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Randomised Controlled Trial of the Fostering Changes Programme

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2. The Fostering Changes Intervention

2.1 Running the Programme

The Fostering Changes programme was delivered by two facilitators over a period of twelve weeks, once a week for three hours, between 11.00 a.m. and 2.00 p.m., which fits in with taking children to and from school. The course does not run during the school half-term week. Carers with pre-school or nursery age children have to be able to make arrangements for regular child care in order to attend the course. In practice this was rarely a problem during the trial, as Local Authorities are keen for their carers to attend training and alternative care is usually provided by a respite carer if a co-carer is not available. A light lunch is provided at the course venue. Carers are asked whether they are able to commit to attending all twelve sessions, as it is important that they cover all the material presented during the course. However, it is inevitable that some foster carers will be unable to attend every session due to unforeseen circumstances (e.g. illness, or appointments that they have to attend on behalf of the child).

Each session starts with a review of the theoretical material underlying the topic to be covered, for example, information about psychological and physiological influences on behaviour. Understanding the antecedents of behaviour helps carers to know why specific patterns of behaviour arise in certain contexts, and helps them to recognise and avoid the psychological or environmental triggers. This material is introduced in a way that is accessible to carers with a wide range of learning styles and includes slides as well as handouts.

New skills are taught at each session and carers are asked to use these strategies at home with their foster child. Each session begins with feedback from carers about using their newly acquired skills before the group goes on to cover additional material. At the end of each session carers are given the opportunity to feed back on their experience of the group, including any concerns they might have.

2.2 Course Content Summary

SESSION ONE

Establishing the group

During the first session, carers are introduced to each other and to the facilitators, and are given an overview of what the whole programme will cover. Carers are asked about their own goals and expectations of the training.

How children Thrive and Develop Resilience

Carers are encouraged to reflect on what they think children need to thrive, and ideas such as love, encouragement, guidance, boundaries, routines, good food and good education are discussed.

Experiences of Looked After Children

This is an exercise during which themes such as separation from family, uncertainty about the future, and experience of former caregivers are considered. It provides a context for introducing the principles of calm, sensitive and consistent care-giving.

Developmental Stages
Describing the cognitive and emotional stages that all children go through can help carers to think differently about behaviour that they have been regarding as bad, mean or naughty.

Tracking & Observing Behaviour
Carers are asked to think about both desirable and difficult types of behaviour and how to observe and record incidences of both as part of their 'home practice'. *Example: When Carole clears the table after dinner. When Jo starts shouting abuse when asked to go to bed.*

SESSION TWO

Context of Behaviour
How behaviour is shaped by antecedents and consequences. Medical, situational, physical and emotional, family environment (past and present) and personality characteristics are discussed as factors which can influence a child's behaviour.

Attachment – Child and Carer
Attachment theory is central to the programme, and time is spent on reviewing the latest theories and evidence that supports them. The effect of disrupted care-giving on the attachment relationships of looked after children is considered.

Social Learning Theory
The role of antecedents and consequences in maintaining behaviour ('ABC's) is considered i.e. how both positive and negative behaviour can be influenced by the environment and, importantly, by relationships with carers.

ABC Analysis of Behaviour
Antecedents and triggers are discussed in more detail. For example, a place, person or even a time of day can cause anxiety in a child. Strategies for dealing with behaviour that escalates out of control are discussed.

SESSION THREE

The relationship between need and maladaptive behaviour
Children who have grown up in environments of neglect and abuse may be less able to express their needs in appropriate ways. Dysfunctional behaviour may have emerged as a response to these needs.

Praise
This session is experiential. In small groups carers are asked to remember their experiences of being praised. This raises awareness of the importance of praise and can be painful for carers who were not praised as children themselves. Other exercises include practicing how to give effective praise, following the theoretical input. Carers give labelled praise to each other, they then praise themselves. There is a space to discuss their views about the benefits of and any resistance to praise. Their home practice for the week is to identify particular behaviours that they are going to praise in their young people, to ensure they praise their young person 5 times a day as well and to praise themselves last thing at night for something they did well as a foster carer that day. Practicing giving and how it feels to receive praise is an important part of the training.

Positive Strategies
Practical strategies for using praise and positive attention to enhance children's self-esteem and social skills.

Obstacles to Praise and Using Praise effectively
How praise needs to be specific, sincere, immediate and appropriate. Examples to illustrate how praise can be used with impatient, impulsive or defiant children.

SESSION FOUR

Using Praise to Support Learning
The relationship between self-regulation and children's ability to learn and achieve in school. Qualities such as the ability to concentrate, to pay attention, think flexibly, motivation and confidence are considered as part of the domain of self-regulation.

Developing a Positive Environment
Ways in which carers can use their attention to support and facilitate the child's development

Play
The function of play in the development of skills from physical co-ordination to creative, linguistic and cognitive skills. Many looked-after children have not experienced play and foster carers need to be skilled in facilitating and supporting their children's play.

Attending
How to follow the child's agenda during play without imposing expectations on the child gives the carer an opportunity to experience the world from the child's point of view, and results in an increase in the child's positive feelings about themselves and a stronger sense of trust in their carer.

Descriptive Commenting
Carers are encouraged to describe what their children are doing out loud, rather than relying on constant questioning which children find intrusive and distracting. Children enjoy being the focus of attention and feeling that the carer has a genuine interest in their activities.

SESSION FIVE

The Importance of Focusing on Children's Ability to Understand and Manage Emotions
How children develop emotional skills when carers both notice and are sensitive to the child's emotions and when carers model awareness and effective use of their own emotions. Identifying the skills involved in good listening and sensitive responding.

Effective Communication
Techniques for reflective listening (listening to the child as if from their own perspective) are introduced e.g. stop and look at the child, allow the child to say what they need to, try to see things from the child's perspective.

Sensitivity to The Expression of Feelings
The importance of being able to interpret and respond to the child's non-verbal as well as verbal communications. Awareness that feelings and concerns may be expressed through, nightmares, phobias, loss of appetite, sleep difficulties or behaviour problems.

Expressing Feelings
The benefits of adults showing their feelings to children (e.g. "I" felt pleased when I saw your school report).

Using Questions
Types of question to ask children which show that the carer is interested, without making excessive demands or being intrusive.

Being Non-Judgemental
The need to take a non-judgemental stance when looked-after children talk about their history or their feelings. How to help the child to restructure their understanding of past events.

When Listening is Difficult
How to proceed sensitively and cautiously when a child is silent and withdrawn.

SESSION SIX

The Educational context of looked after children
How to encourage emotional regulation in an educational context and how this promotes the emotional, social, and cognitive skills that have a positive effect on learning and academic attainment.

Special Educational Needs
The importance of a thorough knowledge and understanding of the education system, given the high level of looked after children with special educational needs. Strategies to assist carers in communication with professionals.

Importance of Carers Supporting their Child in Reading
The links between good attachment, reading and attainment. Reading together as an opportunity not only to learn, but also to discuss feelings, events and ideas in a safe and thoughtful space.

Carers' Role in Supporting Learning More Generally
The importance of carers' involvement in school events, interests and homework. The value of extracurricular and leisure activities. The rights of looked after children to have the same access to culture, arts, sports and leisure as their peers.

Different Styles of Learning
Visual, auditory and kinaesthetic learners and their learning preferences.

Managing Carers' Thoughts and Feelings
The CBT (Cognitive Behavioural Therapy) model for helping carers to think about how to solve problems encountered while working with their children's education. For example, children with a history of rudeness to the teacher, resulting in exclusion. Learning how to understand how negative reactions to behaviour can produce emotional, physiological and behavioural consequences for carers.

SESSION SEVEN

Assertive Communication and "I" messages
How carers can communicate effectively with other professionals. Techniques to help carers cope with feelings of being rejected and taken for granted.

Reinforcing Positive Behaviour Through Rewards
Social rewards (praise and attention) and tangible rewards (treats, activities, pocket money)

Using Consequences
Describing effective consequences (positive or negative). Reward Charts and choosing rewards; token systems.

"Extinction"
The importance of consistency in decreasing undesirable behaviour (e.g. tantrums in supermarkets).

SESSION EIGHT

This session concentrates on techniques for encouraging compliant behaviour and discouraging undesirable behaviour.

Giving Effective Instructions
How to avoid conflict by giving clear and precise instructions, followed by praise for compliance.

Differential use of attention: selective ignoring
How children misbehave to attract negative attention, and ignoring minor misbehaviour can bring about changes in difficult behaviour

SESSION NINE

Positive Discipline
Styles of discipline and constraints on carers' use of discipline; safe caring

Setting Limits Through Family Rules
The function of family rules and how they contribute to the harmonious running of the home.

Natural & Logical Consequences
Guidelines for the positive and effective use of logical consequences i.e. discussion in advance of setting rules, appropriate consequences with immediate effect. Helping the child to learn the negative consequences of their choices.

SESSION TEN

Punishment
Myths and unhelpful assumptions that carers may hold about punishments. Rather than thinking in terms of punishment, we ask carers about their preferred term e.g. discipline, sanction or guidance.

'Time Out' From Positive and Negative Reinforcement
How to address things in the environment that reinforce undesired behaviour. Appropriate uses of time out. What procedures to use. What happens during time out and at the end.

When The Child Does Not Co-operate With Time Out
How to deal with a child who refuses to go to time out or is destructive

Problem-Solving Strategies
How to empower looked after children to clarify the choices they have, and to implement decisions

The Stop, Plan and Go Approach to Problem-Solving
How to discourage children from rushing into acting without thinking and to realise that there are a whole range of potential solutions to a problem. Putting the child's strategies into action and helping them to think about how well they achieved their desired outcome.

Managing Carers; and Children's Feelings in Problem-Solving
Carers' negative feelings when listening to a child and guidelines for problem-solving communication.

SESSION ELEVEN:

Endings & Review
Providing carers with the opportunity to think about the ending of the Fostering Changes course, and to review some of the skills then have acquired during the programme.

Carers' role in Helping Children to Understand Their Life Story
Helping children to make sense of their lives: how carers should help the child integrate information from their past into their existing situation.

Looked After Children and Endings
Facilitating Positive Endings: Making the end of placement a positive experience

Transition to Secondary School
Preparing children for changes which may make them feel anxious

SESSION TWELVE

Taking Care of Yourself

The last session focuses on the carer and encourages them to take stock of their achievements and take enough care of themselves in order to ensure that the have the resources to fulfil their role as carers.

