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Spedsberg, Maria Schelde (2019) *Qualitative investigation into assessment approaches to maltreated pre-school children in care and clinical research portfolio*. D Clin Psy thesis.

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**Qualitative investigation into assessment approaches
to maltreated pre-school children in care
And Clinical Research Portfolio**

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Submitted in partial fulfilment of the requirements for the degree of
Doctorate in Clinical Psychology

Institute of Health and Wellbeing
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October 2019

ACKNOWLEDGMENT

Firstly, I would like to thank the informants, without them this study would not have been possible. I appreciate the frank insight that each person has provided me with.

Thank you to Dr Fiona Turner-Halliday who, as one of my research supervisors, guided me through conducting qualitative research. Your expertise is much appreciated. Professor Helen Minis, I am grateful that I have had the opportunity of having you as a research supervisor. Professor Hamish McLeod thank you for answering my numerous questions as a research supervisor. Irene O'Neil, thanks so much for supporting me with the transcripts and numerous other enquires - your efficiency and positive attitude is infectious. Adele and Cathie, I appreciate the time you took in supporting me finding contact details.

I would like to thank the 2016 Doctorate in Clinical Psychology class. I am grateful to have ended up with you all. You have made the last three years a fun experience. Thank you to my friend's outwith the field of Psychology for all the encouragement and general greatness.

Thanks to the whole Armitago family. You have all always made me feel part of the family from the moment we met and I appreciate your support. Mor, your love and support throughout my life has always been with me, thank you for being a great mum. My final thanks are to Lucy; having you in my life is a blessing. Your natural ability to help me reflect on the wider picture when stressed makes any process much easier. I appreciate your humour, love and never-ending support. I think you deserve an honorary degree for all the proof reading you have done over the years. Thanks for everything, I love you.

Table of Content

Acknowledgements.....	2
-----------------------	---

CHAPTER ONE: SYSTEMATIC REVIEW

How effective are mental health interventions for children under five who have experienced maltreatment? A systematic review.....	6
---	---

Abstract	7
-----------------------	---

Introduction	8
---------------------------	---

Adverse Childhood Experience.....	8
-----------------------------------	---

The Matrix.....	8
-----------------	---

Interventions for Maltreated Children.....	9
--	---

Aim of the Review	9
--------------------------------	---

Methods	10
----------------------	----

Search Strategy.....	10
----------------------	----

Search Terms.....	10
-------------------	----

Procedure.....	11
----------------	----

Data Extraction.....	13
----------------------	----

Quality Appraisal.....	13
------------------------	----

Results	13
----------------------	----

Description of Included Studies.....	13
--------------------------------------	----

Interventions.....	23
--------------------	----

Discussion	28
-------------------------	----

The main findings.....	29
------------------------	----

Limitations of included studies.....	30
--------------------------------------	----

Implication of review.....	31
----------------------------	----

Limitation	31
-------------------------	----

Conclusion	32
-------------------------	----

References	33
-------------------------	----

Table & Figures

Table 1	Characteristic and findings of studies	14
---------	--	----

Table 2	Summary of effect sizes for ABC interventions.....	24
---------	--	----

Table 3	Summary of effect sizes for Psychotherapy interventions	26
---------	---	----

Table 4	Summary of effect sizes for VIPP interventions	28
---------	--	----

Figure1	PRISMA study flow chart	12
---------	-------------------------------	----

CHAPTER TWO: MAJOR RESEARCH PROJECT

Qualitative investigation into assessment approaches to maltreated pre-school children in care.....	37
Plain English Summary.....	38
Abstract	41
Introduction	42
Infant Mental Health.....	42
Assessment in the child welfare system.....	42
BeST? Trial.....	43
The Benefit of Qualitative Assessment Methods.....	44
Aim and Objectives	44
Methods	45
Design.....	45
Informant.....	45
Interview Procedure.....	47
Data Analysis.....	48
Reflexivity.....	48
Ethical Considerations.....	49
Results	49
Themes.....	49
Impact of time.....	50
Importance of Communication.....	54
Impact of legal services.....	58
Discussion	65
Implications and future research.....	66
Limitations.....	67
Conclusion	67
References	68
Table & Figures	
Table 1	An outline of the decisions that were made for the four families 46
Table 2	Outline of 2019 interviewees..... 47
Table 3	Phases of thematic analysis (Braun and Clarke, 2006)..... 48
Figure1	Thematic Map outlining themes that were identified 50

APPENDIXES

1.1	Instruction for authors from the selected journal	71
1.2	Outline of search terms in databases.....	74
1.3	Data Extraction Sheet.....	77
1.4	Clinical Trials Assessment Measure (CTAM).....	78
1.5	CTAM Scores.....	79
2.1	Instruction for authors from the selected journal.....	80
2.2	MRP Proposal.....	83
2.3	Research Question Guide.....	103
2.4	NHS GGC ethical approval for Best trial.....	104
2.5	Researcher added to ethical approval.....	111
2.6	Participants Information Sheet.....	113

CHAPTER ONE: Systematic Review

How effective are mental health interventions for children under five who have experienced maltreatment?

A systematic review

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Declaration of Conflict of Interest: None

Chapter word count (with references): 8,050 words

Prepared in accordance with manuscript guidelines for the Journal of Child Psychology and Psychiatry (Appendix 1.1).

ABSTRACT

Background: Adverse Childhood Experiences (ACE's) and maltreatment have a significant impact on the development of young children, impacting their attachment to care providers. Scotland has a guideline for psychological intervention called The Matrix (2015), which recommends interventions to support young children who are at risk of disruption in their attachment. The purpose of the review is to identify randomised controlled trials (RCT) of the interventions recommended by the Matrix to review the current evidence base.

Aim: To review interventions that are recommended by the Matrix in supporting children (0-5 years old) who have experienced maltreatment.

Methods: A systematic search of electronic databases was conducted and journals were hand-searched to identify further research. The quality of the papers was completed using the CTAM measure. A Narrative Synthesis approach was applied to compare interventions.

Results: Sixteen studies were identified for recommended interventions, which included Video Interactive Guidance (VIPP), Child-Parent Psychotherapy (CPP), Attachment and Bio-behavioural Catch up (ABC) and Circle of Security (CoS). The studies measured a range of outcomes and the effect size of each study was reported for comparison.

Conclusion: Outcomes for ABC, CPP and VIPP showed the most significant effect sizes. Limited evidence for CoS was found. The findings of this review reflect the ratings that the Matrix (2015) provides in regard to recommended interventions for concerns around attachment difficulties.

Key words: Systematic Review, 0-5 years old, ACE's, attachment, RCT

INTRODUCTION

Adverse Childhood Experiences

The term Adverse Childhood Experiences (ACE's) was initially described by Felitti and colleagues (1998) and has received extensive attention within research. Numerous studies confirm that the number of ACE's experienced in childhood correlate with the development of physical, social, emotional and mental health difficulties during childhood and in later life (Coles et al., 2015). Prevention of child maltreatment and number of ACE's is a public health priority (Cuthbert et al., 2011); policies focus on preventive actions (NHS Health Scotland 2017; The Scottish Government, 2017) and supporting children who have experienced ACE's (The Scottish Government, 2018). Focus has been also been on supporting professionals to recognise signs of maltreatment for early intervention (Boullier et al., 2018). It is therefore clear that supporting children with ACE's is an essential social and political responsibility.

Previous systematic reviews have focused on the impact ACE's have across the life span (Hughes et al., 2016), on interventions for physical abuse (Montgomery et al., 2009) and how attachment-based interventions can help (Barlow et al., 2016). A scoping review was completed by Landers et al (2018), which examined the literature on parenting interventions for children who have experienced maltreatment. No systematic review was identified where interventions were based on a guideline. Considering the Scottish policies, the current review aims to conduct a search of interventions recommendation by The Matrix for Psychological Therapies in Scotland.

The Matrix

The Matrix was developed for the National Health Service (NHS) boards in Scotland to plan and provide for the most effective evidence-based treatments for various populations and presentations, including children (The Matrix, 2015). SIGN and NICE guidelines were used as a foundation in the development of the Matrix alongside expert opinion for each diagnostic classification. The framework thereby outlined a matched /stepped care approach to meeting the mental health needs by promoting the delivery of effective treatment. It also supports government targets, such as the HEAT (Health Improvement, Efficiency, Access to treatment, Treatment) Psychological Therapies Access Target. As such, it is the go-to guide for psychological service provision within Scotland. Therefore, it was chosen as a guide for recommended interventions to structure this systematic review.

Interventions for Maltreated Children

Children who experienced maltreatment are at risk of disorganised attachment relationships (Zeanah 2009). This can significantly impact their current and long-term wellbeing and lead to the development of mental health difficulties. The Matrix outlines that to prevent this, children at risk should receive an intervention that focuses on the important components for attachment to occur, which consist of sensitivity, warmth and consistency (Bakermans-Kranenburg et al., 2003). Four intervention models are recommended by the Matrix; Video Interactive Guidance (VIPP), Child-Parent Psychotherapy (CPP), Attachment and Bio-behavioural Catch up (ABC) and Circle of Security (CoS) (The Matrix, 2015). The Matrix also outlines that for children in foster care, who present with moderate to severe difficulties, CBT based group intervention is effective. When the guidelines were compiled, the evidence base for effective attachment-based interventions was limited in its scope of quality and quantity (The Matrix, 2015). It provided the evidence base which was available at the time of publication. The study will review if further studies have been conducted since the completion of the Matrix. This is to determine if further support for these interventions has been identified.

The review will follow a narrative synthesis approach, as this has been identified to be effective when comparing heterogeneous groups (Popay et al, 2006). Mays et al. (2005) outlined that it can be applied instead of a meta-analysis where the studies are too dissimilar to allow for statistical comparisons, aggregation, and analysis. The review focuses on numerous treatment approaches with different outcome variables so therefore a narrative synthesis appears a best fit for this review.

