventions offered and thus give both families and clinicians more choice of treatment. A couple of participants also highlighted the benefits of being an organisation engaging in research, particularly when undergoing inspections or scrutiny from external bodies.

Participants whose services were actively involved in delivering VIPP-FC spoke of how their service had developed as a result of engaging in the RCT. Service managers spoke about it being “*nice*” to be able to offer staff new opportunities for CPD that may not have been available otherwise. They also reflected that their teams had been able to share some of the learning from VIPP-FC training which brought new perspectives to their work.

Several participants expressed the view that through engagement in the study, services would benefit not only from having clinicians with additional skills,

but also from foster carers with more resources and strategies, which in turn may be of economic gain.

“...if there are less placement breakdowns and more placement stability that’s going to save the local authority money...”

There were mixed comments in relation to the impact on time and workload that came with study involvement. A handful of participants felt being involved was not “*overly onerous*” and therefore could easily fit in with the service’s usual day-to-day. However, some raised that the training and intervention were more “*time-consuming*” and “*intensive*” than initially described, which meant that there was “*a limit to the amount of it people can do, along with their day job*”.

2.3 Benefits to the Families

Nearly all the participants described VIPP-FC as an “*enjoyable*” intervention both for families and practitioners. The strengths-based nature of the program was highlighted as a core feature for its positive reception. There was a sense amongst the stakeholders that VIPP-FC was more “*therapeutic*” and “*holistic*” than many other approaches currently offered, and less likely to have any aversive or “*harmful*” effects.

Participants spoke of how the visual aspect of the intervention is hugely empowering as it goes beyond praise and allows foster carers to see for themselves what they are doing well.

“...things which usually stick in your mind may be the more difficult moments, whereas when you watch it back on video you can’t escape those positive moments, especially with the way that VIPP really highlights them.”

Several of the VIPP-FC interveners also emphasised the power video has in building foster carers' insight and ability to be more mindfully present. They referred to the "*slowing down*" during the video feedback as being a key moment for foster carers, allowing the moments of sensitivity and attunement to be "*magnified*" and further reinforced. Alongside this, participants thought that this gave them and the families an opportunity to spot things which may have otherwise been missed.

For the children, practitioners felt that it carved out time for important aspects of a child's development that are crucial for relationship building, specifically noting the importance VIPP-FC places upon "*play*". They reflected upon their experiences of seeing the children engage in certain games and how "*special*" the experience of just those few minutes of interaction were for the child.

Several participants spoke of how engaging in the VIPP-FC study could have a legacy impact for families. They shared that even if VIPP-FC had not been completed in its entirety, families could still benefit from its core messages of sensitive discipline and attunement. Nearly all the participants felt that the intervention would stand to benefit both children and families in the long term by building children's resilience and foster carers' understanding, regardless of whether they were still placed together.

"...they're going to be able to use those skills, not just with this one child, but with all the children who go through to stay with this particular foster carer."

All the participants were hopeful that the VIPP-FC intervention would allow foster carers to feel better skilled and supported for working with these vulnerable children.

3. Overarching theme 3: Key Learnings

This overarching theme consisted of two main sub-themes; “Importance of relationships” and “Recruitment 101”. The latter comprised of three subthemes which addressed barriers and facilitators to the recruitment process.

Table 3.

Overarching theme and subthemes in: Key Learnings

| Overarching Theme | Subthemes |
|-------------------|---|
| 3. Key Learnings | 3.1. Importance of Relationships 3.2. Recruitment 101 3.2.1. Lack of Understanding 3.2.2. Contextual Issues 3.2.3. Presence |

3.1. Importance of relationships

Nearly all the participants mentioned the importance of adopting a relational approach to this type of study. Several of the participants spoke of the confusion they encountered at various points both in the setting-up and delivery of VIPP-FC. There did not appear to be clearly delineated roles which they felt contributed to the slow progress of the study.

““Oh, I thought you were doing that”, “no I thought you were doing that”, “oh you mean we must do that?”, and so that sort of is problematic.”

These participants called for earlier planning and “clarity” over responsibilities and expectations of the various professionals involved in the study. A few participants felt that for this to be successfully achieved, it would be aided by an identified “key person” in each team who would take “ownership” and be services’ first port of call for all things VIPP-FC related. For participants who felt they did have this person in place, it allowed them to not fall “at the first hurdle”.

However, for those who lacked clearly designated VIPP-FC leads they noted that their services were very busy with mandatory tasks, and therefore no-one was willing to volunteer to sign up and take on this added responsibility. One way to overcome this, that participants identified, was to have the key person's and all those involved in the research, roles clearly documented so everyone knew who oversaw what aspect.

“...there's almost like an agreement that everyone's signing saying what they're actually going to take responsibility for.”

Many of the participants called for a greater sense of unity and sharing between the research team and local authorities. Some explained that VIPP-FC is not *“very useful if it's a standalone thing”* and by not actively trying to engage the entire network, the study could be *“quite counterproductive, even dangerous actually”*. They felt that if the network was targeted and the team could share more of their findings from individual interventions, then the L.A.s may see the study as beneficial to their care planning for their LAC and place greater import on engagement. However, participants felt that information sharing in a research study compared to routine practice may be tricky due to permissions and protocol.

Participants shared that it was not enough just to establish an initial link between local authorities and those involved in the research, there also needed to be effort put into maintaining these relationships. One learning point participants highlighted was that the research team needs to understand that actually whilst it is necessary to seek support from *“the top”* it is just as important to engage key stakeholders *“on the ground”*, as these people act as the *“gatekeepers”* for this type of intervention.

Innovative ideas were put forward by several of the participants with regards to how to overcome some of these difficulties. A number of them discussed the idea of holding a “*network meeting*” to share the learning from the VIPP-FC intervention with those involved in the child’s care. However, one participant felt that “*you couldn’t include the intervener into a network meeting or something because it’s just not catered for as part of the research*”.

3.2. Recruitment 101

3.2.1 Lack of understanding

One of the major areas of learning participants identified regarding the study was relating to the understanding and lack of understanding around the recruitment process. They hypothesised many reasons why the uptake for intervention was low and were able to think about potential solutions to these issues.

There was a distinct view amongst many participants that one of the major barriers was around lack of understanding both amongst those offering the study and those being offered the intervention. Some participants questioned whether the recruiting social workers really understood the VIPP-FC study, and the potential benefits if families engaged. They felt that if these social workers could recognise that the questionnaire itself could provide them with valuable information about the child and that the intervention may mean their foster carer is better able to manage potential challenging behaviours, then the social workers may be more engaged in the recruitment process.

“...has anyone gone through the form with a social worker? What might be the value of completing that questionnaire with the social worker and foster carer

together? What might they glean about the foster carer that they don't already know?"

Another issue participants identified connected to lack of understanding, was around the dynamics which may be playing out between the social worker and the foster carer. Some of the participants noted that foster carers can sometimes feel “*judged*” by professionals, so they emphasised the importance of being clearer on the potential benefits to foster carers, and specifically mentioning that it is a strengths-based approach.