Self-Esteem

The effects of working in isolation on self-esteem. Giving carers space to think about themselves.

What I Appreciate About You

Carers are asked to think of and state one thing they want to praise themselves for, and one thing to thank the group for.

Certificate Giving, Celebration and Goodbyes

Carers often bring refreshments to contribute to a farewell party. They are thanked for their effort and the time they have shared together, and wished well in their career as foster carers.

3. Pilot Study

A pilot study was carried out in advance of the randomised-controlled trial in order to ensure that it was feasible for the facilitators to cover all the material contained within the revised manual in 12 weeks. It was also an opportunity to pilot the assessment measures with foster carers, to see how long it took them to complete interviews and questionnaires, and to receive their feedback about the process.

Four groups of Foster Carers were invited to take part in *Fostering Changes* pilot courses run in Lambeth, Greenwich, Croydon and Islington by the Clinical Specialists. They were sometimes accompanied by Social Workers from the Children's Services teams involved. These boroughs were selected either because they were already rolling out Fostering Changes programmes to their carers or for their geographical proximity to King's College. It was not intended to use this data as part of the RCT assessment, so issues about sampling were not relevant at this stage.

It has previously been found that visiting carers at home prior to *Fostering Changes* training ensures very high rates of attendance at the first session and increases the level of engagement with the course materials and facilitators throughout the course. These pilot trials indicated that it was acceptable to carers in both the intervention and control arms of the trial to receive a visit from a researcher or clinical specialist at home. It was also felt that it was best to conduct interviews while the children were at school.

The length of the questionnaire booklet was mostly acceptable to carers, although they found filling in the economic analysis complex and time-consuming. Researchers found that it was much easier if they read the economic-related questions to the carers, as they were familiar with the content and could facilitate completion of the questionnaire in a far shorter time. For this reason it was decided that this measure would be presented as part of the initial interview.

There was an attempt to introduce a computerised version of the assessments that carers could access by logging on to the *Fostering Changes* website from home, but neither researchers, clinicians nor foster carers felt that this made the task easier. In fact, they felt that adding additional technology de-personalised the process, and introduced unnecessary worries about confidentiality.

Social Workers and the clinical team felt that it was intrusive to give carers post-course evaluation questionnaires at the last session, because this was a time when information from the course was consolidated, and carers were preparing to say goodbye to the facilitators and to the other carers in the group. It was therefore decided that these would be distributed at the penultimate session so that carers could complete them at home.

4. Recruitment for the Randomised Controlled Trial

4.1 Participation by Local Authorities

Recruitment for the *Fostering Changes* trial was carried out in four LAs in and around London. These were boroughs who were currently unable to run their own courses and who would, therefore, benefit from having the courses run for them. It was also important to select areas both within and outside of London in order to recruit a mix of carers who were a representative sample of all carers in England. Initially, the Heads of Fostering Services from several boroughs were contacted and asked whether they would be interested in hosting a Fostering Changes course which formed part of a Randomised Controlled Trial. The LAs of Bexley, Medway, Enfield and Haringey agreed to participate in the trial, and to provide assistance with recruitment of carers and provision of a suitable venue from which to run the courses.

4.2. Inclusion Criteria

The carers could male or female, and of any age (although the minimum age of a Registered Carer is 21). Because of the practical nature of the course and because of the methods of evaluation, carers had to have at least one child (male or female) currently in placement aged between 2 and 12. It was important that this child was likely to remain in the placement for the duration of the course (3 months). The child could be under Special Guardianship*, but kinship carers** were not eligible for inclusion in the trial.

**Special Guardianship is a legal order which allows non-parents to provide long-term and secure placements for children. In practice, this means that the child is no longer the responsibility of the LA.*
***Kinship carers are relatives or friends of the child*

4.3 Selection of Foster Carers for the Trial

The LAs were asked to select carers from their databases who fulfilled the trial's inclusion criteria. The Local Authority then contacted carers either by letter or telephone to inform them that they were being invited to join an evaluation of a trial which might, or might not, involve them also taking part in the *Fostering Changes* training course. Carers who responded to the initial invitation were contacted by the Fostering Changes research staff, who explained the aims of the trial in more detail as well as what participation would entail for carers.

Details from individual LAs about how many carers were eligible and then contacted, were not always available to the co-ordinator of the trial, but this is an example:

One participating Local Authority had 125 carers on their database. Of these carers, around 45 fulfilled the trial's inclusion criteria. Twenty-eight consented to being in the trial and 3 dropped out before the course began.

Because carers could only be contacted by RCT research staff if they had given permission by the Local Authority, it was not possible to compare the characteristics of those who responded with those who did not.

Once selected, carers had to be able and willing to attend for the entire 12 weeks of the course. Carers of children with learning and specific disabilities were encouraged to take part, as were new or inexperienced carers.

5. Design

5.1 Randomisation

Carers who fulfilled inclusion criteria and who gave consent to take part in the trial were randomly assigned in equal numbers to either the treatment arm of the trial (Fostering Changes Intervention), or to a control group. The treatment group received the revised version of the Fostering Changes Training soon after randomisation. The control group were placed on a waiting list to receive the same training at a later date, after post-trial data had been collected. Trial research staff made no further contact with participants in the control arm of the trial until three months after the initial interview, and no alternative treatment was offered during this period.

An independent statistician who was not associated with the trial compiled the randomisation schedule and was asked to assign participants to one of the two groups prior to each course.

5.2 Power Calculation

The Carer Defined Problems Scale* (Scott et al 2001) is employed in the present study as the main measure of behavioural change. In previous evaluations of the *Fostering Changes* programme, this measure was found to reliably detect pre- and post- intervention changes with effect sizes ranging from 1.3 to 1.4 (Pallett et al 2002; Warman et al 2006).

In order to control for the possibility that a similar sized effect might not be detected, we used the more conservative prediction of an effect size of 0.7 standard deviations which would still be considered large for an intervention of this type (Cohen, 1998). In order to detect this level of effect with a power of 80% at a 0.05 level of significance, a sample size of 68 was required. The study therefore aimed to obtain in excess of this number in order to control for attrition.

**This measure is derived from 'The Visual Analogue Scale' (Aitken 1969) which has been widely used to measure subjective feelings (e.g. pain) in medical research, and validated across a range of different contexts.*

5.3 Distribution of Training Areas

Four separate courses which were held in Bexley, Medway, Enfield and Haringey comprised the trial. The facilitators who were running the courses for the trial had been engaged in running facilitator courses nationwide, and maintained that

evidence from the accreditation process and consultation was that the course ran equally well over a range of different localities (e.g. London, city or rural). There was therefore no reason to suppose that results from the areas chosen would not generalise to other areas in the UK.

The courses were carried out between April 2010 and July 2011. It was planned to run four separate groups of the Fostering Changes intervention, each aiming to recruit 10 carers. Evaluation of these carers would be compared with evaluation of a similar-sized group of carers on the waiting list.

5.4 Ethical Considerations

It was not felt that there were any major ethical considerations associated with the RCT of Fostering Changes. Measures were straightforward and did not contain any potentially upsetting material. The study did not require the foster children to be directly involved. Participants were identified only by a unique identification number, and data and contact information was securely stored in accordance with the Data Protection Act (1998).

Ethical permission was obtained from King's College London Health Schools - Research Ethics (Psychiatry, Nursing & Midwifery sub-committee), Reference PNM/09/10-87.

6. Procedure

6.1 The Initial Visit

All participants were interviewed in their own homes. The initial interview was conducted to obtain background information about the carer's home circumstances. For example, how many children they were looking after (fostered and adopted, as well as their birth children), whether any other adults lived in the home, their current socioeconomic status, their educational background and the ethnicity of both foster child and carer. The interview also gathered information about the type of problems they were experiencing with the child/children currently placed with them, and what strategies they were using to cope with these difficulties. It was important at this stage for the researcher to establish which child the carer considered to be exhibiting the most challenging behaviour, because for the purposes of the trial this child would be designated the "target" child i.e. the main focus of the evaluation.

Additional information regarding current service use was obtained using the CSRI (Client Service Receipt Inventory) (Beecham & Knapp 2001). This had been adapted to include information regarding the amount and level of contact with foster-care professionals e.g. social workers and link workers. *(Results from this measure will be presented in a separate report).*

At the same visit, carers were asked to complete a set of questionnaires. Each questionnaire was an evaluation of one aspect of child or carer functioning. These included an assessment of current parenting style (The Alabama Parenting Questionnaire), an assessment of the child's behaviour (The Carer-Defined Problems Scale), a measure of child adjustment and psychopathology (The

Strengths and Difficulties Questionnaire), a measure of carer confidence (The Parental Efficacy Questionnaire), an assessment of carers' coping strategies (CCS), and an evaluation of the carer-child relationship (Quality of Attachment Relationship Questionnaire)*. Carers were requested to complete child-related questionnaires with reference to the "target" child. For every additional foster child they were caring for, they were asked to complete the SDQ and the Carer Defined Problems Scale only.

** For more detailed information about evaluation measures, see Section 9 "Measures"*

It took approximately 1½ to 2 hours to conduct the initial interview and to administer the questionnaires. The variation in time was due to factors such as the number of looked-after children per household, and the type of problems currently experienced by the carer. Some carers preferred the researcher's assistance whilst filling in questionnaires, but there was no need for translation services for any carers in the trial.

Because every carer eligible for the trial received a home visit, response rates were almost 100%. The only questionnaires not included in the data were two SDQ questionnaires which were cancelled when the carer completed post-trial SDQs for the 'wrong' child (i.e. not the child nominated at the start).

6.2 The Intervention Group

During the initial visit, the Intervention Group also received information about the course i.e. how it was structured, what topics would be covered, and what participation in the group would entail. Following this, the treatment group attended *Fostering Changes* training at a venue provided by their Local Authority for one day per week (3 hours) for a total of 12 weeks. Each week they were asked to provide feedback on the content and delivery of the course module. At the end of the course, the treatment group were asked to fill in follow-up questionnaires and an end-of-course evaluation form.

6.3 The Control Group

The control group were also visited at home, interviewed and asked to complete questionnaires. They were informed that they would subsequently be invited to do the same training, subject to courses being available in their area. At the end of the course being attended by the Intervention Group, post-trial questionnaires were posted to them. In some cases, they also received a follow-up visit, if their preferred method of completing post-trial questionnaires was with the researcher present.