AIM OF REVIEW

The aim was to systematically assess the literature for randomised control trials that have evaluated interventions recommended by the Matrix. The focus will be on children under the age of five who have experienced numerous ACE's that places their emotional well being at risk. Therefore, the review aims to address the following question:

1. How effective are interventions recommended by the Matrix in supporting children (0-5 years old) who have experienced maltreatment?

METHOD

Search strategy

The following electronic databases were searched: Ovid Embase 1947- 4th April 2019, Ovid MEDLINE(R) and In-Process & Other Non-Indexed Citations 1946 to April 4, 2019, PsyINFO (EBSCO) and Cochrane Library. The final search was conducted on the 12th April 2019. Following completion of the electronic databases, a search of the grey literature was conducted in the Open Grey, The Social Science Research Network and the Glasgow University Library network. The key publication *Journal of Child Psychology and Psychiatry* was hand searched for any papers not identified during the electronic search. The reference lists of the final studies were hand searched to locate any relevant papers. The hand search was conducted across a wide range of sources as this is an essential part and avoids missing key literature (Armstrong et al., 2005).

Search Terms

The search terms were constructed using the PICO (Population, Intervention, Control and Outcomes) model (Heneghan et al., 2002). Children who have been looked after and accommodated (LAAC) were included due to higher presentation of childhood adversities (Blower et al., 2004). The intervention search terms were based on recommendations in the Matrix (2015) for attachment that is at risk and fostered children with moderate to severe difficulties. The design of the studies was Randomised Controlled Trial (RCT), due to RCT being viewed as a gold standard for minimising bias (Hariton et al., 2018). The following terms were used:

1. (child* or infan*).ti,ab.
2. exp Child/
3. 1 or 2
4. (((child* adj3 (abuse* or neglect* or mistreat* or maltreat* or (sex* adj3 abus*) or (physical* adj3 (abuse* or neglect* or violent*)) or (emotion* adj3 (abuse* or neglect*)))) or adverse child* experienc* or (child* adj5 ACE*)).ti,ab.
5. exp Child Abuse/
6. 4 or 5
7. (video* interact* guid* or psychother* or attachm* bio* behavior* or abc or circle of security or cbt or cognitive behavior* therap* or intervent*).ti,ab.
8. 3 and 6 and 7
9. limit 8 to english language

10. limit 9 to ("all infant (birth to 23 months)" or "newborn infant (birth to 1 month)" or "infant (1 to 23 months)" or "preschool child (2 to 5 years)")

The above outline in the search terms used in Medline (OVID) and the terms were adopted according to the database (Appendix 1.2). The studies were reviewed according to the following inclusion and exclusion criteria.

Inclusion

- Children aged 0 - 5
- Children who are looked after and accommodated
- Child abuse, neglect and / or Adverse Childhood Experiences (ACE's)
- Randomised controlled trials
- The following interventions were included
 - Video interactive guidance
 - Child-Parent Psychotherapy
 - Attachment and Bio-behavioural Catch-up
 - Circle of security
 - Cognitive Behavioural Therapy (CBT)
- Any setting
- Peer reviewed
- English Language
- Time span from 1946 to 12th April 2019

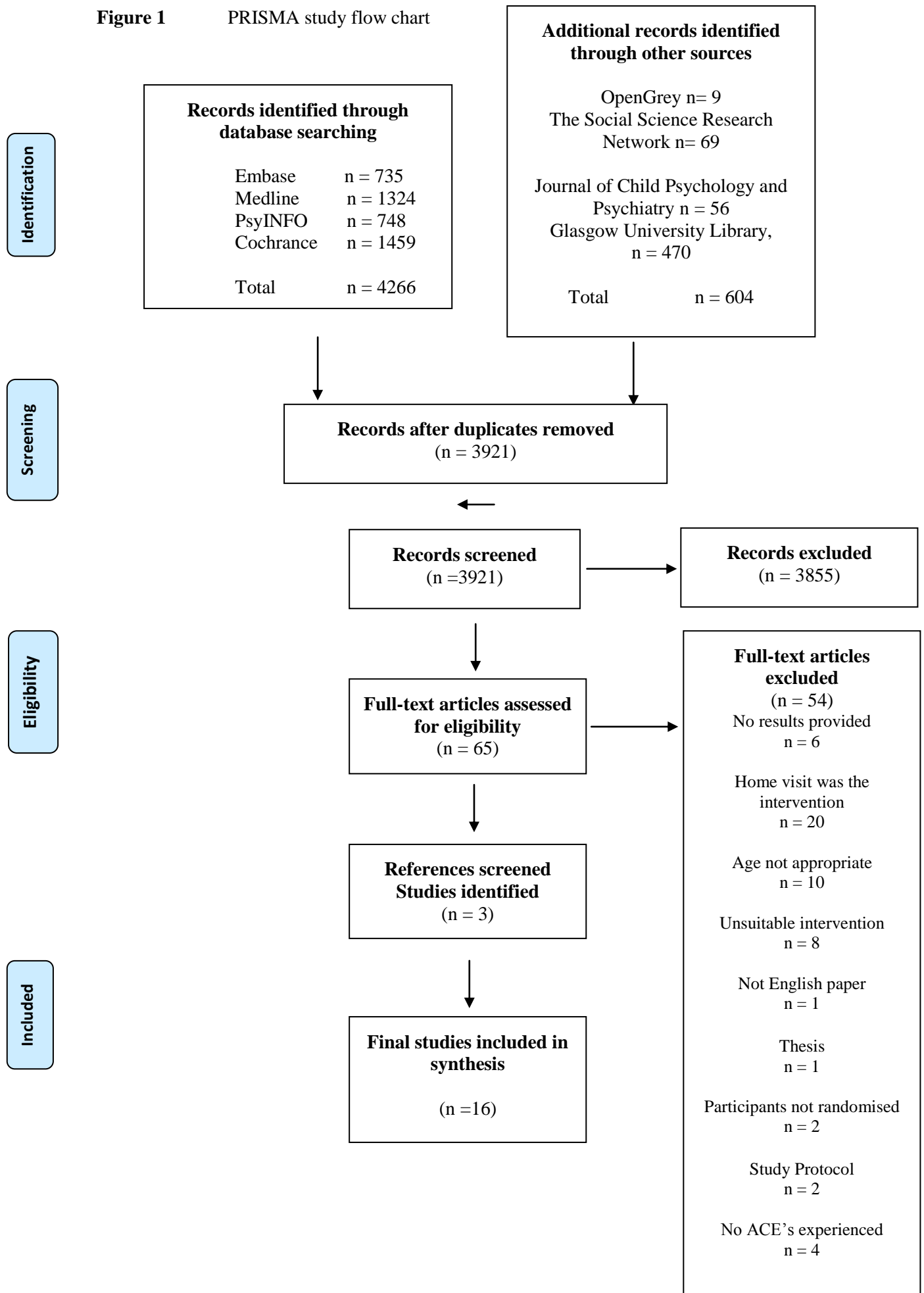
Exclusion

- Qualitative research studies
- Single case research design

Procedure

Following completion of the electronic search 4266 papers were indentified. The hand search of the grey literature and key journal identified 604 additional papers. This meant a total of 4870 papers were identified. The review followed the PRISMA guidelines (Liberati et al., 2009) and an outline of this can be seen in Figure 1. After duplications were removed, 3921 journals were searched using the title and abstract to identify relevance. This was followed by the full text of 65 journals being screened against the inclusion and exclusion criteria. Reasons were provided for exclusions and 13 papers met all criteria for inclusion. Reference lists of these papers identified 3 further eligible papers, which meant that 16 studies were included in total. The author conducted all aspects of the review.

Figure 1 PRISMA study flow chart



Data Extraction

To ensure a systematic data extraction process, an extraction sheet was designed (Appendix 1.3). The lead researcher completed all gathering of data with uncertainties discussed with the research supervisor.

Quality Appraisal

To access the methodological rigour of the studies the Clinical Trials Assessment Measure (CTAM) was applied (Tarrier & Wykes, 2004). The CTAM was developed from the CONSORT guidelines (Boutron et al., 2008) and provides adequate internal consistence, good inter-rater agreement and excellent concurrent validity (Wykes et al., 2008). It contains 15 items over six trial domains (Appendix 1.4) and points are allocated depending on quality standards, with a maximum score of 100. A score of 65 and above indicates adequate methodology. The lead researcher assessed the methodological quality independently, with the research supervisor conducting a review of the included papers.

RESULTS

Description of Included Studies

The included studies are outlined in Table 1. Six studies had ABC as an intervention, one Circle of Security, five studies on Psychotherapy and four on VIPP. The studies had a total of 2295 participants (median 76), with an age range of 0 to 60 months. All the participants in the intervention groups had experienced a range of ACE's and 5 out of the 16 studies included LAAC children (Dozier et al., 2006; Dozier et al. 2008; Bernard et al. 2012; Lind et al, 2017; Casonato et al. 2017). The majority were conducted in the United States, with four studies being conducted in Europe, UK (Fonagy et al., 2017), Italy (Casonato et al., 2017) and Portugal (Pereira et al., 2014; Negrão et al., 2014). All the studies used a RCT design, with one secondary analysis (Ippen et al., 2011) and a pilot RCT (Casonato et al., 2017). There was a wide range of outcome measures for the child and parent. Effect size was reported to compare outcomes and when absent the researcher calculated this (Cohen d; 0.2 small, 0.5 medium, 0.8 large). It was not possible to calculate the effect size for one study (Cassidy et al., 2017) due to an absent mean and SD. The effect sizes reported were between-group. The methodological quality score ranged from 46 to 97 (median = 76.5) with five studies below the cut off point of 65 for adequate methodological quality. Appendix 1.5 provides an outline of the calculation.