One of the ways nearly all the participants felt the study could overcome these misunderstandings would be to involve someone with “*lived experience*” in the recruitment process. They felt that whether this was through video, case studies or presentations by foster carers who had completed the intervention, it would be a significant facilitator to the recruitment process and demystify any unhelpful beliefs.

“...have a sort of service user foster carer who had been through it coming round talking to foster carers going “Oh my God I did this study, this is what I got out of it” so sort of modelling “this is okay, this is what I did and I really enjoyed taking part in it. These are the benefits to me; these are the benefits to the kids...”.”

3.2.2. Contextual Issues

Opinions were united in relation to the contextual issues which may have been impacting upon recruitment. Participants felt that whilst they as stakeholders could see benefits to engaging in the study, they also understood social workers’ and foster carers’ apprehensions, as “*foster care is not a permanent solution*”. They felt that this issue of placement instability and unpredictability may be blocking the recruitment and may be a significant reason why people are not engaging.

“Looked after children it’s just chaotic, you know, there’s no point in investing in now because who knows what is going to happen in six months’ time?”

A few participants spoke of the framing of the intervention being “*attachment*” based could be off-putting to foster carers as they may be fearful of forming relationships when the child is likely to move-on. They explained that perhaps moving forward if VIPP-FC was reframed as a “*training opportunity*” to increase foster carers’ understandings and develop their resources and skills, it may aid the recruitment to the study.

3.2.3. Presence

Linking with the earlier theme of “Importance of relationships”, the presence and approach of the research team was stressed as being an area to further develop, which could help engagement in the study.

Opinion was somewhat divided on the matter as several participants held the view that the research team had been “*helpful*” and “*available and supportive*”. Yet, majority of participants felt that the research team would need to go beyond what they are currently doing and play a more “*active role*” by having more of a physical presence within teams and with foster carers.

The core component to ameliorate this process, recognised by nearly all the participants, was the need for more “*face-to-face*” communications.

“...you know you can send emails until you’re blue in the face, but until you actually make eye contact with someone and see them, it’s a different thing”.

Participants felt that by having more visibility within the network, attending meetings, making introductions in person etc. would boost the L.A.s interest in being

involved in the study. It was acknowledged that this would require a lot of “*perseverance*” from the team, but many participants felt strongly that “*a physical presence and a relationship*” would make the difference.

Discussion

Stakeholders’ accounts demonstrated the complexity of conducting the VIPP-FC RCT in L.A.s, and the barriers and facilitators which impacted on its acceptability and feasibility. In this study these factors were expressed through three overarching themes; Challenges of Implementation; Benefits and Impact of VIPP-FC; and Key Learnings.

In keeping with general implementation science (Beidas et al., 2016) the themes in this study often arranged themselves in a multi-level manner, with emphasis placed upon the organisational level. The qualitative accounts highlighted challenges working in such a chaotic and disorderly structure. Unsurprisingly, difficulties were encountered by stakeholders attempting to get research involvement made a priority when it was viewed by many as a non-statutory, additional task. Stakeholders hypothesised that this may be due to competing demands and overwhelming caseloads, which echoes previous findings by Gilbertson and Barber (2002). The positioning of the study as being something “extra” that did not come from within social care seemed to be a recurring obstacle to the smooth running of the research. It poses the question that despite social workers being exceptionally busy, perhaps if the L.A.s had more ownership in the research such as co-production then there may be greater top-down pressure to make the study a priority.

One of the largest challenges to the research was the organisational structures within the L.A. As proposed by Mezey et al (2015), we found that the lack of an

embedded research infrastructure was a significant hurdle to try and overcome. Greater attention was given by participants in this study to the churn within children's social care, perhaps as the research was conducted after significant policy changes and budget cuts, whilst most of the previous studies pre-dated these changes. The high staff turn-over, combined with a fatigued and overstretched system, made for a more hostile environment for external researchers to infiltrate. This echoed some of the contextual issues Dale and Watson (2010) encountered in their attempts to recruit LAC for health research and the scepticism they encountered when approaching stakeholders about their research.

Linking with this, stakeholders reflected upon L.A.s' readiness and preparedness to change. In thinking of the acceptability of VIPP-FC in this context, participants highlighted the struggles encountered in trying to implement change in a system that undergoes constant change and restructuring. Whilst many other studies addressed intra-organisational issues to implementing EBP (Beidas et al., 2016; Langley et al., 2010), few have discussed the defensive mechanisms organisations adopt against new ideas and research to maintain homeostasis at times of uncertainty, which was touched upon by participants in this study. Stakeholders identified that holding such a position stifles innovation and in the longer term means we remain stuck as to what to offer and how to treat LAC with attachment difficulties.

The study identified essential elements of an RCT which were presented as major roadblocks by social workers to study engagement. Whilst this finding was not unexpected given previous studies which illustrated similar results (Goodkind et al., 2017; Gray et al., 2014), it is nonetheless noteworthy as we know that social workers act as the gatekeepers for research with LAC. Again, randomisation was

highlighted as an issue which stakeholders found difficult to accept. However, unlike previous studies which suggested that this dilemma arises from social workers' perhaps lack of understandings of the importance of randomisation in research, the social workers in this study spoke comprehensively of the need for bias-free samples. It appeared that their difficulties were more ethically grounded, with there being concerns over children not getting treatment which matches Dixon and colleagues' (2014) findings, and, interestingly, something not addressed previously by the literature - how it was hard to maintain boundaries i.e. focusing solely on their research role when they were also a trained clinician.

Participants spoke of their belief that the study utilised diagnostic criterion and how uncomfortable it felt to potential give pathologizing labels to children. This did not emerge as a finding in previous implementation and LAC research, but perhaps it is because most studies were conducted with adolescents and were not mental health based. Connected to concerns of diagnoses, information sharing was also brought up by participants. Whilst other researchers (Mezey et al, 2015) have encountered social workers wariness of engaging in an RCT, few have specifically spoken about the potential effects of sharing information within the network. This could be linked to age, as generally younger children have a higher chance of being adopted than their older counterparts (Department of Education, 2018) thus stakeholders may have been fearful of the impact certain information has on children's adoptability.

As recognised by Bogolub and Thomas (2005), consent was viewed by stakeholders as a complex problem. It appears that there is still confusion with LAC populations around who must provide consent and how the process should be conducted. Whilst participants raised this as an issue, they were still uncertain as to

how this could be overcome. Therefore, the challenge remains of how feasible research can be with LAC when we are uncertain if we can legally and ethically consent them to studies.

Stakeholders' accounts highlighted the potential positives of VIPP-FC as a study, alongside drawbacks they encountered. From an organisational and systems level, it was viewed as beneficial to be engaging in research and contributing to developing an evidence base for LAC. The majority of research to date on implementing EBP has focused upon stakeholders as sometimes being sceptical of engaging in health and mental health research (Gray et al., 2014), however in this study participants were enthused to be contributing to scientific research and intervention development. This may be somewhat explained by the fact that many of the stakeholders had previous experience of engaging in research.