6.4 Follow-up Assessments

Every participant was asked to complete the same set of questionnaires that they had completed during the initial interview, approximately 12 weeks later. For intervention group carers, these were delivered to the course venue on week 11, and carers were asked to complete them at home and return them on the last (12th) week of the training. Follow-up questionnaires were posted to control group carers 11 weeks after their initial interview, with a request to return them as soon as possible.

Control group carers were reminded by telephone if they had not been returned within a week, and those who preferred the researcher to be present whilst completing questionnaires were visited at home.

All carers were asked whether they had attended any other kind of training during the period of the trial. None of the carers in either the intervention or control groups had received any training similar to Fostering Changes (i.e. in behaviour management according social learning theory principles) during this time. However, some carers had attending short courses such as, for example, first-aid, which are part of the mandatory training provided by all local authorities.

The response rate for the return of post-course questionnaires was high. The only questionnaires not returned were 2 Strengths and Difficulties questionnaires (out of a total of 89) and one CSRI (out of a total of 63).

7. Participants

7.1 Participants in the Trial

Following contact by *Fostering Changes* researchers, 77 carers expressed interest in participating in the study, consented to take part and were randomised to either the intervention or control arms of the trial. Of these, 63 carers completed the trial i.e. supplied assessment information before the course commenced, and after the course was completed.

[see Appendix I: Participation Flow Chart]

The majority of carers were female (94%), although several partners of carers accompanied the primary carer on the training course. The 34 carers randomised to the Intervention group were caring for a total of 51 foster children in the 2 to 12 age range. Control group carers were looking after 38 foster children in the same age group.

7.2 Characteristics of Foster Carers

7.2.1 Age and Experience of Foster Carers

Foster carers participating in the trial were aged between 29 and 63 years of age (mean age 50, standard deviation 8 years). The length of time that they had been foster carers ranged from less than a year to 42 years with an average of 11 years (standard deviation 8 years).

There were great differences in the number of children that carers had fostered during their careers. Two carers reported that they had looked after more than 100 children, although many of these had been emergency placements of short duration (sometimes for just one night). The median number of placements that carers had experienced was 13. The majority (78%) had looked after up to 30 children.

Table 1: Number of children carers had fostered during their career

Number of Children fostered (Range)	Number of Carers (Total n = 63)	Percentage of carers
1 to 10	25	40%
11 to 20	15	24%
21 to 30	9	14%
31 to 50	6	10%
51 to 100	6	10%
101 to 300	2	3%

There were no significant differences between the intervention and control group participants in any of the above characteristics.

Although it is not possible to say whether this sample is representative of the whole population of UK carers, it is the case that they represent a very wide spectrum of experience, both in terms of age, number of years as a foster carer, and in the number of children they have looked after during their careers. Given the shortage of placements, it is fairly common for carers to be looking after more than one child and for there to be a significant number of short-term carers.

7.2.2 Education and Ethnicity of Foster Carers

Thirty-nine percent of foster carers were educated up the age of 16 and 30% had gone on to further secondary education or to achieving a secretarial or technical qualification. Twenty-one percent of carers had acquired a higher professional qualification e.g. Teacher training, State Registered Nurse or University Degree.

Seventy-one percent of carers described their ethnicity as being “White British” or “White Other”, and 33% as being from an ethnic minority. However, ethnicity varied between the courses according to recruitment area, with the majority of carers from ethnic minorities being located in the inner-London Boroughs.

There were no significant differences between Intervention and Control groups on the above characteristics.

7.2.3 Foster Carer’s Household composition

The majority of Foster Carers were living with a husband/wife or partner (71%). A small number (7%) had another adult family member living in the home. Carers had between 1 and 5 children currently placed with them (median 2 children). This figure includes foster children over the age of 12, and in some cases young people who were over 18. It does not include adopted children.

Table 2: Foster children of all ages currently in placement

Number of foster children (range)	Number of carers (Total n = 63)	Percentage of carers
1	30	48%
2	21	33%
3	8	13%
4 or 5	4	6%

Many carers had birth children of their own, and/or children who they had adopted. Their birth children were often over the age of 18 and living away from home.

[See Appendix III: Characteristics of Foster Carers].

7.3 Characteristics of Looked after Children

7.3.1 Age and Gender

The foster children who were included in the trial were all aged between 2 and 12. The mean age was 7.9 (standard deviation 3.1) and there was no significant difference between the mean ages of children in the intervention and control groups.

There was no significant difference between the mean ages of children identified as the "target" child and "other children".

*N.B. In homes with more than one foster child, the "**target**" child is the one that the carer identifies as having the most challenging problems. "**Other**" children are the other foster children in the home, not the carer's own or adopted children. There are "target" and "other" children in both the intervention and control groups.*

Fifty-seven percent of all children in the trial were male. There was a higher proportion of males in the intervention group (59%) compared with the control group (45%), but this difference was not statistically significant.

7.3.2 Ethnicity of Looked After Children

Foster-carer's report of the ethnicity of the children was that 66% were White British or White Other, and that 34% were from ethnic minorities. There were no significant ethnic differences between intervention and control group children, or between 'target' and 'other' children.

7.3.3 Placement History

Information regarding current placement duration and number of previous placements was collected for the Target Child.

The length of time that children had been in their current placements ranged from a few months to 8 years. The median length of time that children had been in their current placements was 15 months.

Most children (40%) were in their first placement, while others had experienced up to 5 changes of placement. One child had experienced 10 different placements.

Table 3: Number of placement changes (target children):

Number of Previous Placements	Frequency (n = 63 Target Children)	Percent
0	25	40%
1	20	32%
2	10	16%
3	2	3%
4	4	6%
5	1	2%
10	1	2%

There were no significant differences between intervention and control group target children in the length of time they had been in their current placement, nor in the number of previous placements they had experienced.

7.3.4 Type of current Placement

Forty-four percent of children were in a long-term placement, 33% in a short-term placement and 22% were awaiting a decision on their future.

Table 4: Type of current placement

Type of Placement	Number of Children (n = 63 Target Children)	Percentage
Long-term	28	44%
Short-term	21	33%
Not Decided	14	22%

[see Appendix IV: Characteristics of Looked After Children].

8. Measures

The measures were selected in order to assess the extent to which foster carers and looked after children had benefitted from the programme - particularly from the new material that has been introduced. The domains that these measures were designed to tap into were changes in child behaviour, improvements in relationships between carer and child, increased foster carer confidence and evidence that the core principles of the course had been put into practice.

Parenting style was assessed, as was the level of social and emotional adjustment of the child. For participants in the Intervention Group, information about their perceptions of how the course was run was also considered important.

Lastly, a detailed economic analysis was carried out in order to find out whether changes in the uptake of services had resulted from attending the programme. These could be positive in terms of a decreased need to contact Social Workers with

day-to-day problems, but also positive if a carer had felt confident enough to access additional services from the school on behalf of the child. *(This report is presented separately).*

8.1 Outcome Measures

Primary Outcome Measures:

- Child Behaviour Problems: *The Carer-Defined Problems Scale* measured at baseline interview directly before treatment (Time 1), and again three months post-randomisation (Time 2).

- Foster Child's attachment relationship with foster carer: *The Quality of Attachment Relationships Questionnaire (QUARQ)* measured at baseline interview directly before treatment (Time1), and again three months post-randomisation (Time2).

- Foster child's social, emotional and behavioural adjustment: *Strengths and Difficulties Questionnaire (SDQ)* (Goodman 2001) measured at Time 1 and Time 2

- Carer Satisfaction: *Satisfaction Questionnaire* (Intervention Group only) measured at the end of the training.

The primary outcomes were those considered to be central to the aims of the *Fostering Changes* training i.e. to improve relationships, decrease the incidence of difficult behaviour, enhance social and emotional adjustment, and to deliver a training which meets the needs of carers.

Secondary Outcome Measures:

- Foster Carer's sense of confidence: *Carer Efficacy Questionnaire* measured at Time 1 and Time 2

- Foster parent's parenting style, relationship with child and coping strategies: *The Alabama Parenting Questionnaire Short Form* (Scott et al 2011), measured at Time 1 & Time 2

- Foster Carer's coping strategies: *Carers' Coping Strategies* measured at Time 1 and Time 2

- Service Use and Demographics: *Client Service Receipt Inventory* measured at Time 1 and Time 2)

[See Appendix V: Evaluations and Measures used in the RCT]

8.2 Evaluation Measures

Child Behaviour Problems: The Carer-defined Problems Scale (Scott et al, 2001) asks carers to list their foster child's three main problems, and then to indicate how severe the problems by placing a mark on a 10 cm line. Data from this measure has been shown to be a very useful indicator of pre- and post- intervention change.

The Quality of Attachment Relationship Questionnaire (QUARQ) is an assessment of the attachment relationship between carer and foster child. Derived from key concepts that define our understanding of attachment theory, it includes items which tap into the child's ability to show or accept affection, to trust the carer, and whether the child seeks help from their carer under stressful conditions. It also asks about the carer's understanding of the child's feelings. This measure was devised by our in-house research team.

The Alabama Parenting Questionnaire Short Form (APQ-SF) (Scott et al, 2011) is a measure of empirically identified aspects of positive and negative parenting styles which relate to conduct problems in children. The questions are divided into four domains of parenting practice: Positive parenting (e.g. praising your child for good behaviour); Inconsistent Discipline (e.g. saying that you will punish bad behaviour and then not doing it); Poor Supervision (e.g. not knowing who your child is out with); and Involvement (e.g. helping your child with their homework).

The Strengths and Difficulties Questionnaire (SDQ) (Goodman 2001) is a measure of adjustment and psychopathology of children and adolescents. It consists of 25 traits, comprising five sub-scales: Emotional Symptoms, Conduct Problems, Hyperactivity-Inattention, Peer Problems, and Pro-social Behaviour. It has been widely used as a research screening tool and its validity has been confirmed in analyses of many different populations.