Table 1. Characteristics and findings of studies

Author, Date, Location, Design	Intervention	Control Group	Participants N, Age, ACE's	Outcome Measured & Duration of Treatment	Findings	Effect size	CTAM Total
01. Dozier, M. et al 2006 USA RCT	Attachment and Bio-Behavioural Catch up (ABC)	Developm ental education for families (DEF) CS	N = 60 ABC 30 DEF 30 104 CS Age = 3.6 months to 39.4months ACE's = LAAC	Morning and Evening stress hormone levels (Cortisol) Behaviour difficulties (PDR/IT) <u>10 weekly sessions</u>	The control group (DEF) showed higher cortisol levels, indicating greater distress, than children in the ABC group. There was a main a effect for the Intervention Group $F(3,198) = 5.24, p < .002$. No significant difference in behaviour measures was found.	Morning cortisol d = 0.5 Evening cortisol d = 0.6 Behaviour d = 0.1	78
02. Dozier, M. et al 2008 USA RCT	ABC	DEF CS	N = 95 ABC 46 DEF 47 CS 48 Age = 15 to 24 months ACE's = LAAC	Attachment response to Ainsworth Strange Situation Protocol <u>10 weekly sessions</u>	The ABC group, showed lower initial levels of cortisol in the Strange Situation than in the DEF group. Children in the community group levels were not significantly different from the children in the ABC group.	Effect size not reported	64

<p>03. Bernard, K. et al</p> <p>2012</p> <p>USA</p> <p>RCT Clinical Trial</p>	ABC	DEF	<p>N = 120</p> <p>ABC 60 DEF 60</p> <p>Age = 1.7 to 21.4 months</p> <p>ACE's = LAAC</p>	<p>Attachment response to Ainsworth Strange Situation Protocol</p> <p><u>10 weekly sessions</u></p>	<p>ABC group showed lower rates of disorganized attachment after treatment compared to the control group $\chi^2(1,120) = 7.60, p < .01$</p> <p>ABC had higher rates of secure attachment relative to children in the control group $\chi^2(1,120) = 4.13, p < .05$</p>	<p>Lower rates of dis-organised attachment d = 0.52</p> <p>Higher rates of secure attachment d = 0.38</p>	94
<p>04. Lind, T. et al</p> <p>2017</p> <p>USA</p> <p>RCT</p>	ABC -T	<p>DEF</p> <p>CS</p>	<p>N = 173</p> <p>ABC 63 DEF 58</p> <p>52 CS</p> <p>Age = 14 to 56.3 months</p> <p>ACE's = LAAC</p>	<p>Attention Regulation (CBCL)</p> <p>Cognitive Flexibility (DCCS)</p> <p><u>10 weekly sessions</u></p>	<p>ABC-T group demonstrated fewer attention problems than the DEF intervention M = 2.73, SD = 2.11, $F(1, 114) = 5.26, p < .02$</p> <p>ABC-T showed greater cognitive flexibility than the DEF intervention M = 23.67, SD = 13.06, $F(1, 91) = 4.14, p < 0.4$</p> <p>The ABC-T group did not differ from the low-risk comparison group</p>	<p>Attention d = 0.4</p> <p>Cognitive flexibility d = 0.4</p>	68

<p>05. Bernard, K. et al</p> <p>2015</p> <p>USA</p> <p>RCT</p>	ABC	DEF	<p>N = 260</p> <p>ABC 129 DEF 131</p> <p>Age = 5.0 – 33.8 months</p> <p>ACE's = Neglect</p>	<p>Stress hormone levels (Cortisol)</p> <p><u>10 weekly sessions</u></p>	<p>The ABC group showed higher wake-up values of cortisol $\beta_{01} = 0.21, p < .01$</p> <p>And a steeper wake-up to bedtime decline in cortisol than the control intervention. $\beta_{11} = 0.16, p < 0.05$</p> <p>These findings indicate that the intervention is effectiveness in supporting children's stress (cortisol) regulation.</p>	<p>Morning cortisol d = 0.48</p> <p>Evening cortisol d = -0.38</p>	91
<p>06. Lind, T. et al</p> <p>2014</p> <p>USA</p> <p>RCT Clinical Trial</p>	ABC	DEF	<p>N = 260</p> <p>ABC 129 DEF 131</p> <p>Age = 3.4 – 25.8 months</p> <p>ACE's = Neglect</p>	<p>Affect regulation assets by completion of the Tool Task</p> <p><u>10 weekly sessions</u></p>	<p>The ABC group showed lower levels of negative affect compared to the control $F(1, 115) = 5.04, p < .05$</p> <p>The ABC group displayed lower levels of anger $F(1, 115) = 4.69, p < .05$</p> <p>Lower levels of anger toward parent $F(1, 115) = 5.35, p < .05$</p> <p>Lower levels of global anger/sadness $F(1, 115) = 5.66, p < .05$</p>	<p>Negative Affect d = 0.42</p> <p>Anger d = 0.40</p> <p>Anger towards parent d = 0.43</p> <p>Anger / Sadness d = 0.44</p>	94

07. Cassidy J. et al 2017 USA RCT	Circle of Security	Waiting list (WL)	N = 164 Circle of Security 91 Control 73 Age = 3 – 5 years ACE's = Numerous	A range of measures were applied to measure attachment and behaviour <u>10 weekly sessions</u>	No main effects of intervention were found	No effect found	64
08. Cicchetti, D. et al. 2006 USA RCT	Infant – Parent Psychotherapy (IPP)	Psycho education Parenting Programme (PPI) CS NC	N = 137 IPP 32 PPI 24 CS 81 NC 52 Age = Mean 13.3months ACE's = Abuse, Neglect, maltreatment	Attachment response to Ainsworth Strange Situation Protocol <u>Weekly sessions for one year</u>	IPP and PPI, both were successful in altering the predominantly insecure attachment organizations of infants X ² (9, N = 149) = 43.75, p<.001	Change from Insecure to secure attachment style d = 1.34	91

<p>09. Stronach E.P. et al</p> <p>2013</p> <p>USA</p> <p>RCT</p>	<p>Child – Parent Psychotherapy (CPP)</p>	<p>PPI</p> <p>CS</p>	<p>N = 137</p> <p>CPP 53 PPI 49 CS 35</p> <p>NC 52</p> <p>Age = Mean 13.3months</p> <p>ACE's = Abuse, Neglect, maltreatment</p>	<p>Attachment response to Ainsworth Strange Situation Protocol Strange Situation</p> <p>Maternal report of behaviour</p> <p><u>Weekly sessions for one year</u></p>	<p>CPP was more likely to demonstrate secure attachment than children who received PPI X2 (1, n= 49) = 5.41, p = 0.2</p> <p>And less likely to be classified disorganized at follow-up X2 (1, n= 49) = 5.52, p = 0.2</p> <p>There were no significant differences at the follow-up assessment for maternal perceptions of internalizing, externalizing, or total behaviour problems among the study groups.</p> <p>F (9, 145) = 0.86, p = .56</p>	<p>CPP had higher secure attachment and lower disorganized then control group (CS) d = 0.23</p> <p>CPP higher secure attachment d = 0.33</p> <p>Lower dis-organised attachment then PPI group d = 0.34</p>	<p>91</p>
<p>10. Fonagy, P. et al</p> <p>2016</p> <p>UK</p>	<p>Parent – Infant Psychotherapy (PIP)</p>	<p>Secondary and specialist primary care treatment</p>	<p>N = 76</p> <p>PIP 38 Control 38</p> <p>Age = 0.5- 11months</p>	<p>Attachment response to Ainsworth Strange Situation Protocol</p>	<p>In the PIP group, Mothers presented with less helplessness and hostility towards their child</p> <p>Mothers in the PIP group tended to report a greater sense of warmth toward their babies. The general level</p>	<p>CES-D d = 0.6</p> <p>Parental Stress d = 0.4</p>	<p>80</p>

RCT			ACE's = Numerous	<p>Parent infant interaction</p> <p>Maternal reflection</p> <p><u>Weekly sessions for one year</u></p>	<p>of parenting stress decreased significantly in the PIP group.</p> <p>There were no significant improvements in the group assigned to PIP for child development and parent-child interaction</p>	<p>MOMs Warmth d = 0.3</p> <p>Invasion d = 0.3</p>	
<p>11. Lieberman, A. F. et al</p> <p>2005</p> <p>USA</p> <p>RCT</p>	CPP	CM	<p>N = 76</p> <p>CPP 43 Control 33</p> <p>Age = 3-5 years</p> <p>ACE's = Numerous</p>	<p>Child Behaviour</p> <p>Trauma Symptoms of Child and Parent</p> <p><u>Weekly sessions for one year</u></p>	<p>Children assigned to CPP improved significantly more than children in the control group, for decreased trauma symptoms. T (32) = 5.46, p < .001</p> <p>Mothers receiving CPP showed significantly fewer PTSD avoidance symptoms in comparison with control group mothers. F 1,57 = 5.08, p < .05</p> <p><u>Child behaviour</u></p> <p>There was a decrease in behaviour problems F 1,31 = 4.72, p < .05</p>	<p>Trauma symptoms d = 0.63</p> <p>Trauma symptoms over time d = 0.57</p> <p>Child Behaviour d = 0.24</p> <p>Maternal Symptoms Avoidance d = 0.50</p> <p>Effect over time d = 0.68</p>	46