Value was placed upon developing evidence-based interventions, and participants spoke of frustrations felt when others did not understand the potential benefits of doing so. This presents a somewhat conflicting view to early concerns stakeholder raised in relation to the RCT elements. There appeared to be an acceptance of the importance and necessity of the research but reluctance to follow some of the RCT guidelines in practice. Perhaps it is the case that the VIPP-FC research is acceptable theoretically but in actual application there are components which feel less palatable (MacDonald, 2000), and this may account for some of the study's difficulties with recruitment.

On an intervention level, stakeholders were largely positive about VIPP-FC. It was felt that this adapted version of VIPP was beneficial to the families stakeholders worked with, and they highlighted the strengths-based nature (Juffer et

al., 2008) and emphasis placed on play as being key elements to its success. Whilst we have not yet received quantitative data on the outcomes of VIPP-FC, it appears to be an acceptable and enjoyable intervention for this population thus far according to stakeholders. However, the VIPP-FC program was not without its issues. The manualisation aspect posed several difficulties for interveners, namely that it lacked flexibility and sometimes, they felt, took from the importance of clinical judgement. Whilst manualisation perhaps is containing and provides helpful guidance for those with less clinical experience, the interveners in this study had significant clinical experience, which may be partly why they felt frustrated having to stick to a script.

There was also a sense that whilst VIPP-FC had adaptations to suit the population's unique characteristics and needs, from a logistical standpoint operating a strict manualised protocol often did not fit in with the LAC context. Stakeholders felt that for VIPP-FC to be more feasible as an intervention for foster carers, there needed to be greater flexibility in timings and further considerations given to the environment VIPP-FC was being conducted in and how to adapt for this.

Stakeholders generated several ideas for mitigating some of the difficulties encountered in the research and provided ideas for the future. It was evident in the qualitative accounts that taking a relational approach was key to the smooth running of VIPP-FC. As Beidas and colleagues (2016) emphasised, implementation of EBP requires three core components; co-ordination, cooperation and communication. Stakeholders identified the need for role clarity, leadership, persistence and physical presence in order to make VIPP-FC more feasible within this context. Many of these recommendations echo Dale and Watson's (2010) learnings from their research with LAC, however, there was a greater prominence across stakeholders' accounts relating to the importance of face-to-face contact. Perhaps this arose as the study

came via a university as opposed to a National Health Service and therefore more focus was placed upon the need to bridge the gap of internal and external positioning.

Whilst much of the literature detailing barriers to LAC research focuses on the importance of continual dialogue (Goodkind et al., 2017) and assistance from gatekeepers, few generated ideas of how to achieve this beyond offering financial incentives. The suggestion by stakeholders in this study to use someone with lived experience could be a cost-effective way to improve study engagement. It could also be a way of demystifying and clarifying misunderstandings which stakeholders felt were a significant, influential obstacle amongst social workers in terms of recruitment.

Methodological Limitations

Whilst every effort was made to invite stakeholders from a range of different service contexts and positions in order to make the findings as generalisable as possible, those that agreed to interview either worked in a LAC service or had previous experience of VIPP, which may have resulted in some positive bias.

Alongside this, despite this research being separate to the larger trial and the researcher assuring participants that data would be anonymised, the researcher was being supervised by the principal investigator of the RCT and participants were aware that this study's results would be shared with the wider research team (see Critical Appraisal for more in-depth discussion). This may have led to some stakeholders feeling unable to speak as freely as they may have done with an external third party and may have meant that participants spoke of the study in a more favourable light.

The final sample size was also relatively small, and whilst the data captured a diverse range of views, it is unlikely that these are representative of all stakeholders in the study. In addition, the interviews largely involved London based sites, with only two participants based outside the city which may impact the generalisability of findings. Whilst it is anticipated that many of the barriers and facilitators expressed in this study are universal, there may also have been different influencing factors present on other sites that this study does not capture.

Implications for future research and practice

The stakeholders in this study were able to provide in vivo insights into obstacles encountered and practical solutions and ideas for overcoming these. Foster carers were key stakeholders not interviewed as part of this study due to their ongoing involvement in the intervention at the time of this study. It would be worthwhile conducting similar research including their perspectives, as the emphasis placed on carrying-out research within the research (Clarke et al., 2015) allowed for the emergence of valuable information in this study which can be utilised to improve methodological design and conduct. Future research, particularly if involving agencies from a different discipline, should always aim to conduct these trials within trials (Rick, Clarke, Montgomery, Brocklehurst, Evans & Bower, 2018) as it has the potential to not only increase problem identification and solving, but also to foster greater collaboration. This would be especially informative if stakeholders could also complete relevant quantitative measures examining the relationship and sense of collaboration amongst internal and external agencies, and attitudes to and perceived benefits of engagement in research.

The process of consent posed significant confusion in this study and acted as a barrier to engagement. Research on consenting procedures with LAC and ways to better facilitate this process would be beneficial as it could ease the way for future studies hoping to improve the mental health and wellbeing of these children.

Based on the findings from this study and previous research (Dixon et al., 2014), it does not seem feasible to offer an intervention to LAC without the support of social workers. Investigators need to place equal emphasis on the relational element of the research alongside the scientific if studies are to be successful. As Lennox and colleagues (2005) illustrated, without direct contact and the use of an “insider” successful recruitment to EBP research is limited.

Furthermore, this study highlights the importance of understanding cultural dynamics and resources within social care in order to work collaboratively to appropriately meet LAC’s needs. It calls for social care to create a more benign environment that is open to external bodies who wish to support their work. For this to be possible a cultural shift needs to occur at all levels within social care systems (Mezey et al., 2015). However, in the current climate this is unachievable without the government supporting this process through additional financial backing and there being a greater emphasis placed upon utilising evidence-based approaches as best practice.

There is still no consensus in the literature on how to adapt interventions for the unique characteristics of LAC (Hambrick, Oppenheim-Weller & Taussig, 2016). Nonetheless, in this study stakeholder reports suggest that this modified version of the VIPP program holds promise as being an acceptable intervention for foster families of children with attachment difficulties. Whilst there have been some

difficulties highlighted surrounding the manualisation of the programme and logistical issues, it appears that the intervention is still being viewed as a positive opportunity to reduce impairment and prevent further attachment difficulties in LAC. Perhaps this study needs to be reframed for social care as a means of potentially reducing placement breakdowns and universally improving foster carers skills, then we may see an increase in the synergy between L.A.s and the research.

Conclusion

In summary, findings suggest that VIPP-FC holds promise as being a useful intervention for foster carers of children with attachment difficulties. However, the significant barriers encountered to recruitment and engagement pose questions relating to the study's feasibility and sustainability if delivered through L.A.s. Greater utilisation of potential facilitators to these processes need to be adopted swiftly if the study is to meet universal acceptability.

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PART THREE: Critical Appraisal

Introduction

This critical appraisal addresses the processes of conducting Chapter Two of this paper. The ways in which the study design and methodology may have impacted upon the results are explored. Particular attention is given to the researcher's own perspective, issues with recruitment, reflections on interviewing, and the process of analysis. In addition, the study's strengths and weaknesses, and research and clinical implications are also addressed.