The Carer Efficacy Questionnaire (CEQ) ("How it feels to be a Foster Carer") was designed by the clinical team as an assessment of the extent to which carers feel able to cope with and make positive changes to the lives of their foster children. It taps into domains related to knowledge (e.g." I don't know what I can do to control my foster child"), ability (e.g. "The things I do make a difference to my foster child's behaviour") and the possibility of change (e.g. "I can make an important difference to my foster child"). It also assesses the confidence of carers to facilitate education by, for example, feeling able to contact their foster child's school if they have concerns. Three final questions relate to stress and quality of life e.g. "I feel confident about the future".

Carer's Coping Strategies (CCS) was also compiled by our in-house team to find out whether carers have absorbed and put into practice the principles introduced on the course such as praise and consistent discipline. Other domains include giving clear instructions, attending, and remaining calm in situations involving difficult behaviour.

9. The Intervention Arm

9.1 Participants in each group

Group size for each of the courses was as follows: 6 carers from Bexley LA, 11 from Medway, 8 from Enfield and 9 from Haringey (Total number of carers in the intervention arm = 34). There were also a further 5 partners who accompanied the main carer on the training.

9.2 Attendance rates and drop-outs

Two of the courses had to be shortened to 11 weeks (because of weather conditions), but mean attendance rates were good. They varied between 8 and 12 sessions with a mean of 10.5 (standard deviation 1.2).

Thirteen carers dropped out between randomisation and the start of the intervention. Eight had been allocated to the intervention group and 6 to the control group. Two of the carers reported that their placement had ended and the child had left, and the remainder had simply had second thoughts about committing to a 12 week course. One carer dropped out after having started the training (after 5 weeks) because she took charge of an additional child and was unable to arrange for childcare at short notice.

[see Appendix II for Participation by Local Authority]

10. Results

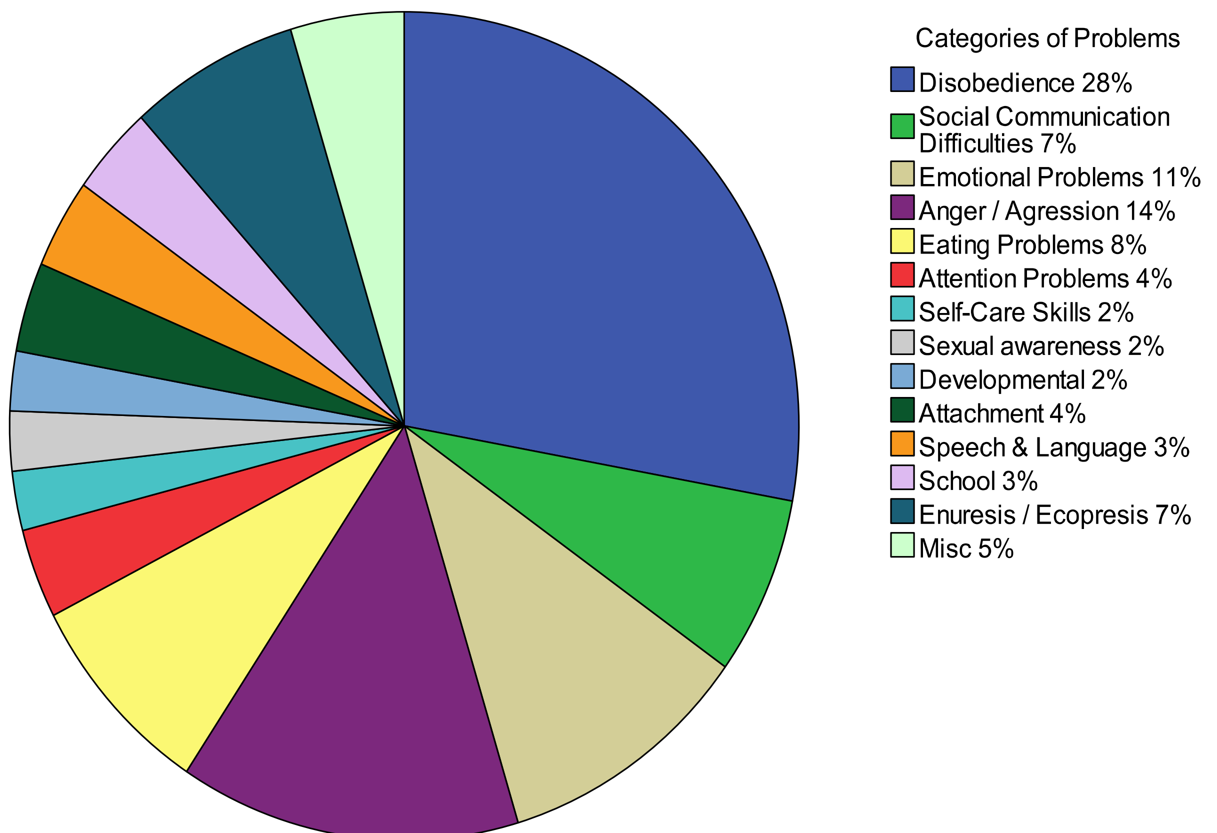
10.1 Child Problems: The Parent (Carer)-defined Problems Scale

The ‘Parent-defined Problems scale’ has been widely used as a measure of the subjective feelings (e.g. pain) of patients in a medical context (Aitken, 1969), but more recently a variation of this has been adopted to give an indication of the severity of children’s problem behaviour as rated by parents and carers (Scott et al, 2001).

Professional evaluation of improvement does not necessarily take account of the areas that a parent or carer considers most problematic. The Carer-Defined Problems Scale gives carers the opportunity to nominate those difficulties which are currently causing most concern to them. It is these specific difficulties that they are asked to focus on during the training, and which they are asked to monitor for evidence of change.

During the initial interview, carers from both groups were asked to list the three most serious concerns they had concerning their foster child/children. Carers were able to name at least one type of behaviour that was a cause for concern for 81 of the 89 children in the trial. (The remaining carers were unable to name a particular type of behaviour because they felt their problems to be more general, or because the child was too young to display many of the problems reported below). Reports of specific problems revealed a wide range of difficulties.

Figure 1: Foster carers’ primary concerns (number of foster children = 81)



The most common problem was disobedience, reported by 28% of respondents. Carers described problems with getting children to comply with requests, arguing, stealing and lying. Anger and aggressive behaviour was reported by 14% of respondents who described temper tantrums and hitting out at other children. Emotional problems were reported by 11% of carers, who described children who were unable to control their emotions or who had difficulty in expressing their feelings, or who had completely shut down emotionally.

Carers were then asked to rate the severity of their foster child's most challenging problem by placing a mark on a 10 cm line which was labelled "not a problem" on the left, and "couldn't be worse" on the right. Parents and carers from a wide range of backgrounds have found this a simple and convenient way to quantify their concerns, and have experienced no difficulty in understanding what it means to make a rating between two extremes (e.g. Scott et al, 2001). The score was converted into marks out of 100.

Example:

"Please list below, in order of priority, the three problems you have with your child that you would most like help with. Then rate the severity of the problem at present by marking the line at the most appropriate place between the two comments."

Concern 1: Temper Tantrums at Bedtime

No longer a problem ....|................................. *Couldn't be worse*

At the three-month follow-up, respondents were reminded of what their principal concern had been at the start of the trial, and asked to rate this particular behaviour a second time (although they were not reminded of the size of their original rating). Changes in Pre- and Post- ratings for the target child were compared between Intervention and Control groups.

Table 5: Changes in carer-defined problems (target children) n = 61

Randomisation Group	n	Pre (sd)	Post (sd)	Difference
Intervention	34	71.2 (21.8)	41.2 (23.2)	30.0
Control	27	67.3 (22.7)	59.4 (25.7)	7.9

(F 23.935; p = .006) Effect size = .99

At the initial interview the mean rating of carers randomised to the intervention group was 71 out of 100 for the target children, and that of the control group 67 out of 100 (there was no statistically significant difference between the means of both groups at this stage). [See figure 2].

The intervention group achieved a larger pre-to-post decrease in severity ratings when compared to the control group and the difference between the groups was statistically significant (f=23.935; p=.006). There was a large effect size (distance in standard deviations between the post-trial group means) of 0.99 which provides unequivocal evidence of improvement in principal problems by foster children of carers who had attended the training.

Figure 2: Changes in foster carers' ratings of primary concern (target children)

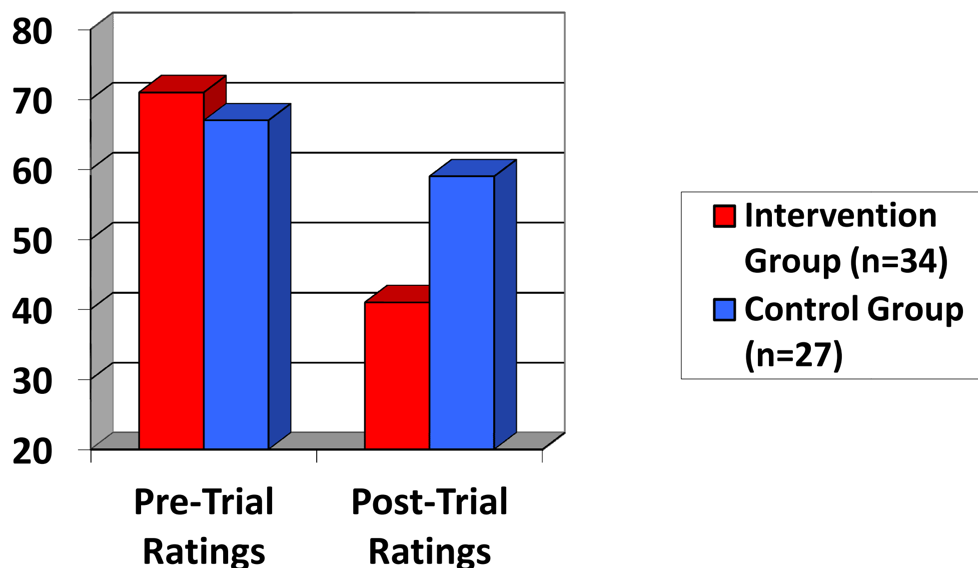


Figure 2 shows that the mean ratings made by both intervention and control groups at the beginning of the trial did not differ significantly, but when ratings were taken at the end of the trial, the mean ratings of problems reported by the intervention group had dropped significantly in comparison to that of the controls.

It was not possible to perform the same analyses on the "other" children (for families with more than one foster child), because the group numbers were too low (i.e. 13 in the intervention group and 7 in the control group). However, analysis of the entire sample of children, whilst lacking some degree of statistical independence, showed very similar results to that of the target children alone.