<p>12. Ippen, C. G. et al</p> <p>2011</p> <p>USA</p> <p>RCT follow up</p>	<p>CPP</p>	<p>CM</p>	<p>N = 53</p> <p>CPP 27 Control 25</p> <p>Age = 3-5 years</p> <p>ACE's = Numerous</p>	<p>Child Behaviour (CBCL)</p> <p>Trauma Symptoms of Child and Parent</p> <p><u>Weekly sessions for one year</u></p>	<p>CPP children showed greater reductions in PTSD and depression symptoms, number of co-occurring diagnoses, and behaviour problems compared to the comparison group $X^2(1) = 10.48, p < .01$</p> <p>CPP mothers showed significant reduction in PTSD and depression, whereas comparison group mothers showed no improvements in any of these domain $X^2(1) = 7.70, p = .01.$</p>	<p>PTSD, depression and co-occurring diagnoses d = 1.0</p> <p>Behaviour Problems d = 0.5</p> <p>Mothers reductions in depression and PTSD symptoms d = 0.9</p>	<p>53</p>
<p>13. Pereira, M. et al</p> <p>2014</p> <p>Portugal</p> <p>RCT</p>	<p>VIPP-SD</p>	<p>TC</p>	<p>N = 44</p> <p>VIPP-SD 22 Control 22</p> <p>Age = 12-48 months</p> <p>ACE's = Numerous</p>	<p>Decreasing Harsh Discipline</p> <p><u>Six weekly one hour sessions</u></p>	<p>VIPP-SD is effective in decreasing maternal harsh discipline, but only under conditions of self-perceived higher parenting stress. $F(1, 39) = 5.84, p < .05$</p>	<p>Parenting stress d = 0.3</p>	<p>75</p>

14. Negrão, M. et al 2014 Portugal RCT	VIPP-SD	TC	N = 55 VIPP-SD 29 Control 26 Age = 12-48 months ACE's = LAAC	Maternal Interaction Child Behaviour <u>Six weekly one hour sessions</u>	The VIPP-SD proved to be effective in enhancing the overall quality of the interaction style between mothers and their children. Improvement was identified in maternal non intrusiveness, child responsiveness, and involvement $F(3, 38) = 5.68, p < .01$	Positive Parenting d = 0.3 Positive Child Behaviour d = 0.5 Relational Function d = 0.4	53
15. Casonato, M. et al 2017 Italy Pilot RCT	VIPP-SD	Tele- phone calls (TC)	N = 12 VIPP-SD 7 Control 5 Age = 10-36 months ACE's = LAAC	Maternal Behaviour <u>Six one hour visit over four months</u>	In the VIPP-SD there were significant differences between Inflexibility $(Z = -2.12; p = .03)$ Laxness $(Z = -2.27; p = .02)$	Inflexibility d = 0.7 Laxness d = 0.1	75
16. Steele, H. et al. 2019 USA RCT	VIPP (GABI)	STEP	N = 228 GABI 117 Control 111 Age = 0-36 months ACE's = Numerous	Maternal Behaviour <u>26 weekly one hour treatment</u>	<u>Maternal supportive presence</u> A significant main effect of treatment group for "maternal supportive presence" $F(1, 73) = 9.50, p = .05$	Maternal supportive presence Partial $\eta^2 = 0.12$	97

					<u>Maternal hostility</u> Mothers in GABI displayed less hostility $F(1, 73) = 3.82, p = .05$. <u>Dyadic reciprocity</u> Children and mothers in GABI showed significantly more dyadic reciprocity $F(1, 73) = 17.56, p = .0001$	Maternal hostility Partial $\eta^2 = .05$ Dyadic reciprocity Partial $\eta^2 = .16$	
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Abbreviations: **ABC:** Attachment and Bio-Behavioural Catch up, **ABC – T:** Attachment and Bio-Behavioural Catch up Toddler, **ASQ: SE:** The Ages and Stages Questionnaire: Social-Emotional, **BSI:** The Brief Symptom Inventory, **CAPS:** Clinician-administered PTSD Scale, **CBCL:** Child Behaviour Checklist, **CES-D:** The Centre for Epidemiological Studies Depression Scale, **CG:** Control Group, **CIB:** Coding Interactive Behaviour, **CM:** Case Management, **CPP:** Child Parent Psychotherapy, **CS:** Community Sample, **CTNS:** Coping with Toddlers negative emotions scale, **DC:03:** Semi-structured Interview for Diagnostic Classification, **DCCS:** Dimensional Change Card Sort, **DEF:** Developmental Education for Families, **DHQ:** Daily Hassles Questionnaire, **DSM-IV:** The Diagnostic Interview Schedule – Version IV
EAS: Emotional Availability Scales, **ECR:** Experience in Close relationships scale, **FES:** Family Environment Scale, **GABI:** Group Attachment-Based Intervention, **IPP:** Infant Parent Psychotherapy, **LAAC:** Looked after & Accommodated, **MBQS:** Maternal Behaviour Q-Set, **MORS:** Mother's Object Relations Scales, **NC:** Non Maltreated Control, **PD:** The Parent Development Interview–Revise, **PDR/IT:** Parent's Daily Report, **PIP:** Parent Infant Psychotherapy, **PSI: SF:** The Parenting Stress Inventory Short Form, **PPI:** Psycho educational parenting intervention, **RCT:** Randomised Control Trial, **SCL-90-R:** Symptoms Checklist-90 Revised, **STEP:** Systematic Training for Effective Parenting, **TC:** Telephone Calls, **TSE's:** Traumatic and Stressful events, **VIPP:** Video-feedback Intervention to promote Positive Parenting, **VIPP-SD:** Video-feedback Intervention to promote Positive Parenting and Sensitive Discipline, **WL:** Waiting List

Interventions

Attachment and Bio-behavioural Catch up (ABC)

To compare the outcomes of the ABC studies, Table 2 provides an outline of the effect sizes. The ABC intervention consisted of 10 weekly sessions and all studies reported a significant difference when comparing to the control group. Three out of the studies (Dozier et al., 2006; Dozier et al., 2008; Bernard et al., 2015) measured the regulation of cortisol for treatment effect and they all found a significant change in the intervention group when compared to the control group. The effect size ranged from medium to large ($d = 0.38-0.6$) in two studies. Dozier et al (2008) reported a significant difference in the ABC group in comparison to the control group, however did not report the effect size or means and SD for calculation. It is also worth noting the methodological quality for this study was below the CTAM cut off point (64), which should be considered when interpreting the studies outcome. Bernard et al (2015) and Dozier et al (2006) methodological quality was high and combined with the effect size indicates that the intervention was effective on cortisol regulation.

The Stranger Situation was used in two of the studies (Dozier et al., 2008; Bernard et al., 2012). Bernard et al (2012) was the only study that used this to measure attachment style. They found a medium effect size for lower rates for disorganised attachment and higher rates of secure attachment in the ABC group. This study presents as high methodological quality on the CTAM score (94). It is worth noting that though Dozier et al (2008) reports a difference in attachment, but there are no effect sizes reported and a low methodological quality. This means that only one study (Bernard et al., 2012) supports the outcome of positive impact on attachment style.

Dozier et al (2006) measured behaviour but found no significant difference. Lind et al (2014) measured affect of the child and found a medium effect size for anger and sadness. This indicated that the intervention had a significant impact on affect regulation. Lind et al (2017) measured attention and cognitive flexibility and found a medium effect size for both. Considering that the study had a high methodological quality (CTAM 94), it can be assumed that the findings are of significance.

Table 2 Summary of effect sizes for ABC interventions

Study	Measure	Effect size
1. Dozier et al 2006	Cortisol levels	Morning cortisol d = 0.5 Evening cortisol d = 0.6
2. Dozier et al 2008	Cortisol levels Attachment	None reported
3. Bernard et al 2012	Attachment	Lower rates disorganised attachment d = 0.52 Higher rates of secure attachment d = 0.38
4. Lind et al 2017	Cognitive Functioning	Attention d = 0.4 Flexibility d = 0.4
5. Bernard et al 2015	Cortisol levels	AM cortisol d = 0.48 PM cortisol d = 0.38
6. Lind et al 2014	Affect regulation	Affect Expression d = 0.42 Anger d = 0.40 Anger towards parent d = 0.43 Anger and Sadness d = 0.44

Circle of Security

The search identified one study that focused on the CoS intervention (Cassidy et al., 2017). Comparing the treatment and control group, no effects were found on the child's attachment, behaviour problems or cognitive flexibility. Additionally the study was below methodological quality (CTAM 64).

Child-Parent Psychotherapy

Table 3 provides an outline of the effect sizes of the psychotherapy studies. There was some discrepancy in treatment descriptions. CPP were based on different models, with Cicchetti et al (2006) and Stronach et al (2013) using a model derived from Fraiberg et al (1975) and Fonagy et al. (2016) using a manualised program from Baradon et al (2005). This is worth noting as it may impact how the CPP intervention is facilitated and therefore provide some discrepancies in treatment. Additionally, Lieberman et al (2005) and Ippen et al (2011) based the intervention on Lieberman (2004) and outlined that the CPP intervention lasted around 50 weekly sessions. A large discrepancy might mean that the intervention is more difficult to classify due to variations.

Two of the studies that had a high methodological quality rating focused on measuring the attachment style of the children using the Stranger Situation. Cicchetti et al (2006) found a large effect size (Cohen $d = 1.34$) for changing an attachment style from insecure to secure. However the same effect was found in the PPI control group. The difference was found when comparing CPP to the community and non-maltreated control groups. Stronach et al (2013) found an effect for attachment change for children receiving CPP in comparison to the PPI that ranged from small to medium in effect size ($d = 0.23- 0.34$). No difference was found in regard to behaviour.

Fonagy et al (2016) applied a range of measures to record the parenting style. They found a small effect size in relation to the mother's warmth and invasion and medium effect size in regard to parental stress and depressive symptoms. No significant improvements were found for child development and parent-child interaction in the PIP group. The result of this high methodological quality paper indicates that the main changes occur with the parent rather in the child's presentation.