Researcher's theoretical orientation and experience

A researcher's positionality can impact upon all stages of the research process (Foote & Bartell, 2011). Elliot and colleagues (1999) set good practice guidelines for reliable and valid qualitative data analysis, and in it they detail the need to own one's perspective. However, for this study I wanted to go slightly deeper than this and understand more about what had influenced my perspective so I could be more mindful in navigating my interviews and analysis. Through conducting a bracketing interview, I began to recognise the impact my own clinical experience had on how I positioned myself, and the potential influence some of my preconceived ideas had on my approach to the research (Tufford & Newman, 2010). Beliefs I held about the importance of taking a pro-active and preventative approach to mental health issues meant that I was strongly aligned with the ethos of the VIPP-FC program and the study's goals. The more literature I read in preparation for the study the more invested I felt in wanting the study to be a success and the more import I placed on its potential contribution to an already scant evidence base. I also felt a strong sense of unity with the research team having previous experience of trying to evoke change in an overworked and exhausted social care system during a clinical placement.

Interestingly, whilst conducting the interviews, I actively tried to distance myself from the research team in my initial introductions; stating that I was doing this research for my thesis as opposed to be employed within the research team. Trying to pre-empt and pro-actively address my position I hoped would mean that I would be viewed as a neutral party and encourage more open dialogue. As Karnieli-Miller, Strier, and Pessach (2009) have emphasised it can be helpful for researchers in qualitative studies to strive to reduce the distance and power imbalances in research-participant relationships. Yet despite my efforts, I found that participants often grouped me unconsciously as part of the research team; asking me questions relating to different aspects of the study to which I had no knowledge of, or using phrases such as “you and the rest of the research team”. This could have impacted upon and created positive biases within participants’ reports. In the future I think I would try to be clearer in stating my position from the first initial contact, in this case the first email I drafted, and then spend more time discussing this prior to interview commencement.

Study recruitment – difficulties and dilemmas

Conducting research as a non-social care profession within the social welfare system has been frequently documented as being a hugely difficult task (Dixon et al., 2014; Gray et al., 2014). Studies often addressed social workers perceptions and beliefs about RCTs, their role as informal gatekeeper, and resource limitations (Mezey et al., 2015) as significant barriers to implementation. Therefore, it is not surprising that whilst many social workers who were actively involved in the project either in the setting-up and designing of the study, or in offering VIPP-FC as an intervention were happy to be interviewed, I failed to recruit a single social worker who acted solely as a gatekeeper to the project i.e. the ones introducing the

intervention to prospective families. The difficulties I encountered trying to engage social workers in my research seemed to reflect issues the research team had with the level of social worker involvement.

This felt particularly significant as the larger study was struggling with getting suitable families referred into the trial, and it would have been helpful to gain social workers' hypotheses about why this may be occurring, their insights into problems they have encountered, and ideas for solving and negotiating these (Hurlburt, Aarons, Fettes, Willging, Gunderson & Chaffin, 2014). It was somewhat disappointing realising that none of the social workers I contacted who were recruiters for the study were willing to be interviewed or at least return my calls or emails to express an interest in participating, as it felt that despite substantial efforts made by the research team we were falling at the same hurdle as many researchers before us. This contributed to a feeling amongst those involved in the research that conducting such a study with L.A.s is an almost insurmountable challenge.

Participants in the study spoke of the importance of a face-to-face presence, which reflected previous learnings and recommendations proposed by Dixon and colleagues (2014) after their attempts at offering an adolescent intervention via social care. In hindsight perhaps had I gone to the sites in person to talk about my project with staff I may have increased my own recruitment numbers and the diversity of my participants. This may also have helped to overcome the gap between agreeing in theory to be interviewed when they signed up to the study, and the actual follow-through in practice, which echoes Mezey et al's (2015) findings of there being a stark contrast between theoretical acceptance and practical application. By being present in the teams I may also have had opportunities to open a dialogue

about why they had not responded to my email invitations and had some more concrete evidence to back up the hypothesis of needing direct, face-to-face contact.

Developing an interview schedule and conducting interviews

The interview schedule was created in accordance with guidelines outlined by Smith (1995). Questions were open-ended, tried to avoid the use of jargon or being value-laden, and each topic on the interview schedule followed a funnelling type approach i.e. starting more broadly before becoming more specific (Guba & Lincoln, 1985). One of the difficulties encountered in developing these interviews was in relation to the varying roles and positions stakeholders held in the study. As the participants worked on different sites, were at different stages of implementation and came from different professional disciplines, it meant that I had to develop four interview schedules, just to account for these factors. Consequently, the process was far more time consuming than originally anticipated.

In hindsight I was glad to have taken the time to do so, as it allowed for more natural reciprocity between the stakeholders and I (Galletta, 2012), as I had some understanding of what they were trying to achieve in their roles, could empathise with this, which in turn aided the development of a rapport. Knox and Buckard (2009) describe the relationship between interviewer and interviewee as being a key element in qualitative research. Mindful of this, I tried to adopt a relational approach, spending time with participants in the briefings getting to know a bit more about their backgrounds and interests prior to commencing the interviews.

As a Trainee Clinical Psychologist my professional background held similarities to a small number of clinicians involved in my study, which allowed me to hold a certain “insider” stance. However, with the other participants from different

disciplines, I could hold a more curious and not-knowing (Monk, 1997) position. In this study the “insider-outsider” stance was somewhat dichotomous (Corbin-Dwyer & Buckle, 2009) and I felt able to move between the two at different points. For example, although I was a Trainee Clinical Psychologist my career was at the beginning stages, whilst the Clinical Psychologists I interviewed had been practicing for quite some time. I was also quite naïve about how VIPP-FC was progressing in each service as I did not hold any prior knowledge of this, yet on the other hand I had access to information that many of the stakeholders did not yet know such as the research team’s issues with recruitment rates. The fluidity of being able to transition between the two positions I believe allowed for richer and more in-depth discussions during the interviews and helped to reduce potential power imbalances.

I tried to take brief notes during the interviews and jotted down things which had struck me after each interview as Ahern (1999) suggests that by doing so it allows for a deeper engagement in the research processes. These observational and retrospective comments were helpful as they provided further insight into what I was noticing in the data and allowed me to reflect on why this may be the case. This was particularly useful when I began to code my data as I was able to note unexpected findings that I did not see initially, add this information to what I had learnt from the bracketing interview, and be more conscious of my own biases and preconceptions.

Throughout the interviewing process I was struck by the general enthusiasm held amongst stakeholders for the research and their willingness to try and support the study as best they could. Some participants gave examples of ways in which team members had gone above and beyond what was expected of them, and it really fostered a sense of the import these individuals placed upon the research and their commitment to improving the care of LAC. I think this helped me to keep going in

my work also, as there were certainly times when the amount of tasks I had yet to complete felt overwhelming, but reading through their transcripts and remembering the effort everyone was putting in reminded me of the importance of the work and kept me focused.