Table 6: Changes in carer-defined problems (whole sample) n = 81

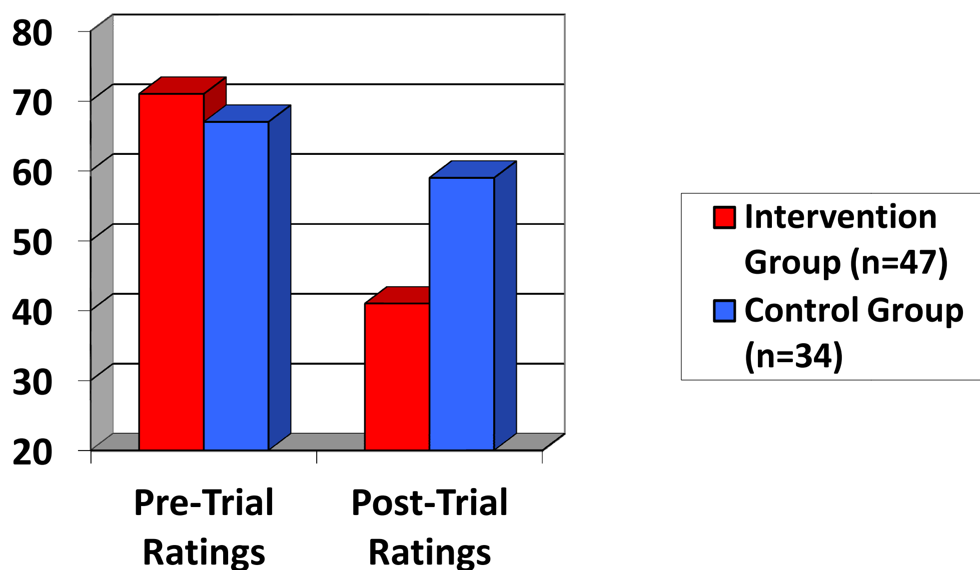
Randomisation Group	n	Pre (sd)	Post (sd)	Difference
Intervention	47	70.7 (20.1)	41.5 (23.8)	29.2
Control	34	65.2 (23.2)	56.5 (26.8)	8.7

(F 31.671; p = .003) Effect size = .95

For all the children in the study, pre-trial mean group ratings were similar to those of the target children only (i.e. 71 and 65 for intervention and control groups respectively). Again, there was no statistical difference between the groups at this stage. [See figure 3]

The intervention group achieved a large pre-to-post decrease in severity ratings when compared to the control group and the difference between the groups was significant (f=31.671; p=.003). There was a large effect size (distance in standard deviations between the post-trial group means) of 0.95 which is comparable to that obtained for the target children alone.

Figure 3: Changes in foster carers' ratings of primary concern (all children)



Incorporating the "other" foster children's scores into the analysis of the differences between pre- and post- trial scores did not significantly diminish the outcomes, indicating that the effect of the intervention had generalised beyond the target child to other fostered children in the family.

10.2 Child Attachment Relationship

The QUARQ (Quality of Attachment Relationships Questionnaire) was constructed of items relating to broader attachment concepts. Examples include seeking carer's help under conditions of stress, ability to express appreciation or accept praise, and ability to show or accept affection. Corresponding questions were "My foster child comes to me is s/he is not feeling well"; "My foster child tells me that they appreciate what I do for them" and "My foster child lets me give him/her a hug".

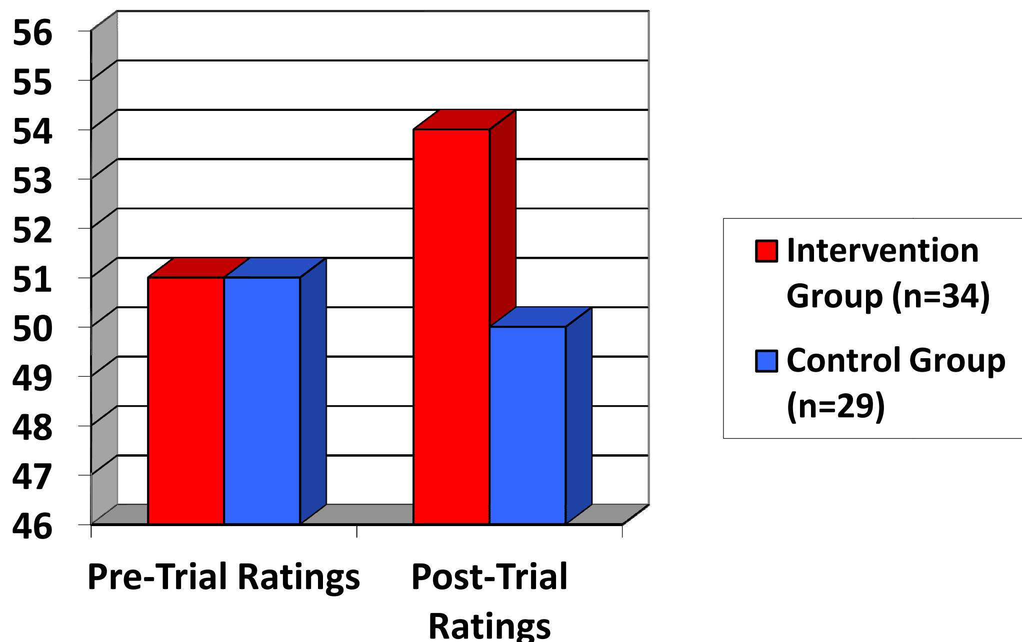
The scale was comprised of 16 items and responses were on a 5 point Likert scale with response options ranging from 'Never' up to 'Very Often'. A high total score indicates better quality of attachment. Total scores could vary between zero and 64.

Carers were asked to complete the questionnaire at the initial interview in relation to their relationship with the target child (they were not asked to complete it for any

other children they were looking after). They were then asked to fill it in again at the end of the trial three months later. All carers completed this questionnaire.

At the beginning of the trial, both the intervention and control group mean scores were 51 [see Figure 4].

Figure 4: Changes in quality of attachment relationships with target child



There was an improvement in total scores for the intervention group when compared with controls and the difference between the change in group mean scores was significant (f=4.401; p=0.04), with an effect size of 0.4.

10.3 Carer Efficacy

The 9-item 'Carer Efficacy' questionnaire taps into carers' belief in their own ability to make positive changes in the lives of their foster children. It is sub-divided into 'Knowledge' (example: "In most situations I know what I should do to ensure my foster child behaves"), 'Outcome' (example: "I can make an important difference to my foster child"), and 'Action' (example: "I am able to do the things that will improve my foster child's behaviour").

Supplementary questions were added to this questionnaire in order to assess carers' motivation and confidence in facilitating the child's learning (Education sub-scale), and some general questions pertaining to quality of life.

Carers were asked to answer the questions in relation to the 'target' child where applicable.

Table 7: Carer efficacy (n = 63)

Randomisation Group	n	Pre (sd)	Post (sd)	Difference
Intervention	34	26.6 (3.7)	27.9 (3.8)	+1.3
Control	29	28.1 (3.8)	27.1 (3.9)	-1.0

(Significant group by treatment interaction (p = .056)   Effect size = 0.7

The change in scores from pre- to post-trial was higher for carers in the intervention group, and differences between groups were statistically significant with a large effect size of 0.7.

The significance of these results is that only those carers who attended the training acquired stronger beliefs about their own ability to make positive changes to children's behaviour and outcomes.

The 'Education' supplementary questions were introduced to measure to what extent carers felt able to facilitate their foster child's learning by helping them with reading and homework. No difference between the groups was found for changes in pre- and post-trial scores.

Table 8: Education (n = 61)

Randomisation Group	n	Pre (sd)	Post (sd)	Difference
Intervention	34	10.82 (1.1)	10.71 (1.2)	+0.11
Control	27	10.76 (1.7)	10.81 (2.0)	-0.05

(p=.679)

Three additional items relating to quality of life were introduced (example: "Being a foster carer has changed my life for the better"). There were no significant changes in scores for either group over the trial period.

Table 9: Quality of Life (n = 63)

Randomisation Group	n	Pre (sd)	Post (sd)	Difference
Intervention	34	10.06 (1.6)	9.79 (1.8)	+0.27
Control	29	10.59 (1.6)	10.28 (1.8)	+0.31

(p=.905)

10.4 Carer's Coping Strategies

This questionnaire was intended to assess to what extent carers had put into practice the principles absorbed during training, as the items were selected to be closely related to the core principles of the Fostering Changes Programme i.e. the use of praise, consistent discipline, clear instructions, attending, and remaining calm. Total pre- and post-trial score was obtained by summing all the items, and intervention and control group carers compared on changes in score from pre- to post-trial.

Table 10: Carer's coping strategies (n = 63)

Randomisation Group	n	Pre (sd)	Post (sd)	Difference
Intervention	34	58.99 (5.7)	62.59 (5.8)	+3.60
Control	29	61.11 (6.4)	61.47 (6.6)	+0.36

Significant group by treatment interaction (p = .011) Effect size = 0.5

There was an increase in intervention group carers' scores relative to those of the control group, and the difference between groups was statistically significant with a moderate effect size of 0.5. These results provide evidence that carers attending the Fostering Changes training were putting the principles they had learned into practice.

10.5 The Alabama Parenting Questionnaire (Short Form)

There were no between-group differences in changes in parenting practices over the course of the trial.

Table 11: Results from the Alabama Parenting Questionnaire (target children) n = 55

Randomisation Group	n	Pre (sd)	Post (sd)	Difference
Intervention	32	39.9 (3.7)	41.0 (3.8)	+1.01
Control	23	42.1 (3.7)	41.9 (3.5)	-0.2

(p = .242)

Although there is some overlap between the Alabama and the 'Carer's Coping Strategies Questionnaire' as they are both measures of parenting practice, the Alabama is a more general indicator of parenting style and may not have been sensitive to changes in specific parenting strategies. It also contained items relating to supervision which may not have been relevant to carers with younger children and which would therefore not contribute to the total score.