Lieberman et al (2005), measured trauma symptoms of both the child and parent and behaviour. Children in the CPP group decreased in behavioural difficulties, with a small effect size ($d = 0.2$). There was a large effect size on a reduction on trauma symptoms at the time of recording ($d = 0.63$) and medium effect size for future symptoms ($d = 0.57$). The study also measured the trauma symptoms of the parent and found a significant reduction of avoidance symptoms, with a medium effect size at recording ($d = 0.50$) and large ($d = 0.68$) on future symptoms. The follow up RCT Ippen et al (2011), showed similar effect with a reduction in PTSD and co-occurring diagnosis in the CPP group with a large effect size for the children ($d = 1.0$) and mothers ($d = 0.9$). A medium effect was found for behavioural problems. Both these papers had low methodological quality rating (46 and 53 CTAM). Though large effects sizes were found, it has to be considered that they quality of the papers were below cut off point.

Table 3 Summary of effect sizes for Psychotherapy interventions

Study	Measure	Effect size
8. Cicchetti et al 2006	Attachment	Insecure to secure attachment style d= 1.34
9. Stronach et al 2013	Attachment	Lower disorganised attachment d= 0.23 Secure attachment d = 0.33 Lower disorganised d = 0.34
10. Fonagy et al 2016	Parent infant interaction	CES-D d = 0.6
	Maternal reflection	Parental Stress d = 0.4 Mothers Relation Warmth d = 0.3 Invasion d = 0.3
11. Lieberman et al 2005	Trauma Symptoms	Child's trauma symptoms d = 0.63
	Child Behaviour	Child's trauma symptoms over time d = 0.57 Child Behaviour d = 0.24 Maternal trauma symptoms Avoidance d = 0.50 Maternal trauma symptoms effect over time d = 0.68
12. Ippen et al 2011	Trauma Symptoms	PTSD, depression and co-occurring diagnoses d = 1.0
	Child Behaviour	Behaviour Problems d = 0.5 Mothers depression and PTSD d = 0.9

Video Interactive Guidance (VIPP)

Table 4 provides an outline of the effect sizes from the four studies on VIPP. All studies focused on gathering outcomes on parental functioning through self-report measures and observations. All but one study (Negrão et al., 2014) had high methodological quality rating on the CTAM. Pereira et al (2014) measured parental stress and found that VIPP was effective for a decrease in comparison to the control group with a small effect size ($d = 0.3$). This was only found under of perceived stress levels by the parent.

Negrão et al (2014) looked at interactive style between the mother and child and found a small to medium effect ($d = 0.3 - 0.5$) on maternal non-intrusiveness, child responsiveness, and involvement. Effect on maternal sensitivity, structuring, and non-hostility failed to reach significance. However, with a CTAM score of 53 there is a reduction in the quality of the finding.

Casonato et al (2017) found a small effect ($d = 0.1$) on laxness and large on inflexibility ($d = 0.7$) with a decline in the intervention group, however no effect was found to maternal sensitivity, physical interference and supportive presence. Steele et al (2019) provided the intervention three times weekly over 26 weeks and found that there was a small effect size change on the hostility displayed by mothers in the treatment group. A medium effect ($\eta^2 = 0.12 - 0.16$) was found for maternal supportive presence and dyadic reciprocity. It is worth noting that the intervention (GABI) had significant more treatment contact with compared to the control group (STEP), which consisted of 10-12 weekly sessions. Though the study has a high methodological quality rating (CTAM 97), the contact time was not controlled for and may have impacted outcomes.

Table 4 Summary of effect sizes for VIPP interventions

Study	Measure	Effect size
13. Pereira et al 2014	Maternal Behaviour	Parenting stress d = 0.3
14. Negrão et al 2014	Maternal Behaviour	EAS Positive Parenting d = 0.3 EAS Positive Child Behaviour d = 0.5 FES Relational d = 0.4
15. Casonato et al 2017	Maternal Behaviour	Inflexibility d = 0.7 Laxness d = 0.1
16. Steele et al 2019	Maternal Behaviour	Maternal supportive presence Partial n² = 0.12 Maternal hostility Partial n² = .05 Dyadic reciprocity Partial n² = .16

DISCUSSION

This review used a narrative synthesis to investigate RCT's for children under five who have experienced numerous adversities. The interventions were guided by the recommendations of the Matrix (2015) for children at risk of attachment disruption. Overall sixteen studies were identified for the review. The interventions consisted of six studies on Attachment and Bio-Behavioural Catch up (ABC), five on Child-Parent Psychotherapy (CPP) and four on Video Interactive Guidance (VIPP) and one study for Circle of Security (CoS). No interventions were found for CBT. Overall the RCT's measured varying outcomes and presented different treatment effect.

The main findings

Some studies (Dozier et al., 2006; Dozier et al., 2008; Bernard et al., 2015) focused on the outcome of cortisol regulation in children. Research indicates that children who have experienced adversities are more prone to neuroendocrine dysregulation (Dozier et al., 2002), impacting cortisol secretion. This can influence the development of the brain's stress-response system in young children, impacting the long-term effect of stress regulation (Fisher et al., 2006). The studies that explored this all consisted of the ABC intervention and found a medium to large effect size, indicating that the intervention is effective in supporting children's mental wellbeing.

The attachment of the child was assessed by three of the studies (Cicchetti et al., 2006; Stronach et al., 2013; Cassidy et al., 2017) using the Stranger Situation, a validated and reliable measure to assess young children's attachment style (Ainsworth et al., 1978). It illicit an attachment response by placing a child in a controlled stress-inducing environment, which involves separation and reunion to a care provider. The impact of the intervention on the attachment style is of importance, as the research question is exploring interventions that support the disruption in attachment. The studies using a Psychotherapy approach found a small to large effect size, however the large effect size was only found when comparing the intervention group to the community and non-maltreated group (Cicchetti et al., 2006). The study on CoS found no significant difference between the groups. The review by Barlow et al (2016) identified a number of intervention approaches that impacted attachment such as VIDD. However, it was not highlighted if the Stranger Situation was used as a measure. It would be of interest to explore if other interventions would present with similar outcomes using the same assessment measure.

Cognitive delays have been found to be prevalent in children who have had numerous care placements (Klee et al., 1997) and are important when supporting young maltreated children (Dicker et al., 2004). Lind et al (2017) explored attention and flexibility following completion of the ABC intervention and found that it enhanced executive functioning skills. Research also indicates that affect regulation is significantly important for development and Lind et al (2014) found that the ABC intervention had a positive impact on a child's ability to regulate emotions. Both studies have promising outcomes with good effect sizes.

Studies on VIPP and CPP focused mainly on the parent's behaviour (Fonagy et al., 2016; Pereira et al., 2014; Negrão et al., 2014; Casonato et al., 2017; Steele et al., 2019) and trauma symptoms (Lieberman et al., 2005; Ippen et al., 2011). The interventions showed a significant

impact and research indicates that the ability of a parent to engage in reflection increases the likelihood of them being able to respond sensitively to a child's emotional-cues (Zeanah 2009). This attunement has been called '*maternal mind-mindedness*' (Meins et al., 2001) and an absence has been linked to maladaptive parenting behaviour. A promising finding was that trauma symptoms did reduce for both the parent and the child following CPP intervention (Lieberman et al., 2005, Ippen et al., 2011), but the quality rating of the papers was low.

In regard to behavioural difficulties, two studies (Lieberman et al., 2005, Ippen et al., 2011) found a small to medium effect. Both studies were below CTAM cut off score. This is worth considering as another study with a high methodological rating found no effect on behaviour following intervention (Dozier et al., 2006). However, the studies had different interventions that may have impacted outcomes.

The findings of the review are promising as they link in with the recommendations of the Matrix (2015). The rating for VPP, CPP and ABC is a recommended intervention (B), whereas Circle of Security has limited evidence, but expert opinion outlined that it may be helpful (C). This indicates that the findings reflect the recommendations of the Matrix.

Limitations of included studies

The ABC interventions appeared with the most consistent treatment effects ranging from medium to high, when measuring cortisol levels, cognitive domains and affect regulation. This was supported by all but one of studies having a high methodological quality rating. The intervention was constructed for infants and was completed after 10 weekly sessions (Zeanah 2009). All the studies focused on measuring child outcomes, which could be considered a strength.

This review did not find evidence in support of the Circle of Security. It may be that the intervention has been explored using different design and the recent case study (Kim et al., 2018) showed a positive change post intervention.

In regard to the Child- Parent Psychotherapy, a limitation was that there was a difference in the length of time for intervention, with up to 60 months as the treatment period. The studies were based on the same principals, but there were uncertainties around the comparative element of the intervention. At times the control group found a similar treatment effect (Cicchetti et al., 2006) and some of the comparison groups consisted of non-maltreated children. It appeared that there was more flexibility in the approach of the intervention and this may be due to CPP being based on the same principles with the option of facilitating it in

difference constructs (Fraiberg et al., 1975). This is possibly a strength that comes from CPP, however makes it more difficult to compare ‘*like to like*’.

The studies that used VIPP mainly measured parental outcomes through observation and self-report measures. It would be of interest to explore the outcomes of VIPP using child measures. Additionally, there appeared some discrepancy in treatment length, with Steele et al (2019) intervention sessions occurring three times weekly over 26 weeks, in comparison to a total of 6 sessions in Negrão et al (2014) study. This could be seen as a limitation as the intensity of the intervention differs, which leads to a question around ability to compare.

The majority of the studies were mainly with mothers. It would be of interest if future research would increase its inclusion of fathers to compare outcomes.

Implications of review

This review provides an update on the research that was compiled when the Matrix (2015). Searching a broad database in a structured manner, it found six RCT’s that were completed after the publication. This highlights that research is ongoing, and that the interventions recommended are effective in supporting different aspects of the wellbeing of young children at risk.