Reflections from the analytic process

The interviews ranged from 50mins to an hour and 15 minutes, and due to the participants' detailed, well-articulated accounts I had a large data set to work with. This posed challenges which ironically reflected one of the subthemes from the data, regarding how and what to prioritise. I found myself really utilising my learnings from the bracketing interview to notice when I was gravitating towards something which I found interesting but was not representative or coherent with the narrative within the data set. The desire to capture all the data was also something I grappled with and I found myself getting drawn into some of the common pitfalls in qualitative analysis that Braun and Clarke (2006) had cautioned against. I tried to take regular breaks throughout the analytic process to avoid becoming overly saturated in the data and thus unable to see items which may be novel or inconsistent with my own hypotheses (Smith & Noble, 2014). Having an external researcher code some of my transcripts and look over my initial themes also really helped to move me away from purely providing a description for each of my illustrative quotations, to creating a more coherent and analytic narrative.

One of the most prominent things to emerge during the analysis, which my supervisor and I reflected upon, was the fact that there was an unheard voice (Kristensen & Ravn, 2015) within the narrative we were creating. The ideas behind implementation science and “conducting research on the research” (Clarke et al.,

2015) are about gaining insights and perspectives which can improve trial conduct (Rick, Clarke, Montgomery, Brocklehurst, Evans & Bower, 2018). However, we had omitted one of the largest stakeholders in the research by not interviewing the research team. They could have potentially provided an entirely different perspective on the study, or they could have held very similar views, both of which would have been interesting to have explored and could have provided a more inclusive picture of the impact, acceptability and feasibility of VIPP-FC.

Much of the implementation science research that has involved researcher perspective has been reflective accounts written by the researchers themselves. In a similar way to my learning from the bracketing interview, perhaps having a third party conduct semi-structured interviews with the research team may introduce more spontaneous and unexpected findings (Breakwell, Smith & Wright, 2012) and provide innovative ideas for the future. It may have also helped the researchers who were becoming disheartened by the poor uptake rates by reminding them of their initial interest in the research, and thus strengthen its application (Slunge, Drakenberg, Ekblom, Gothberg, Knaagard & Sahlin, 2017).

Study's strengths and weaknesses

Whilst the study had a relatively small number of participants, those interviewed did represent a diverse range of stakeholders, from more senior managers, to those working on the ground offering the intervention. This helped to make findings more generalisable and it was felt that the data had reached saturation (Saunders et al., 2018) by the time interviewing had finished. Due to time constraints of the research, testimonial validity was not sought and whilst consensus and auditing with external researchers was conducted, it would have been beneficial to

have stakeholders' views of the findings. This could have created an opportunity to further check the validity of our interpretations, as well as see their reactions to these, and allowed for further commentary or deeper discussions to occur (Stiles, 1999).

One of the limitations of the study related to the narrow geographical area of the sites involved. This was partly due to the timings of the different phases of the RCT, but also one may hypothesise that those sites invited to participate that did not engage may be reflective of some of the issues raised by stakeholders, such as not receiving face-to-face contact from the team which results in poorer engagement. It would have been interesting to see if findings differed across sites as stakeholders spoke of the systemic issues and disorganisation in social care, but perhaps outside of London where the numbers of LAC may be lower, these issues may be less significant, and other influential factors may have emerged.

One of the strengths of the study was its usefulness for the conduct and application of the VIPP-FC RCT. It follows guidelines set by the Medical Research Council (2006) for the development and evaluation of a complex intervention which aim to support researchers in producing more relevant, implementable data. As this study was carried out during the earlier stages of the RCT's implementation, the findings can be shared with the research team and appropriate adaptations made which hopefully will bolster the potential success of the project. I also feel the sense of shared frustration with, and empathy for the research team expressed by stakeholders in the study may have a positive impact upon collaboration and co-production moving forward.

Study's clinical and scientific implications

The determination of who must provide consent for a LAC to partake in research was something that stakeholders in this study grappled with. This is not unsurprising given the literature on the issue detailing the complexity and confusion involved in the process (Dale & Watson, 2010; Bogolub & Thomas, 2005). Despite this current study involving professionals from a range of different L.A.s there was still no consensus about how to ameliorate this process. It would be helpful for further research to be conducted specifically on how consent can be achieved with LAC which included all stakeholders i.e. foster carers, also. If a standardised approach to consent can be developed for this population then perhaps in the future, researchers will find L.A.s more willing to engage in research as there are clear structures and protocols in place to aid the process (Mezey et al., 2015).

This study gave insight into the intervention-context fit of VIPP-FC. Though there is a level of acceptability relating to the importance of developing an evidence base, and the intervention proving to be enjoyable and useful for those receiving it, there are a number of obstacles which beg the question of how feasible and sustainable it is to offer such an intervention through L.A.s. Whilst LAC remain an under supported group in terms of what can be offered that is tailored to their needs (Tarren-Sweeney, 2009), and there is a need to be more holistic and pro-active in our approach to working with these children, as called for by the Munro report (2010). It seems that these are ideals which are difficult to implement in real life without some significant change occurring within the structures and available resources of the L.A.

Given the current financial strain faced by Children's Social Services it is unlikely that these macro changes will occur anytime soon, however as illustrated in the qualitative accounts of the stakeholders in this study, this does not mean that such studies and interventions are impossible. Introducing small changes to the

framing of an intervention, utilising resources which are already available such as foster carers with lived experiences of VIPP-FC, and demystifying RCT components seem to be a key starting place.

In addition, stakeholders also spoke about the intervention and adaptations that could be made to VIPP-FC to further improve the “fit” for this population and context. Modifying such an intervention when part of a research trial introduces dilemmas regarding research fidelity. There are also questions regarding how much the program can be altered before the content becomes damaged (Hall & Hord, 2001). However, Blakley (1987) found that adding elements that were appropriately adapted could improve a program’s effectiveness. Many of the interveners in this study called for more flexibility and greater use of clinical judgement in the VIPP-FC program. On a deeper level however, this highlighted the potentially conflicting goals between the research team and clinicians, as to change the manual could impact the efficacy of the study, however it may improve the effectiveness of the intervention. In order to overcome such dilemmas it appears that adopting a more relational approach from the very beginning, as called for by the stakeholders, could create continued, open, and transparent dialogue (Goodkind et al., 2017) around these issues and may lead to mutual solutions which are acceptable to all those involved in the research. As Lang and McAdam (1999) have suggested “well begun, half done”.

Conclusions

Stakeholders in this study provided rich and detailed accounts of the barriers and facilitators to the implementation of the VIPP-FC study. They

highlighted systemic, organisational and intervention-based issues which impacted upon the program's acceptability and feasibility. Their innovative solutions to some of these challenges emphasises the value of implementation research and provide key ideas for adaptations and changes that ought to be considered in order to improve the intervention-context fit, and the usefulness of this intervention for LAC and foster carers.