10.6 The Strengths and Difficulties Questionnaire (SDQ)

The SDQ is a 25-item behavioural screening questionnaire which is designed for the 3 to 16 age group. It can be completed by parents/carers, by teachers or by young people (over the age of 11) themselves. The 25 items are divided into 5 scales; emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems and pro-social behaviour. All of the items (excluding the pro-social behaviour items) are added together to generate a “total difficulties score”. It is in general use by many child and adolescent mental health clinics as part of the initial assessment and has been used to reliably detect behavioural, emotional and concentration problems among looked after children (Goodman et al 2005).

The SDQ was standardised on a large representative sample of British children (over 10,000) aged 5 to 15, and therefore data from this sample can be used as a useful baseline index of social and emotional functioning against which other, smaller samples of children in the same age range can be compared.

10.6.1 Comparison with National Norms

The mean sub-scores and total scores of target Children, ‘other’ Children and the whole sample of foster children from the trial (n=87) were compared with the national norms generated from the SDQ. [See Table 7]

Table 7: Trial sample data (Time 1) compared with British norms (Goodman 2001)

SDQ Subscale	**Target Children Only (n=63)** (sd)	**Other Children Only (n=24)** (sd)	**Total Trial Sample Mean (n=87)** (sd)	British Means (Age 5-15) (sd)
Total Score	16.7 (6.6)	14.8 (7.7)	16.1 (6.9)	8.4 (5.8)
Emotional symptoms	3.1 (2.1)	3.3 (2.3)	3.2 (2.2)	1.9 (2.0)
Conduct problems	3.9 (2.7)	2.8 (2.2)	3.6 (2.6)	1.6 (1.7)
Hyperactivity	6.1 (2.9)	5.8 (3.4)	6.0 (3.0)	3.5 (2.6)
Peer Relationships	3.6 (2.3)	2.8 (2.1)	3.4 (2.2)	1.5 (1.7)
Pro-Social	6.4 (2.1)	6.3 (2.3)	6.3 (2.1)	8.6 (1.6)
Impact	3.0 (3.0)	2.1 (2.8)	2.7 (2.7)	0.4 (1.1)

The whole sample of foster children in the trial had higher mean scores than the national norms in all problem areas and lower scores on the pro-social subscale. As expected, target children’s scores were higher on average than those of ‘other’ children, but these differences were not statistically different.

Impact score is generated by adding together ratings of distress caused to the child by his/her difficulties, taking into account the level of interference that the difficulties cause in the child’s home life, friendships, classroom learning and leisure activities. This index of the impact of the children’s difficulties on all areas of their lives was nearly seven times higher than for that of the national sample, as rated by their foster carers.

These findings are not unexpected, but they are confirmation that the sample of looked after children who were part of the randomised trial was representative of foster children in the UK, as they shared many of the characteristics that have been documented in previous studies (e.g. Ford et al 2007).

10.6.2 Pre- and Post-trial SDQ scores

The Total Problems Score is the sum of the Emotional symptoms, Conduct problems, Hyperactivity and Peer Relationships sub-scales of the SDQ. A high score indicates problems in one or more of these domains. It does not include the Pro-Social scale, which stands alone, and for which a high score indicates better social functioning.

Table 13: Pre- and post-SDQ scores for the intervention & control groups (target children only)

SDQ Subscale	Intervention Group Target Children only (n=34)		Control GroupTarget Children only (n=29)	
	Pre-Trial (sd)	Post-Trial (sd)	Pre-Trial (sd)	Post-Trial (sd)
Total Problems Score*	17.6 (6.3)	17.1 (6.4)	15.6 (6.8)	17.3 (6.9)
Emotional symptoms	3.3 (2.2)	3.5 (2.4)	2.9 (2.1)	3.7 (2.3)
Conduct problems	4.0 (2.6)	3.9 (2.6)	3.8 (2.8)	4.4 (2.7)
Hyperactivity**	6.7 (3.0)	6.2 (2.7)	5.3 (2.6)	5.8 (2.7)
Peer Relationships	3.5 (2.4)	3.5 (2.3)	3.6 (2.2)	3.4 (2.1)
Pro-Social	6.6 (1.9)	6.2 (1.9)	6.1 (2.3)	6.2 (2.8)
Impact	3.4 (2.6)	3.2 (2.8)	2.5 (2.6)	3.2 (2.8)

There was a significant difference between groups on changes in Total Problems Score (*F=4.953, p=.030) with an effect size of 0.32, indicating a protective effect of the intervention on children's emotional and behavioural symptoms. There was also a significant group difference on Hyperactivity score changes (**F=4.185, p=.045) with an effect size of 0.37. This was confirmation of the improvement made by children in the intervention group, relative to controls.

Table 14: Pre- and Post SDQ scores for the intervention & control groups (whole sample)

SDQ Subscale	Intervention Group Total Sample (n=48)		Control Group Total Sample (n=37)	
	Pre-Trial (sd)	Post-Trial (sd)	Pre-Trial (sd)	Post-Trial (sd)
Total Problems Score*	17.4 (7.1)	16.8 (6.8)	14.8 (6.5)	16.2 (6.7)
Emotional symptoms	3.4 (2.3)	3.5 (2.3)	2.8 (2.1)	3.4 (2.2)
Conduct problems**	3.8 (2.6)	3.5 (2.7)	3.5 (2.6)	4.0 (2.6)
Hyperactivity	6.6 (3.2)	6.2 (2.8)	5.4 (2.6)	5.7 (2.6)
Peer Relationships	3.6 (2.3)	3.5 (2.4)	3.1 (2.2)	3.0 (2.1)
Pro-Social	6.2 (2.0)	6.1 (2.0)	6.5 (2.3)	6.3 (2.6)
Impact	3.2 (2.8)	3.0 (3.1)	2.1 (2.4)	2.7 (2.7)

The same analysis was carried out on the total sample of foster children and similar results were obtained. There was a significant difference in change scores between the groups on Total Problems Score ((*F=5.091, p=.027) with an effect size of 0.30 indicating improvements relative to controls for the intervention group. Significant group differences in change scores were also found for the Conduct Problems subscale (**F=5.233, p=.025) with an effect size of 0.30, indicating a positive effect of the intervention in this domain.

11. Results (qualitative feedback data from carers in the intervention group)

The following information was obtained from foster carers who participated in the Fostering Changes training and who completed a "Satisfaction Questionnaire" at the last session of the course. The questions asked were in the following categories:

- Carer's perceptions of changes in the child behaviour
- How carers felt that the course had changed carer-child relationships
- Feelings about how the course has impacted upon themselves as carers
- Retaining and using new knowledge and skills with other foster children
- How the course was run and competence of the practitioners

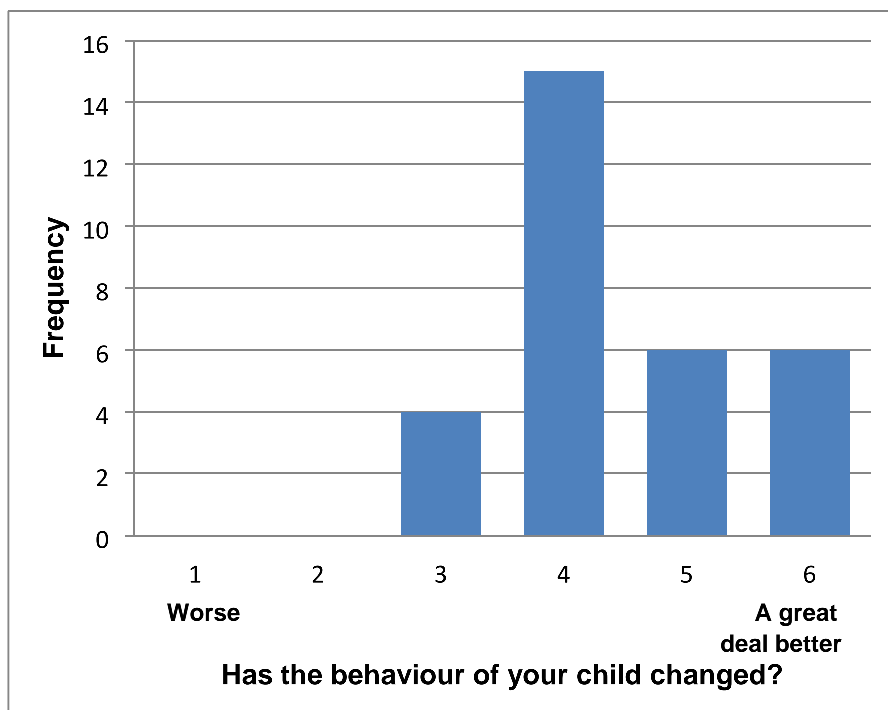
Questions were often open-ended in order to give foster carers the opportunity to raise issues that may not have been included. Thirty-one carers out of the 34 who participated in the trial, completed the Satisfaction Questionnaire.

11.1 Carer's perceptions of child outcomes

How has the behaviour of your child/young person changed?

Participants rated this question in relation to the Target Child on a scale of 1 (worse) to 6 (a great deal better).

Figure 5: Carer's perception of behavioural change in the target child (Based on responses from 31 carers)



There was a positive trend (mean 4.45), with no participants rating this question at the lower end of the scale.

Fourteen carers who were looking after an additional child reported similar improvements in behavioural change (mean 4.29), although this was a small sample.

Figure 6: Carer's perception of behavioural change in other children (n=14)

"List three things about your child that have changed"

Carers were asked to list three things about their child that had changed since attending the Fostering Changes training. Twenty-eight (out of 31) carers answered this question. All carers reported positive changes in compliance with requests, angry/aggressive behaviours and emotional problems.