LIMITATIONS

There are some limitations that should be considered. The CTAM score was used as a rating scale, and though this has excellent validity, other tools such as the Cochrane Collaboration Risk of Bias Tool (2011) could have been used. The included studies presented with some degree of heterogeneity, due to differences in sample sizes, outcome measures and ACE’s. The main researcher conducted the screening of the abstract. This reduced inter-rater reliability of having a second screening by an independent evaluator. A further limitation could be the scope of the review. The review focused on a specific age range and studies that start in infancy but go beyond the inclusion age may have been missed. The interventions searched were limited to the ones recommended by the Matrix, and it is worth considering that other intervention can be effective in supporting the population reviewed. An example of this is the Bucharest Early Intervention project that used child-centred foster parenting (Zeanah, 2009).

CONCLUSIONS

The review found that most interventions recommended by the Matrix (2015), for children who have experienced maltreatment and interruption in attachment, continue to be effective when measuring a range of outcomes. ABC provided the most consistent effect across studies, with VIPP and CPP also showing significant impact. Effect of CoS was not identified. This is in line with the Matrix recommendations. Considering that policies in Scotland highlight the importance of supporting children who have experienced ACE's, it is imperative that ongoing research occurs to further the evidence base.

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CHAPTER TWO: Major Research Project (MRP)

Qualitative investigation into assessment approaches to maltreated pre-school children in care

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Declaration of Conflict of Interest: None

Chapter word count (with references): 9,694 words

Prepared in accordance with manuscript guidelines for the Journal of Child Abuse and Neglect (Appendix 2.1).

PLAIN ENGLISH SUMMARY

TITLE

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BACKGROUND

The early years of a child are important and experiencing maltreatment can have negative consequences. It is therefore important to make the right decision if they can return to their parents after they have experienced maltreatment. A major research project in Glasgow called BeST⁷ (The Best Service Trial) is comparing a social work assessment called Family Assessment and Contacts Service (FACS) with an infant mental health approach facilitated by the Glasgow Infant Mental Health Team (GIFT). This study aims to explore what it is like being part of either assessment.

AIMS AND QUESTIONS

The research project aimed to explore the thoughts and experiences of social workers, assessment teams, foster and biological parents of four families. The following was explored:

1. What were the main concerns about the assessment experience?
2. What were their thoughts about the child welfare system as a whole?

METHODS

The participants consisted of key figures surrounding four families. The families agreed to take part in the trial in 2012 after concerns were raised about parenting practise. After they consented, two families each were randomised to either FACS or GIFT for an assessment. The current study revisited the people surrounding the families in 2018 to hear their thoughts about the assessment after it had completed. Previous interviews that happened at the beginning of their involvement helped create question to ask. Once the interviews were transcript, they were analysed using an approach called Thematic Analysis. This approach helps look for patterns of meaning across the interview. By doing so, themes were identified that were common amongst all those interviewed.

MAIN FINDINGS

The participants described that there were three main concerns for them. One concern was that they felt that it was taking too long for an assessment to be completed. Different reasons were given for why that was, but many reported that there was not enough support for social workers to commit fully to the assessment. Another theme was that effective communication was important. It helped with completing the assessment and making difficulties more manageable. The last theme was that the way the Children's hearing system works made things more difficult. Professionals were not always listened to and information had to be presented like it was a court environment. The participants were concerned that there was not enough focus on the child. Many felt that a change was needed to make the hearing system more effective and that training could help with this.

CONCLUSION

Any concern about the assessment process was always based on how this could impact the child. It appeared that clear and open communication could help in working alongside one another and to make the right decision. Training for the children's hearing system and links with the legal profession could also help in improving the assessment system. All this may improve the overall system and will provide a child with the right long term placement as soon as possible.

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ABSTRACT

Background: Infant mental health is crucial for healthy development. Children who have experienced adversities and are looked after in care need to be supported to form healthy attachment through a permanent placement as soon as possible. A major randomised control trial (RCT) called the Best Service Trial (BeST³) is currently investigating the most effective assessment framework for when children enter care. The assessments are facilitated by a social work service called Family Assessment and Contacts Service (FACS) and a team called the Glasgow Infant Mental Health Team (GIFT).

Aim: The research aims to explore the perspective of those involved in the assessment of cases of child maltreatment and their experiences of the wider child welfare system.

Methods: A case study approach was used to gain an in-depth insight. Thematic Analysis (TA) was used to analyse the transcripts from the key stakeholders surrounding four families, which were assessed by either GIFT or FACS.

Results: Three key themes were identified across the dataset. The importance of the duration of the assessment process, the need for effective communication during this and that the legal structure has a significant influence on the overall experience and outcomes.

Conclusions and implications: The study found that joint working was improved by open communication and that delays in outcomes are rooted in concerns around the child having to wait for a long-term home. It was highlighted that training for the Children's Hearing System could improve the current structure.

Key Words: Infant Mental Health, Best trial, Qualitative research

INTRODUCTION

Infant Mental Health

Infant Mental Health is ‘*a young child’s capacity to experience, regulate, and express emotions, from close and secure relationships, and explore the environment and learn*’ within a framework of a safe care-giving environment (Zero to Three, 2001). It has long been acknowledged that care giving relationships are important to the social, emotional and physical growth of infants (Zeanah, 2009).

Maltreatment can lead to disruptions in the formation of crucial positive attachment to carers (Chinitz et al., 2017). This can impact the infant and lead to mental health difficulties both in the present and future (Sroufe et al., 2005). Research indicates a significant link between early adverse life experiences (ACEs) and a range of difficulties (Felitti et al., 1998; van der Kolk., 2005; Pritchett et al., 2013; Bellis et al., 2014).

Early intervention in infancy can have a significant impact on a child’s chances of recovery from adversities (Fox et al., 2011). Developing healthy attachment to a responsive and warm care provider is therefore crucial, as it increases protective factors (Chinitz et al., 2017).

Assessment in the child welfare system

Children in care are among the most vulnerable in society (Minnis et al., 2001). When a child becomes looked after, prompt and effective decision-making about their placement is important to provide them with a permanent place with a secure base (Pritchett et al., 2013). Research now strongly indicates that achieving a consistent nurturing family placement is essential to their mental wellbeing (Gauthier et al., 2004; Lindhiem & Dozier, 2007).

Two thirds of pre-school children who return home to the care of their parents, after a first episode of being accommodated in Glasgow, will eventually return to child welfare services. This demonstrates that decisions made during the assessment period may be inadequate (Minis et al, 2010). Decisions about a permanent living place have historically not been made in Scotland until around the age of four, which means that potentially of years drifting between numerous care providers (Walker et al., 2005; Pritchett et al., 2013). This can place the mental wellbeing of the child at risk. It is therefore paramount that an effective assessment framework makes decision of whether the child should be reunified with their birth parents as early as possible. One way to achieve this is by a collaborative approach between child welfare services and infant mental health practitioners (Chinitz et al., 2017), acknowledging

the importance of time scales. To support the development of this, a major research trial called the Best Services Trial (BeST²) aims to assess which of two different service models is best at assessing children who come into care in terms of mental health, placement stability and cost-effectiveness.

BeST² Trial

The Best Services Trial (BeST²) is a randomised control trial (RCT) comparing two services to identify the most efficacious way of assessing whether a child should return home after maltreatment. The trial focuses on children between the ages of 0 and 5 years who enter the care system after child protection concerns were highlighted. The Glasgow Infant and Family Team (GIFT) provide one assessment framework with an equivalent team in London (LIFT). The approach is based on the New Orleans intervention model (NIM), which emphasises the importance of infant mental health. It follows a structured attachment-based assessment framework (Walker et al., 2013).

GIFT is a multi-disciplinary team of Clinical Psychologists, Therapists and Social Workers, who tailor a therapeutic intervention for the child and their parent, after assessment. This means that there is an additional treatment component, with the aim of enhancing parental capacities to meet their child's needs. At the end of the intervention the GIFT team provide a recommendation about the child's appropriate permanent placement, based on parental capacity and the child's mental health presentation (Minnis et al. 2015; Turner-Halliday, 2015). The teams were created in partnership with the National Society for the Prevention of Cruelty to Children (NSPCC).

GIFT is being compared to service as usual (SAU) which, in Glasgow, is the enhanced control intervention of the Family Assessment and Contacts Service (FACS) provided by a team of Social Workers employed by Glasgow City Council. The FACS assessment consists of monitored naturalistic episodes of arranged contact between the child and their birth parent(s) and the final recommendation for the permanent placement are based on the assessment of parenting capacity (Minnis et al., 2015).

Scotland is unique in that it has a Children's Hearing System that is integral to the care and justice system for children and young people. The system is governed by the Children's Hearing (Scotland) Act (2011) and a lay tribunal panel makes decisions on outcomes for children in care or at risk (The Scottish Government, 2011). The hearings are attended by the child and those deemed essential in making decision about their long term care. The panel is

therefore an important contributor to the long term outcome of a child that has been taken into care.

To evaluate the outcome of the trial, both quantitative and qualitative research methods are applied. This is to measure which service produced the most effective outcome in terms of infant mental health and achieving a permanent placement. Children's mental health and wellbeing is assessed at three time points, shortly after entry to care, around 15 months later and two and a half years later, regardless of whether they have stayed in care, been adopted or returned to the care of their birth parents.

The Benefit of Qualitative Assessment Methods

With any trial involving complex intervention, a qualitative approach is important to provide explanatory power to the quantitative results. Qualitative research provides information on why a framework may be effective and how it impacts those involved in it. Combining qualitative and quantitative research provides the opportunity to look at data on a micro and macro level (Onwuegbuzie et al 2005). Issues can be explored as they arise, as well as investigating pre-defined topics of interest. This bi-focal lens, gives an overall more holistic view of the phenomena studied.

The Medical Research Council framework on complex interventions states that to evaluate the change process, service users should be included (MRC, 2006). Families are not passive recipients of an intervention (Turner-Halliday et al., 2017) and qualitative research can provide information on the contextual nuances that quantitative research may miss.