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Appendix A

Letter of Ethical Approval

Professor Pasco Fearon
Joint Director UCL Clinical Psychology Doctorate
University College London
Research Department of Clinical, Educational and Health
Psychology
University College London
Gower Street, London
WC1E6BT

Email: hra.approval@nhs.net

18 August 2017

Dear Professor Fearon

**Letter of
HRA
Approval**

**Study title: A feasibility
study and pilot
trial of a modified
videofeedback
intervention for
children and
foster carers to
improve mental
health outcomes
of children with
reactive
attachment
problems**

**IRAS 215947
project ID:
REC 17/LO/0987
reference:
Sponsor University
College London**

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability.

Please read *Appendix B* carefully, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities

- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from www.hra.nhs.uk/hra-approval.

Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval

The document “*After Ethical Review – guidance for sponsors and investigators*”, issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

In addition to the guidance in the above, please note the following:

- HRA Approval applies for the duration of your REC favourable opinion, unless otherwise notified in writing by the HRA.
- Substantial amendments should be submitted directly to the Research Ethics Committee, as detailed in the *After Ethical Review* document. Non-substantial amendments should be submitted for review by the HRA using the form provided on the [HRA website](http://www.hra.nhs.uk), and emailed to hra.amendments@nhs.net.

- The HRA will categorise amendments (substantial and non-substantial) and issue confirmation of continued HRA Approval. Further details can be found on the [HRA website](#).

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at <http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rd-review/>.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: <http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/>.

HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details at <http://www.hra.nhs.uk/hra-training/>

Your IRAS project ID is **215947**. Please quote this on all correspondence.

Yours sincerely

Rekha Keshvara
Senior Assessor
Email: hra.approval@nhs.net

Appendix B

Information Sheet



VIPP-FC Scoping Study Information Sheet

We are contacting you because we are undertaking research that is investigating interventions to support looked after children and we would like to invite you to help us with the development process. Before you decide whether you would like to be involved, it is important for you to know the background of the study and what your role would entail.

The Study

Children who are in care can sometimes get upset or worried, or have difficulties interacting with others, and currently there is a lack of research on which forms of support or therapy work best for these children. The aim of this research study is to evaluate a new program designed to specifically address these areas of concern for looked after children, called Video Feedback to Promote Positive Parenting –Foster Care (VIPP-FC). VIPP-FC aims to help foster carers to recognise signals from the child that may be quite challenging and difficult to understand, so that they are better equipped to respond sensitively. We currently do not know which type of support is better for different families and by carrying out this research we hope to be able to improve the kinds of services offered to looked after children.

Your Role

We understand that delivering interventions and testing their effectiveness is inevitably a complex process for children in foster care for a number of reasons. Therefore, we would like to interview key participants to help develop solutions to possible concerns which could arise in the trial. In this scoping study, we will talk to some foster carers, CAMHS practitioners, social workers and other representatives of local authorities.

The interview would explore several key topics, such as the potential barriers and solutions to operating a common screening system for identifying foster children with emotional difficulties. We are also interested in what treatments or support are currently offered to foster children and what referral criteria are applied. We would like to know if there are any possible

concerns regarding children's participation in the research, in particular if there are any clinical or ethical concerns of stakeholders about diagnosis, randomisation and treatment in the population. Furthermore, we would investigate the barriers to obtaining appropriate consents for children in foster care who are on different care orders. We would greatly value your opinions and advice on these matters.

The interview would last approximately ____ and would be carried out in your place of work or at your home.

Confidentiality

We treat all data provided by our participants as confidential. We collect information from you solely for the purposes of doing this study and will not use it for any other purpose. All information (including questionnaires and audio recordings) gathered will be filed in a locked cabinet at our research site, and electronic files transferred and stored safely (using a secure UCL platform). All information that could identify you or your foster child personally (e.g. names, addresses, telephone numbers, email addresses), will be retained for 10 years after the study is complete and then securely destroyed.

To oversee the quality of the study, officials from UCL may look at your research records to check that the study was done properly. Nobody else, apart from the Nurturing Change study team, will be able to see the information you give us without your permission.

When we report the results of the study, we will not include any personal details about any of the families or children that took part, so they cannot be recognised. When the research is complete, we will send out a report to all families who took part to let them know about the results of the study.

Who is responsible for looking after the information I give?

University College London is the sponsor for this study, based in the United Kingdom, and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you

withdraw from the study, we will keep the information about you that we have already obtained.

Contact for further information

If you would like further information about the study, please contact the research team directly on 0207 443 2239. If for any reason you were unhappy about the research process, you may contact you can contact the Chief Investigator Pasco Fearon on 0207 679 1244 (p.fearon@ucl.ac.uk).



Appendix C

Consent Form



Consent Form for Stakeholders

VIPP-FC Scoping Study

Please initial all boxes that apply

I confirm that I have read and understand the information sheet (date.....
Version.....) for the above study. I have had the opportunity to consider the
information, ask questions and have had these answered satisfactorily.

I understand that my interview will be audio-recorded and stored securely at
University College London.

I understand that all published material from this study will not identify any
individuals or organisations by name. I understand that publications may use
anonymised quotes from my interview.

I am happy to take part in the study.

Name of stakeholder

Name of person (researcher) taking consent

.....

.....

Signature:

Signature:

Date:

Date.....

Appendix D

Interview Schedules

Clinicians Interview Schedule

Overall experience

How has the VIPP programme being going?

What have been the most positive aspects of the programme?

Have you encountered any challenges? If so, how have you managed to overcome these?

Study implementation

Are you involved in the screening process for the study? *If so, what is that experience like? How are you find using the psychometric measures? Have you encountered any difficulties? How have you tried to overcome these? What learning have you taken from this recruitment process that you would apply to similar studies in the future?*

How have you found the VIPP training? *Are there ways in which you feel it could be improved? What were the aspects of training/learning that you felt were core to the VIPP study?*

Impact on work

How is being involved in the VIPP programme impacting upon your own clinical practice? *In what ways, can you give me a specific example of that?*

What is the experience like of engaging in VIPP training and implementation alongside managing your other clinical work? *Has it been easy to integrate VIPP alongside your other clinical work as normal?*

Engagement

Can you tell me a bit about your experiences of introducing VIPP to families and trying to engage them thus far? *Are you experiencing any challenges in applying the VIPP models to the families that you work with? What has helped you to manage these? Are there things you would do differently in the future? What helps this process be successful? How important is family engagement for this intervention? Does the VIPP programme help engage families?*

Are there any barriers or challenges you encounter to engagement with this type of intervention? *Can you give an example? How did you overcome it?*

Have any of the families you worked with disengaged? *Why do you think this might be? Is there anything about the VIPP programme that you think may significantly impact upon families' engagement?*

What do you think some of the key moments have been for the foster carers that you have been working with? *What do you think the key moments for the children have been? As a clinician what have been your key moments in using VIPP?*

If you had to summarise your experience of VIPP as an intervention thus far, what are the things that have worked well for families? *What has worked less well? Do you have any ideas how this could be improved?*

Supervision

What has your experience of supervision been like on the VIPP study to date? *What is most useful about it? What is less so? In what do ways you feel supervision in relation to VIPP cases could be improved in the future?*

Acceptability of intervention

If you were to be involved in a similar study in the future, what would be some of the key things you would want to hold in mind or do differently?