"His ability to talk about his feelings, acting less physically"

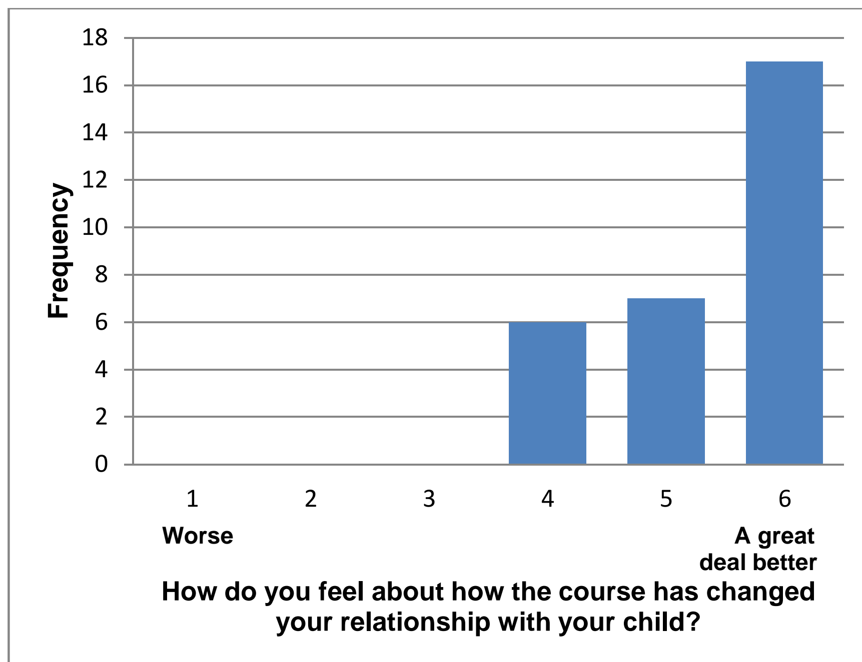
"His response to praise - more compliant, calmer."

"Able to accept boundaries more readily"

How do you feel about how the course has changed your relationship with your child?

This question was rated on a six point scale from "worse" to "a great deal better". Twenty-two carers answered this question and all reported that their relationship with their child had become a lot better (mean score 5.33). No participants reported a decrease in relationship quality.

Figure 7: Carer's perception of change in relationship with target child (n=22)



11.2 Carer Confidence and Self-Esteem

How do you think the course has impacted on how you feel as a carer?

Thirty carers replied to this question. Fifty percent said that it had made them feel more confident, 29% reported increased feelings of self-esteem, 14% said that they felt that they had improved their skills and knowledge, and 7% reported that they felt less stressed. There were no negative responses to this question.

Examples of responses:

"More confident, more aware of difficult behaviour and how to deal with it".

"It has improved my skills and taught me new ones, and made me feel less stressed and more able to cope with certain behaviours".

"It has made me feel as a carer that I am professional and our job is highly regarded".

Carers were asked to rate (on a scale of 0 to 6) how confident they felt about managing behaviour in their homes, having completed the course. All thirty-one carers who replied gave scores of 5 or 6 (mean 5.7).

Do you feel confident about using these skills with other children?

When asked how confident carers felt about using their new skills with other foster children in the future, all of the 19 carers who responded replied that they did.

"Very much so - I have used them on other family members who have special needs and the strategies worked!"

"Much more confident."

"Absolutely as they solve a lot of problems"

11.3 Retaining new knowledge and skills

Carers were also asked how easy or difficult it was going to be to hold onto the ideas that they had learned on the course. Thirty carers replied. Whilst some (14) acknowledged that it was sometimes difficult to remember everything they had learned on the course, they were highly motivated to continue using the strategies. Sixteen of the carers felt that it would be relatively easy to continue to apply what they had learned.

Examples:

"It may be difficult to hold on to as our boys in care are VERY demanding - but I will do my very best to carry on with the strategies."

"Easy, because the content was explained thoroughly and also have handbook to look back through."

"The ideas we've learnt are simple and effective; we will therefore want to try them all the time."

12.4 Course and Facilitator Evaluation

What did you enjoy most about the course?

Participants reported that they enjoyed learning new strategies and techniques, as well as the friendly atmosphere and support from the facilitators.

"The small group of people. Friendliness and openness of tutors - different strategies that taught for praise and attending."

"The support from the tutors and other participants and listening to other participants' experiences and how they dealt with them"

"Everything. How to praise young people more often on their good behaviour, than focus on the negative."

"Thought we were a good group all participating in the role plays and exercise. The experiences of other foster participants and all the positive ways in dealing with the children."

12. The Control Group Carers

12.1 Follow-up courses for Control Group Carers

Carers who had been allocated to the control groups were subsequently invited to attend follow-up courses (which were not evaluated as part of the RCT). In Bexley, 10 carers attended a course between January and April 2011, of whom 7 had been RCT controls. Between May and July 2011, 12 carers attended a course in Medway, of whom 6 had been RCT controls. A course has been planned for Enfield carers in 2012 to which RCT controls will be invited, and there will also be further training hosted by Barnet in 2012 which Haringey controls may be able to attend (negotiations pending).

12.2 Total number of carers trained during the RCT

For the pilot study, 36 foster carers took part in the training; for the RCT, 51 carers plus 4 additional partners attended the courses, and to date 23 control group carers have received training. Thus, a total of 114 foster carers have received training for the duration of the randomised controlled trial. These carers are responsible for over 150 foster children.

13. Discussion

The original aims of the Randomised Controlled Trial of the *Fostering Changes* Programme were as follows:

- To explore whether The Fostering Changes Programme reduces child behaviour problems.
- To investigate whether The Fostering Changes Programme produces changes in the child's attachment security.
- To explore secondary outcomes of the Programme, such as changes in carer confidence, parenting style and coping strategies.
- To provide the first evaluation of the revised Fostering Changes Programme with a target group of foster carers in and around London, providing information on its benefits and potential suitability for wider dissemination and use by Social Services Departments and private fostering agencies around the country.

Reduction in Child Behaviour Problems

Evidence for an overall reduction in child behaviour problems was obtained by comparing data from the Intervention and Control Groups on '*The Carer-defined Problems Scale'*. These results indicated that the behaviour of children of Intervention group carers had significantly improved over the three month period of the trial when compared to children of control group carers. Although the sample size was modest, an effect size of 0.99 (difference between the intervention and control groups measured in standard deviations) which is independent of sample size, is considered to be large for an intervention study of this type.

Evidence for an improvement in intervention group behaviour was confirmed by feedback given by carers who had attended the course, and provided evaluation at the end. All carers said that there had been positive changes in the behaviour of their foster child, and those looking after more than one child said that the same changes could also be seen in the other children they cared for.

Comparison between the mean scores obtained by target children on the SDQ before and at the end of the trial, showed an overall improvement across social, emotional and behavioural domains by intervention group children relative to controls.

Changes in Attachment Security

All the carers completed the Quality of Attachment Relationships Questionnaire before and after the trial. Data from this instrument showed improvements in the relationships between carer and child for those carers who had received the *Fostering Changes* training. No equivalent improvement was seen in the control group.

Secondary Outcomes and mechanisms for change

Measures of carer confidence, parenting style and coping strategies were included in the assessment battery in order to elucidate the mechanisms by which changes in child behaviour can be brought about.

Carers who attended the training were found to have acquired stronger beliefs in their own ability to make positive changes to children's behaviour. No equivalent increase in carer confidence was found in the control group over the course of the trial.

No pre-trial to post-trial difference between intervention and control group carers was detected by the Alabama Parenting Questionnaire. However, the 'Carer's Coping Strategies (CCS)' questionnaire, which directly related to specific techniques introduced during the training, did indicate that there were positive changes in parenting practice by those carers who completed the *Fostering Changes* training. Although the Alabama and CCS overlap to some degree (e.g. in the concept of consistent discipline), only the CCS relates to the key elements of the training such as giving praise, clear instructions, remaining calm and attending (following the child's lead).

The adoption of specific parenting strategies by the intervention group, combined with increased self-efficacy (confidence), are factors that are most likely to underlie the observed improvements in behaviour.

Qualitative carer feedback indicated that 50% of carers felt more confident as a result of attending the training, and a further 29% reported feelings of increased self-esteem. All the foster carers who had attended the course felt confident about using their newly-acquired skills with other foster placements in the future.

Evaluation of the Revised Fostering Changes Programme

The Randomised Controlled Trial of the *Fostering Changes* Programme is the first systematic evaluation of a training course written by practitioners in the UK specifically for British foster carers. The trial results are extremely encouraging, demonstrating positive changes in key areas targeted by the training; that is in decreasing rates of child misbehaviour and by increasing the security of child attachment relationships. Changes in carer confidence and parenting styles brought about by the training are factors which are likely to have influenced the observed improvements. This validates the previous decision by the DCSF to fund a roll-out of the programme throughout England.

A strength of the study design is that randomisation ensured that any changes that occurred during the three month trial could be attributed directly to the effects of the intervention and not to the possibility that the child had simply 'settled' into the placement. This was evident in results which clearly showed that improvements in behaviour and relationships were not duplicated in the control arm of the trial.

Another strength of the study was the extremely low drop-out rate, combined with excellent attendance rates and response rates, indicating that carers were highly motivated to attend and to complete the course, and that the results cannot be undermined by missing data that might be contradictory.

The trial of the *Fostering Changes* Programme involved 63 foster carers who had a total of 89 foster children in their care. Carers looking after more than one child were asked to focus on the child with the most challenging problems, but it is evident that the effects of the intervention extended to the other children in the foster family.

By enabling the carers to define the child's problems, the methods selected to measure change did not impose judgements upon them. Qualitative feedback and comments from carers was unequivocally positive and provides confirmation of the impact of this approach. Carers also felt confident about retaining their new knowledge and skills, and about using the same methods for future placements.

14. Implications and recommendations

The *Fostering Changes* team are currently extending the scope of the training to include children over the age of 12. Further effectiveness trials would be needed to validate the use of this method for other populations of looked after children.

It would be invaluable to obtain first-hand evidence from the children themselves that they had also experienced changes in quality of life. Information obtained from teachers would also be of great benefit as this would provide more objective evidence of the generalisation of improvement to different settings.

It would be informative to conduct a follow-up evaluation to see whether carers were still practicing the skills they had acquired and whether the positive short-term effects of the training on child behaviour had been maintained.

Finally, given the poor educational outcomes of looked after children, it would be worthwhile conducting an RCT of the sister programme, *Fostering Education*.

It has been demonstrated that the *Fostering Changes* Programme is an efficient and successful method of helping foster carers to improve outcomes for the children in their care. It can lead to improvements in quality of life for both carers and children by its effect on the child's behaviour and attachment relationships. It has been successfully rolled out to LAs nationwide and although practitioners have been trained in over 150 LAs, there is continuing demand for additional training.