AIMS AND OBJECTIVES

The current study aims to explore the experience and perceptions of those involved in the assessment of cases of child maltreatment in Glasgow, Scotland. The research aimed to investigate the following questions:

1. What were the main issues from the perspective of the key stakeholders surrounding four families?
2. What were their experiences of issues related to the assessment system within the wider child welfare system?

METHOD

Design

A case study approach was used to gain an insight into the in-depth experiences from the perspective of the key informants. An exploration occurred of being part of both services and perceived outcomes of the proceedings. Thematic Analysis (TA) was selected as the most suitable analytic method to apply. The rationale for TA is that it focuses on gathering a rich and detailed account of informant's experiences. It allows for themes to be developed from small groups, to look for patterns across the datasets leading to identifying themes and meaning (Braun & Clarke, 2006).

Informants

The informants are key figures surrounding four families who took part in the BeST² trial in 2012. Two of the families had been randomised to FACS and two to GIFT. During the family's assessment/intervention with either service, they consented to the research team following them as a case study. The perspective of the key participants was gathered via research interviews involving birth parents, the allocated social worker, foster parents and GIFT/FACS team members. This meant that a total of sixteen data sets from interviews were gathered. Previously gathered data were used to formulate an interview topic guide (Appendix 2.3) for follow-up interviews.

Contact was then made with the previous case study participants to arrange follow-up interviews. The aim was to gain insight into the process that now had been completed. A key difference between the periods of data collection is that, by this second round of data gathering, there had been placement recommendations made about the children. Table 1 provides an outline of the decisions made. The case studies had been originally selected, with the advice of the GIFT and FACS teams, on the basis that there were likely to be varied outcomes.

Table 1 An outline of the decisions that were made for the four families

	LAAC	Foster placement	Permanence Meetings	Recommendation from FACS/GIFT	Outcome	Supervision order
FACS Case 1	Section 25 20.12.2012	One placement	19.09.2013 03.12.2013	Outcome to return to parental care	Return to Parental care 12.01.2014	Terminated on 11.12.2014
FACS Case 2	Section 25 11.12.2012	Three placements	02.11.2017	Outcome to stay in care	Permanent Foster care	Ongoing
GIFT Case 3	LAAC 26.03.2013 Compulsory supervision order 22.04.2013	One placement	29.11.2013	Outcome to stay in care	Permanent Foster care	Ongoing
GIFT Case 4	Section 25 04.03.2013	One placement	28.08.2014	Adoption Granted 03.06.2016	Adopted	Terminated Date unknown

Acronyms: **LAAC:** Looked after and accommodated; **Section 25:** Voluntary accommodation

A total of 13 follow-up interviews were conducted between January and April 2019, as not all 16 participant groups were available. In some instances, the social worker or the foster parent allocated to the child in the assessment period were no longer available. When it was not possible to reach them, the current social worker or foster family were interviewed instead. The birth parents of two of the cases were not reachable. One birth mum did not wish to engage but consented to being contacted in the future while one mother took part in an interview. Table 2 provides an outline profile of the informants who agreed to part take in the follow up interviews.

There was greater success in contacting other key stakeholders and the number of participants was suitable for the methodology: Braun & Clarke (2006) recommend that for a thematic analysis around 6 to 10 interviews should occur. A sample of that size allows for sufficient data to provide a rich account of the experiences within a heterogenous group (Guest et al., 2006).

Table 2 Outline of 2018 interviewees

Case	Social Worker (SW)	Assessment Team	Parent	Foster Parent
1. FACS	Same SW that supported assessment process	Same two assessors that conducted assessment process	Did not wish to engage	Same foster parent who supported assessment process
2. FACS	Current SW. Previous SW had left team and uncontactable.	Same assessor that conducted assessment process	Engaged in interview	Current foster parent. Unable to reach previous foster carer.
3. GIFT	Current SW. Previous SW had left team and uncontactable	Same assessor that conducted assessment process	Unable to reach birth parents	Did not wish to engage
4. GIFT	SW team lead that supported assessment process	Same two assessors that conducted assessment process	Unable to reach birth parents Adoptive parents engaged in interview	Same foster parent who supported assessment process

Interview Procedures

The follow-up interviews were conducted by the principal researcher in the participant's place of work or their home. When interviewing birth parents, a researcher associated with the trial accompanied the principal research to adhere to NHS Greater Glasgow & Clyde lone working policy.

The participant's consent to take part was reviewed and information provided, with the opportunity to ask questions and clarify the aims of participation. The interview adopted a semi-structured approach with open-ended questions based on a topic guide (Appendix 2.3) This allowed for flexibility to gain insight into an area of interest whilst providing opportunity for the informants detailed account of their views and experiences (Willig, 2013). The interviews lasted between 25 minutes to 105 minutes and were audio recorded. An administrator associated with the trial transcribed the recordings verbatim.

Data Analysis

The analysis of the 2014 transcripts used an inductive approach, meaning that the coding and development of themes are guided by the content of the data. The lead researcher completed this. The transcripts from the 2018 interviews were analysed using a theoretical TA approach focusing on analysing aspects of the data that relate to the research question of the study (Patton 1990; Braun & Clarke, 2006). By gathering information at multiple points in time a process of triangulation occurred. This is to provide a ‘richer’ insight into the participant’s experiences. Any consistencies across the two data sources could indicate reliability. The aim of using triangulation is not necessarily to provide reliability, but to increase the overall level of understanding of informant’s experiences, which is reflected in the aim of this study (Barbour, 2001). All aspects of the analysis of the data followed the phase-based approach of thematic analysis as outlined in Table 3. A second rater (F.TH.) completed coding for two transcripts to identify any potential biases in the coding of the primary researcher. No need for significant change was highlighted. The thematic map was created by connecting and identifying overlapping main themes.

Table 3 Phases of thematic analysis (Braun and Clarke, 2006)



Reflexivity

The notion of complete neutral objectiveness when analysing a text has been disputed by a number of authors (Gough 2017). Simply assuming that themes arise from the text does not consider the impact the researcher has on the interpretation process and how decision are

impacted by the mind's eye (Braun and Clarke, 2006). It is important to be mindful of one's own values, theoretical stance and professional and disciplinary practise (Wilkinson 1988). Keeping a research journal can support greater reflexivity, alongside reflective discussions (Gough 2017); these techniques were applied by the researcher with the support of the supervision team.

Ethical Considerations

BeST⁷ had been approved by Glasgow University and NHS research ethics committees (Appendix 2.4). The researcher was added to the research staff and granted approval to contact the key informants (Appendix 2.5). A pre-approved information and consent sheet was provided to informants who had not previously been interviewed (Appendix 2.6). Identifying details were removed from the transcripts to prevent identification and data was stored securely to protect confidentiality.

RESULTS

Themes

Key themes were identified across the dataset. They are presented as separate categories, but there is some inter-relatedness. For the purpose of reporting they have been categorised into superordinate themes with subordinate components (Figure 1). The aim is to provide an analytical narrative, illustrated by extracts from the transcripts. The extracts are *ad verbatim* and (...) indicates that some text has been removed.

1. The first superordinate theme: *Impact of Time*.

The duration of the process was a key theme. Multifaceted reasons were given for what was influencing this and how it was perceived.

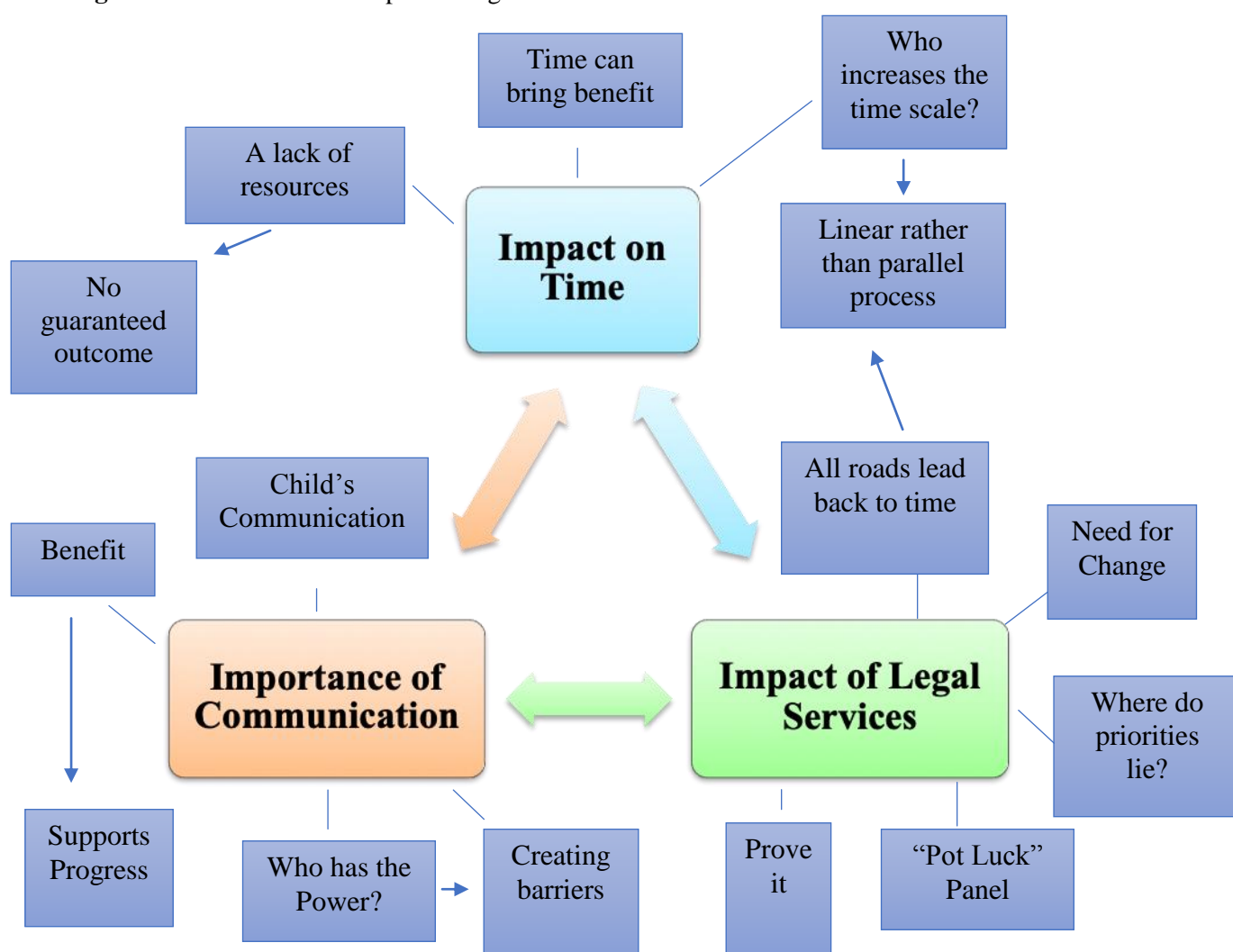
2. The second superordinate theme: *Importance of Communication*

This theme reflects that communication is seen as pivotal. Informants provided information on how this could impact their experience of joint working.