Commissioners Interview Schedule

Overall experience

Can you tell me a bit about what interested you in the VIPP study in the first place?
Why did you feel it was important to get involved in the VIPP study?

What has been your experience of working on the VIPP study to date? *As a commissioner, what do you feel are the most challenging and most positive aspects of being involved in this type of study?*

Can you tell me a bit about the process of implementing an intervention such as VIPP from an external body into NHS services? *Would you/did you have any concerns about this study coming from an external body? One of the potential issues would be trying to get this intervention to work within a CAMHS structure. Have you heard much about how his process has been going so far?*

In your opinion working with looked after children and foster carers, what are some of the most relevant ethical considerations and policies that are relevant to a study such as this? *Have these been challenging to work alongside? How have you overcome such challenges?*

Study implementation

We have been encountering some difficulties in getting families involved with our study, one of the reasons being that in the local authority resources are very stretched, so even though we have been sending materials to potential families, getting the local authorities to follow up has been quite a challenge. Do you have any ideas of what may help the recruitment process for a study such as this? *Have you ever experienced this on projects you've worked on before? What helped to overcome these difficulties?*

Acceptability of the intervention

As a commissioner what have been the major learning points that you will take from being involved in the study to date?

In the future if you were to implement a study like VIPP how would you go about it?
What specific things would you do differently? What would you keep the same?

If we were to try and get VIPP commissioned by social care further down the line, what do you feel would be some of the important things we should think about?
What do you feel would be some of the possible barriers or challenges to this?

Managers Interview Schedule

Overall experience

How has the VIPP programme being going?

What have been the most positive aspects of the programme so far?

Have you encountered any challenges? *If so, how have you managed to overcome these? Why do you think these difficulties arose?*

Study Implementation

How has the process of introducing a new study from an external body been so far as a manager? *What were your main concerns in implementing a study like this? What have been some of the challenges you encountered? How are you overcoming these? Are there ways in which the study could be better supporting your service?*

How are staff members responding to the introduction of VIPP? *As a manager what did you do that you feel was important when introducing VIPP to staff? Were there any barriers or challenges you encountered? If you were to introduce a study like VIPP again is there anything you would do differently?*

Are you involved in the recruitment process for the study? Can you tell me a bit about that experience? *What are the most challenging aspects of recruiting? What do you feel you have learnt about recruiting for a study like this? Would you do anything differently in the future?*

How is being involved in VIPP impacting upon your service? *What do you think are some of the potential benefits and challenges in implementing a study such as this within your service? How do you think these areas could be improved or built upon?*

Is being involved in implementing VIPP influencing or changing your own practice in any ways? *Can you give an example?*

Can you tell me a little bit about your experience of supervision/supervising on this study? *What have been some of the difficulties that have arisen? How are you or did you overcome these? What have been some of the more useful aspects of this style of supervision? **ask only if CAMHS manager***

Engagement

Thinking about the types of families that you work with; are there any potential barriers you see to offering a study such as VIPP? *How do you think these could be overcome? Are there ways in which you feel we could improve people's engagement with the programme?*

In your opinion what are some of the benefits of VIPP for these families?

What has the feedback you received about the VIPP study been like thus far? *What have clinicians said about the study? What have the social workers involved shared? What have you heard from foster carers?*

Acceptability of the intervention

Given the current climate, where there are significant changes occurring in the way in which we work with looked after children, what do you feel has helped or hindered this project from running smoothly? *What areas do you think require further development?*

In the future if you were to implement a similar study are there things that you would do differently? *Can you give me examples?*

Social Workers Interview Schedule

Overall experience

Have you heard of the VIPP study? *What's your understanding of this project? Are you currently involved in the study?*

How has the project been progressing in your service? *What are some of the challenges you have encountered being involved in this study? How have you overcome these? What are some of the positive aspects of being involved in a study such as this?*

What's your understanding of how the local authority is contributing to the VIPP project? *Are there ways in which the local authority could support the project better? What are some the barriers you may have encountered to a study like this within the local authority?*

Have you experience of talking to foster carers about the study, if so, can you tell me a bit about what that experience was like? *What were some of the more challenging aspects you encountered in trying to get families involved? What do you feel you have learnt about trying to get families involved in a study like this? Would you do anything differently in the future?*

One of the things we have struggled with is when we have sent the questionnaires to families, we don't receive many back. Have you any ideas about what we could do to better support families, so they feel more able to complete the forms?

Study implementation

Has being involved in a study such as this impacted upon your own workload compared to normal? *If so in what ways. Have you ideas how this could be managed better or improved?*

In terms of case management are there any additional steps you feel you need to take for the families in this study compared to usual? *How did this impact upon your day to day work?*

In your opinion what do you think are some of the potential benefits and challenges in implementing a study such as this with looked after children? *How do you think these could be overcome? What do you think might help to improve families' engagement?*

In terms of the practical implementation side of the VIPP study, are there things that you feel could be going better? *Can you give specific examples? Have you ideas of how we could improve these aspects?*

Acceptability of intervention

Based upon your knowledge of VIPP and perhaps feedback from clinicians or families who are currently involved in the programme, how useful an intervention do you feel VIPP has been thus far? *What would make it more successful/helpful?*

If you could go back to the start of this study and do things differently what are some of the key aspects that you would change?

Appendix E

Stages of Analysis

Example of Initial Stages of Analysis: Stage 2 Initial generation of codes

Participant 3

The excerpt below is taken from the transcript of an interview with Participant

3. The more positive aspects of being involved in the VIPP-FC study are highlighted by the participant.

I: And you spoke about some of the positive aspects such as the intervention being successfully for the children that received it. Have there been any other positive aspects of the VIPP-FC study in general, or for your service in particular?

P3: Um, for our service in particular it's an additional, an additional intervention which we can offer, which we haven't got funding for otherwise which is good. So, anything we can offer to foster families in addition is great, and it does work quite well as myself, and also another clinician in our team is VIPP trained so obviously from the outset there was a very large interest in using VIPP in this team for this population. And also, I have been involved in the manual development for the VIPP-FC, so I felt that I had a voice in discussing the needs of looked after children and having an input in that, and that felt quite important to myself and the team, because I, umm...having my expertise in work life over the last twenty years with looked after children but also being VIPP trained, I think for me it was particularly important to think about the specific complexity for the VIPP-FC as compared to the VIPP as such, as it's developed in the Netherlands, so there's lots of additional things that needs to be looked at with looked after children and so one of the positive things was that I felt that I was able to input.

Something additional to offer

No funding needed = positive as no extra cost

Team's interest and involvement – previous experience aids this

Having a voice important - utilising expertise available

Experience impacts on level of importance placed on intervention

Example of Stage 3 of Analysis: Clustering into Tentative Themes

Throughout the interview the participant spoke of the logistical difficulties faced when offering VIPP-FC to foster families. Below is an example of the initial

grouping of themes which were selected from their transcript.

Context

Placement issues –Impact of instability or lack of predictability regarding the future placement of the child on implementation of VIPP-FC.