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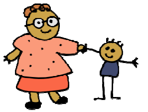
APPENDIX I: Participation Flow Chart



77 Carers of
108 Foster Children
Randomised

14 Carers of
19 Foster Children
Dropped out

63 Carers of
89 Foster Children
Completed Trial

8 Carers of
10 Foster Children
Intervention Drop-outs

6 Carers of
8 Foster Children
Control Drop-outs

34 Carers of
51 Foster Children
Intervention

29 Carers of
38 Foster Children
Control Group

Attrition:

- Ten carers dropped out of the trial following randomisation but prior to being interviewed
- Four carers dropped out of the trial after being interviewed but before the course commenced
- One carer dropped out after attending 5 sessions of the training

Appendix II: Participation figures by Local Authority:

	N	Drop-outs *		Carers who completed Trial = no of Target Children		Total number of Fostered Children (aged 2 to 12) whose carers completed trial	
		Intervention	Controls	Intervention	Controls	Intervention	Controls
Bexley	16	4	0	6	6	10	9
Medway	25	1	2	11	11	19	16
Enfield	16	2	1	8	5	10	5
Haringey	20	1	3	9	7	12	8
Total by Randomisation	**77**	**8**	**6**	**34**	**29**	**51**	**38**
Total	**77**	**14**		**63**		**89**	

* All but one of the carers dropped out before starting the course

APPENDIX III: Characteristics of Foster Carers

Age of Carer

	N	Min	Max	Mean	SD
Intervention Group	29	29	63	48.90	7.97
Control Group	28	29	66	50.68	7.90
All Carers	57	29	66	49.80	7.92

*Six carers did not state their age

Ethnicity of Carer

Ethnicity	**Intervention Group (N=34)**	**Control Group (N=29)**	**All Participants (n = 63)**
White British	20 (58.8%)	22 (75.9%)	42 (66.7%)
White Other	1 (3.0%)	1 (3.4%)	2 (3.1%)
Black British (born in UK)	2 (5.8%)	1 (3.4%)	3 (4.8%)
Black British / Caribbean	4 (11.8%)	2 (6.9%)	6 (9.5%)
Black British / African	2 (5.8%)	1 (3.4%)	3 (4.8%)
Mixed White / Black Caribbean	0 (0%)	0 (0%)	0 (0%)
Mixed White / Black African	0 (0%)	0 (0%)	0 (0%)
Mixed White and Asian	0 (0%)	0 (0%)	0 (0%)
Asian Indian	1 (3.0%)	1 (3.4%)	2 (3.1%)
Other	4 (11.8%)	1 (3.4%)	5 (7.9%)
TOTAL	34	29	63

Education of Carer

Education	**Intervention Group (N=34)**	**Control Group (N=29)**	**All Participants (N=62)**
Left school before 13	0 (0%)	0 (0%)	0 (0%)
Left school at 13 – 16	13 (39.4%)	12 (41.4%)	25 (39.7%)
Further secondary 16 – 18	8 (24.2%)	3 (10.3%)	11(17.5%)
Secretarial or technical qualification	1 (3.0%)	7 (24.2%)	8(12.7%)
Teacher training	0 (0%)	2 (6.9%)	2(3.2%)
University course not completed	1 (3.0%)	0 (0%)	1(1.6%)
Professional Qualification without degree (e.g. SRN)	4 (12.1%)	2 (6.9%)	6(9.5%)
Degree	2 (6.1%)	2 (6.9%)	4(6.3%)
Other	4 (12.1%)	1 (3.4%)	5(7.9%)
TOTAL	33	29	62

*Missing Data for one Intervention participant

Length of time as a foster carer (years)

	N	Min	Max	Mean	SD
Intervention Group	34	1	42	11.21	9.30
Control Group	29	1	32	11.00	8.41
Both Groups	63	1	42	11.11	8.23

Number of foster children currently in placement (Age 2 to 12)

Children in Trial	N	Min	Max	Mean	SD
Intervention Group	34	1	3	1.56	0.70
Control Group	29	1	3	1.31	0.54
Both Groups	63	1	3	1.44	0.64

Number of foster children currently in placement (All Ages)

All Children	N	Min	Max	Mean	SD
Intervention Group	34	1	4	1.76	0.89
Control Group	29	1	5	1.83	1.04
Both Groups	63	1	5	1.79	0.95

APPENDIX IV: Characteristics of Foster Children

Gender of all Children in the trial

	INTERVENTION GROUP (Child n = 51)	CONTROL GROUP (Child n = 38)	ALL PARTICIPANTS (Child n = 89)
Male	30 (58.8%)	21 (44.7%)	51 (57.3%)
Female	21 (41.2%)	17 (55.3%)	38 (42.7%)

Ages of all Children in the trial

Age	Intervention Group n=51	Control Group n=38	All Children n = 89
2	3 (5.9%)	5 (13.2%)	8 (9%)
3	3 (5.9%)	3 (7.9%)	6 (6.7%)
4	4 (7.8%)	2 (5.2%)	6 (6.7%)
5	2 (3.9%)	2 (5.2%)	4 (4.5%)
6	4 (7.8%)	5 (13.2%)	9 (10.1%)
7	3 (5.9%)	0 (0%)	3 (3.3%)
8	6 (11.7%)	9 (23.7)	15 (16.9%)
9	10 (19.6)	4 (10.5)	14 (15.7%)
10	6 (11.7%)	3 (7.9%)	9 (10.1%)
11	4 (7.8%)	2 (5.2%)	6 (6.7%)
12	6 (11.7%)	3 (7.9%)	9 (10.1%)
Mean All Children	**8.27 (sd = 3.01)**	**7.34 (sd = 3.23)**	**7.90 (sd = 3.12)**

Ages of Target Children in the trial

Age	Intervention Group n=34	Control Group n=29	Target Children n = 63
2	1 (2.9%)	4 (13.8%)	5 (7.9%)
3	2 (5.9%)	2 (6.9%)	4 (6.4%)
4	1 (2.9%)	0 (0%)	1 (1.6%)
5	1 (2.9%)	2 (6.9%)	3 (4.7%)
6	2 (5.9%)	5 (17.2%)	7 (11.1%)
7	3 (8.8%)	0 (0%)	3 (4.7%)
8	4 (11.8%)	6 (20.7%)	10 (15.9%)
9	9 (26.4%)	4 (13.8%)	13 (20.6%)
10	4 (11.8%)	2 (6.9%)	6 (9.5%)
11	4 (11.8%)	2 (6.9%)	6 (9.5%)
12	3 (8.8%)	2 (6.9%)	5 (7.9%)
Mean Target Children	**8.78 (sd = 2.64)**	**7.49 (sd = 3.16)**	**8.18 (sd = 2.94)**

Ethnicity of all Children in the trial

Ethnicity (All children)	Intervention Group (N=51)	Control Group (N=38)	All Participants (N=89)
White British	29 (56.86%)	26 (68.42%)	55 (61.8%)
White Other	3 (5.88%)	1 (2.63%)	4 (4.49%)
Black British (born in UK)	2 (3.92%)	1(2.63%)	3 (3.37%)
Black British / Caribbean	2(3.92%)	1(2.63%)	3 (3.37%)
Black British / African	8 (15.69%)	4 (10.53%)	12 (13.48%)
Mixed White / Black Caribbean	4 (7.84%)	2 (5.26%)	6 (6.74%)
Mixed White / Black African	0 (0%)	3 (7.89%)	3 (3.37%)
Mixed White and Asian	0 (0%)	0 (0%)	0 (0%)
Asian Indian	0 (0%)	0 (0%)	0 (0%)
Other	33 (5.88%)	0 (0%)	3 (3.37%)
Not stated	0 (0%)	0 (0%)	0 (0%)
TOTAL	51	38	89

Ethnicity of Target Children in the trial

Ethnicity (All children)	Intervention Group n=34	Control Group n=29	Target Children n = 63
White British	17 (50%)	19 (65.5%)	36 (57.1%)
White Other	3 (8.8%)	1 (3.5%)	4 (6.4%)
Black British (born in UK)	2 (5.9%)	0 (0%)	2 (3.2%)
Black British / Caribbean	1 (2.9%)	1 (3.5%)	2 (3.2%)
Black British / African	5 (14.8)	4 (13.8%)	9 (14.3%)
Mixed White / Black Caribbean	4 (11.7%)	2 (6.9%)	6 (9.6%)
Mixed White / Black African	0 (0%)	2 (6.9%)	2 (3.2%)
Mixed White and Asian	0 (0%)	0	0 (0%)
Asian Indian	0 (0%)	0	0 (0%)
Other	2 (5.9%)	0	2 (3.2%)
Not stated	0 (0%)	0	0 (0%)
TOTAL	34	29	63

Target child: length of time in placement (months)

	N	Min	Max	Mean	SD
Intervention Group	34	1	99	31.18	27.89
Control Group	29	1	84	19.38	19.70
All target children	63	1	99	25.75	24.99

Target child: number of previous placements

	N	Min	Max	Mean	SD
Intervention Group	34	0	10	1.5	1.96
Control Group	29	0	4	0.90	1.21
All target children	63	0	10	1.22	1.67

Appendix V: Summary of Evaluations and Measures used in the RCT

Pre and Post-course measures	Administered to
Initial Visit Interview and Demographics Household composition Carer history Carer age, education and ethnicity Child ethnicity Child placement status	**All carers**
TARGET CHILDREN **Pre-course questionnaires:** Alabama Short Form Strengths & Difficulties Questionnaire (SDQ) Carer Efficacy Questionnaire (CEQ) Quality of Attachment Relationship (QUARQ) Carer Coping Strategies Carer-Defined Problems Scale	**All carers**
CSRI (Economic Evaluation) Pre-course questionnaire	**All carers**
OTHER CHILDREN **Pre-course questionnaires:** Strengths & Difficulties Questionnaire (SDQ) Carer-Defined Problems Scale	**All carers with more than one child in the 2-12 age range**
Session Feedback forms Feedback from each week of the course	**Intervention group carers**
Mid-term Evaluations (Session 6)	**Intervention group carers**
TARGET CHILDREN **Post-course questionnaires:** Alabama Short Form Strengths & Difficulties Questionnaire (SDQ) Carer Confidence Quality of Attachment Relationship (QUARQ) Carer Coping Strategies Carer-Defined Problems Scale	**All carers**
OTHER CHILDREN **Post-course questionnaires:** Strengths & Difficulties Questionnaire (SDQ) Carer-Defined Problems Scale	**All carers with more than one child**
CSRI (Economic Evaluation) Post-course questionnaire	**All carers**
End of Course Satisfaction Questionnaire	**Intervention group carers**
Additional courses attended during trial	**All carers**

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