“...For looked after children during such a time their placement might change, or it might be interrupted also. I mean, we had a live case where carer went on a holiday and couldn't take the child as there wasn't a passport and quite typical in looked after children, the child had to move to another place then the child was moved back to the foster carer all during the study, and of course that has an impact on everyone. So there was a lot of concern; where would this child go, would it even come back...so there was so much confusion happening, so it's not the same going through the learning with a parent who has a stable home for their child, it's far more interruptive. So, this is just one example but there are so many of these kinds of things happening.”

Logistical difficulties – Issues with structure of VIPP-FC program and how it fits in with reality of day-to-day life for foster carers and LAC.

“...so, lots of foster carers have several children for a few months, and actually that was the case for the foster family I delivered the VIPP to, so there were 4 children in the placement of different age with different contact arrangements and different needs, and a single carer. So, and this carer was very committed to the study and it went very well, but and I have to say, I admired her for it because had I been her I don't know if I would have been that committed because she had to...it was very difficult to deliver because I delivered a VIPP to one child and three other children had to be, at the same time, in the house, so very complicated to do that because they

don't have necessarily babysitters or they're not necessarily a couple, and even if they are a couple one person is working, it's just time is an issues and if there are contact arrangements which are in the afternoon then it's very complicated."

Understanding this is a unique population – Need to understand the context many of these children are coming from i.e. abusive homes, and the one they are currently in i.e. foster care which is not long term, hold this in mind when planning for VIPP-FC.

"...Whilst I think everyone would get "okay they have been exposed to neglect and abuse and so on, and that has an impact", but I think it's difficult if you're not working in the field to see that the fact that they are in care doesn't mean that they are rescued and their life is now fine. Their life is continuing to be very challenging for most of them or at least a high percentage and I think if this were to be a programme running through, not as a research but as a programme running through CAMHS services I think there would need to be training included about this population. So, it's not just training as a VIPPer but also as VIPPer with foster carers and I think as well the people who supervise, would need to be qualified about the specifics..."

Later stages of analysis: Clustering initial themes across the data set

The initial clustering for the theme "Challenges of the Implementation" is shown below. The qualitative accounts highlighted various subthemes and concepts which could be grouped under this larger theme.

Overwhelming workload – Those in social care are struggling with managing large caseloads and lack of resources making engagement in VIPP-FC difficult.

"...I think it can be easy to say social workers are this or that and they're not engaging, but you know, it's one of the most complex jobs I think someone can do,

working with really complex families in really difficult scenarios, um with insufficient support and you know, it is under resourced, with all of that, well not all, but a lot the preventative services being completely stripped back and that means social workers have less people to refer to and problems are becoming more difficult, and families are becoming more challenging to support, you know it's a melting pot of you know, trouble brewing really, so trying to implement a research study in that context it is going to be really difficult.” (Participant 6)

“...you know social workers are incredibly, incredibly pressured you know the work that they do and the demands on them, you know, court timetables, the demands from the members of the council, no resources...I mean it's really a very, very demanding role and I can quite understand the difficult someone in that role may have to also keep in mind the need to spot certain children who would meet the specific criteria in order to qualify for the VIPP-FC study.” (Participant 5)

“Social workers are so busy and so stressed and have such a high demand to deal with whatever is the most crisis situation, that research, however much they kind of support it, it's kind of on the bottom of their list.” (Participant 3)

Issues with RCT – Feeling uncomfortable with some of the components of an RCT, difficulties with consent and feeling ethically torn.

“One thing that does really need to be thought about is the role of the birth parents in that...in the implementation of it you know, how could they be involved? There might be some children where they're looking to go home and some point and um, regardless of that, having a better or improved relationship with your birth parent is going to give you better outcomes, whether or not you're able to live with them and they're capable of providing the care that you need. I think that's something that

really needs to be thought about, how they're integrated into the process."

(Participant 4).

"...are those documents going to be passed on to potential adopters, and then if a potential adopter for example is thinking "oh this child seems to be wonderful" and then they were to read that and think "oh this perhaps indicates that this child might be a problem, or there might be some sort of psychopathology there later on", I think that needs to be handled really, really sensitively, and I hadn't really thought that through until I read that I was thinking "God does this somehow make these children less adoptable? Do we need to think about that" But that's sort of something that's just come up for me recently and um, as in the last sort of week or so, I've been thinking about that". (Participant 2)

"I guess it's just about that part, because you are you know, a third party to these children's lives, not directly involved in their care or offering day to day therapy, so for me, yeh, there's a little bit of that sharing information and then you step out, so yeh I think it's about the confidentiality more than anything else." (Participant 1)

Structural difficulties – Lack of organisational structure to support research, issues with who to target in the system, chaos and disorder in L.A.s.

"There's so many layers, and every local authority is different, every local authority has a different structure and a different attitude...corporate structure and management structure about who you need to speak to you cannot generalise information from one local authority to the one next door...So it's really difficult."

(Participant 8)

“Without having a structure where the emotional needs of children can be thought about, I think it brings additional challenges trying to bring research projects, like your one into the local arena.” (Participant 5)

“...there’s also the churn within the workforces, you know there are significant retention issues in children’s social work, so you might do all of that work with one local authority and just as you think “great! I’ve got some key contacts”, you then get an email saying “oh I’m actually leaving this team and going to Scotland” or “I’m moving to another team”, so all the work you do might have a very short shelf-life, and then you have to start again, you know, that obviously takes time and is difficult.” (Participant 6)

“I think you’re hamstrung in the same way that many services are hamstrung by the lack of structure for looked after children and having social workers who are having to contend with you know, horrific financial adversity, looking after children in context which, you know, are really quite difficult and um, where there are generally very few services which they can call on for support or assistance.” (Participant 4)

Appendix F

Table illustrating references for each theme

Number of references made in the data set for each identified theme

| Themes | Number of References |
|---|----------------------|
| 1. Challenges of Implementation | 166 |
| 1.1. Chaos in the System | 39 |
| 1.1.1. Priorities | 39 |
| 1.1.1.1. Additional | 20 |
| 1.1.1.2. Capacity | 19 |
| 1.1.2. System Structures | 48 |
| 1.1.2.1. Structural Issues | 36 |
| 1.1.2.2. Implementing Change | 12 |
| 1.1.3. Conducting an RCT in a LAC context | 48 |
| 1.1.3.1. Consent | 9 |
| 1.1.3.2. Ethical Dilemmas of an RCT | 21 |
| 1.1.3.3. Information Sharing | 18 |
| 1.1.4. Elements of VIPP-FC | 18 |
| 1.1.4.1. Manualisation | 31 |
| 1.1.4.2. Logistics | 13 |
| | 72 |
| 2. Benefits and Impact of VIPP-FC | 29 |
| 2.1. Creating an Evidence Base | 15 |
| 2.2. Benefits to Services | 18 |
| 2.3. Benefits to Families | |
| | 88 |
| 3. Key Learnings | 34 |
| 3.1. Importance of Relationships | 40 |
| 3.2. Recruitment 101 | 24 |
| 3.2.1. Lack of Understanding | 16 |
| 3.2.2. Contextual Issues | 14 |
| 3.2.3. Presence | |