3. The third superordinate theme: *Impact of legal services*

The legal system is seen as an intrinsic part of the proceedings. Concerns were raised on how the legal structure impacts the assessment process and the need for change.

Figure 1 Thematic Map outlining themes that were identified



Impact of Time

I mean the frustration comes from the length of time that everyone takes to be honest more than the process itself.

GIFT, Case 4: Social worker

This extract summarises a theme that was interpreted across the 2018 data sets. The majority of informants shared a feeling that the general assessment process was significantly impacted by the time it took to complete. Informants were concerned about the impact this could have on the wellbeing of the children.

A lack of resources

There was a sense that a lack of resources for social work services was significantly impacting the procedure. This theme was present both *within* social work and *out-with*, in partner agencies GIFT and FACS:

It is really hard to manage one-on-ones and all the rest and supervising the contacts whilst still managing your existing caseload which at times is usually about 25-30 cases so it can be very difficult, but that's probably one area I would like to be more involved in.

FACS, Case 1: Social worker

There are so many pressures for social workers in Glasgow just now, really I've never seen social workers on their knees the way they are now, just with the resource context.

GIFT, Case 4: GIFT clinician

I think practice differs across the city and we see that quite visibly...I think some areas are better than others in dealing with risk and need, and permanence, and progressing that and giving the priority that it needs. Resources are a huge strain, area teams are under-staffed in terms of qualified workers so that frustrates me a lot.

FACS, Case 2: FACS social worker

Due to the children's social workers not having the time to engage in the assessment tasks a domino effect occurred that impacted other agencies. There was a sense of frustration on how this influenced their ability to support families. When a social worker would go 'over and above' it was noticed. In the following extract, the clinician reported a sense of gratefulness and reflected on how the social worker may have made personal sacrifices to be able to meet the needs of the family in an under-resourced environment:

I bumped into her ... I think I inappropriately hugged her when I was saying 'hi' to her just because I had such fond memories of working with her, honestly she was just a dream to work with, she really was...we know that every social worker goes into this because they want to be able to work like that and I would be curious to know how she managed it actually because I am pretty sure she was working weekends.

GIFT, Case 4: GIFT clinician

There was a sense of a lack of control in regard to available resources. This meant that regardless of preferred practice, child protection concerns would take priority. The social worker that was praised for her ability to work so effectively with GIFT maybe took ‘*control back*’ by allocating her own time. There was a recognition that all social workers were setting out to adhere to best practise, but that the environment simply did not have enough resources to allow them to always fulfil this. An informant spoke about this in regard to protected reflective space:

...Workers not having that protected space within the area team setting, whereby child protection will always take priority understandably ... having more social workers as well, you know, the child protection work can be done and the tricky work of permanence.

GIFT, Case 4: GIFT clinician

This lack of resource in the child assessment services was influenced by the wider societal structures around it. A social worker reflected on how society did not provide enough to meet, or even cover, support for the families within the child welfare system:

It is the same names we are seeing again ... then when they are in care we have delays because there is not enough workers, there is not enough services, there is not enough reporters that we can get grounds established quicker, we can't get FACS or GIFT assessment started quicker, we are dealing with high numbers of cases.

FACS, Case 1: Social worker

Consequently, the assessment is halted and becomes a linear rather than a parallel process where agencies work along-side one another. The following extract summarises this well and outlines that the ones that will lose out are the children:

..that should be happening concurrently, but again because of many complexities including the things we have talked about already, like the lack of staff, workers just being run off their feet with other child protection things, they are not having the opportunity to progress those things which means then that it happens ...one after each other, which creates huge...much bigger delays for children

GIFT, Case 3: GIFT clinician

A social worker expressed her frustration about this, stating a sense of powerlessness in not being able to manage aspects out-with her control:

... Even if you follow all your processes to the letter it doesn't mean that you are going to get the best outcomes, which is really frustrating.

FACS, Case 2: Social worker

When a sense of powerlessness occurs, it can be a natural response to try and find reason for this occurring in the first place.

Who increases the time scale?

Informants would look for a culprit to blame for longer timescales. The 'newest' assessment facilitated by GIFT was mentioned as influencing the time it took for recommendations to be made. When systems are under stress, which was apparent in the reflections on lack of resources, change can be an added stressor. This can particularly occur if it is not understood why something works the way it does. A foster parent reflected on how the FACS made intrinsically 'more sense' to her, whereas GIFT appeared to provide something additional, but with an uncertainty about what this meant. She described her wonderment about this:

In a way FACS is nicer for the child if the assessment can be done quickly and decisions made whichever way, but then if the GIFT assessment is more, I don't know, in-depth or more conclusive, I don't know.

FACS, Case 1: Foster parent

Other times it appeared that there were questions around the necessity of the intervention:

I think specifically with GIFT probably the timescale is what's difficult and what we work to is that kind of six month, first permanence review, and then at that stage we can absolutely say there is no work needing to be done, but along with the actual assessment process taking a much longer time there is also waiting lists ...

GIFT, Case 4: Social worker

What was of interest is that a member of the GIFT team reflected that blame had been placed on them. This indicates that this had somehow been communicated to the team as this example illustrates:

When she (Social Worker) compared what was happening with her other cases in her case load her sense that it wasn't fair that the particularly family who were attending GIFT and had been attending GIFT and doing well for almost a year there was the

sense of 'they have done well enough now' so just send the children home, and 'why are you holding the things up' ...

GIFT, Case 3: GIFT clinician

This is of interest as it may reflect that since GIFT is the relative 'new kid on the block' it is easier to try and explain delays as being down to their input, rather than other aspects. The added treatment component in GIFT does mean it can take longer for decisions to be made with the offset of accuracy in regard to outcomes.

Time can bring benefit

Though time was a commonly shared concern, it appeared that there were occasions where it was more acceptable, as described by an adoptive mother:

We felt that although it took longer, if it hadn't of taken this long we wouldn't have had ... (Daughter)... so we kind of feel that everything happened for a reason and to tell you the truth I think it was the longest pregnancy ever.

GIFT, Case 4: Parent

This was also reflected by a senior social worker who outlined that to achieve the right outcome, sometimes time is needed:

You need to get these decisions right, you know you are talking about a child being adopted, so if there is scope for them to be returned to their parents' care that's what we would want to do...I have absolutely no objection if this takes a bit longer, but we get the decision right, that's fine.

GIFT, Case 4: Social worker

This reflected a sense that when the best care for the child was achieved, it brought a different sense of understanding to the situation. One aspect that appeared to help the process was the role of effective communication.

Importance of Communication

The importance of communication was another theme. An open and non-judgemental approach to discussing difficulties was both valued and seen to aid the procedure. In some instances it was essential in moving things forward when the process of decision-making had stalled. It was of interest that there appeared to be a link between frequent communication and a sense of being alongside one another. When effective communication occurred, it was a

reminder that there was a shared hope of wanting the best outcome for the child. A foster parent reflected on this:

I think we were all very communicative, my worker, ... (child) worker, the GIFT team, we were all on the same page anyway... the information was shared really readily ... we were all working towards the same goal for her.

GIFT, Case 4: Foster parent

The same was felt by a GIFT clinician who reflected on how communication helped the process and how it could be a massive hindrance when absent:

The absolute difference that makes to running a case here at GIFT is unbelievable, you know it is like we are going with a hand tied behind your back and someone tripping you ...if you don't have a social work team working in like the clear communication flow in both directions...

GIFT, Case 3: GIFT clinician

Effective communication provided a reflective space where practical aspects were discussed, such as roles and responsibilities, but also emotional experiences. A foster mum described the power of communication after being contacted by the parent of a child who she had looked after:

...He just wanted to drop a note to say 'thank you very much for all that I had done for ...(child) and she would've been in a much worse position had it not been for what we had done' which was lovely ... it was absolutely fantastic to hear from them.

GIFT, Case 4: Foster parent

Having difficult conversations helped create a shared understanding of expectations for everyone involved. An adoptive parent recalled how communication helped them deal with a misunderstanding with their social worker, which had been emotionally challenging for them:

We sat down at a table and her line manager came along and said 'how do we move on from here?' and it was a very positive meeting... there was a breakdown in communication and then it got sorted.

GIFT, Case 4: Parent

Communication therefore seemed essential in impacting all nuances of the process. It assisted moving things towards the preferred outcome and dealt with the emotional experiences. It is of interest that the theme of communication ties in well with the other theme of time. It appeared that when effective communication was a major part that it was more acceptable that the assessment took the time it took.

Child's Communication

Communication was important for the adults within the structure, but also with the children. Though it was expected that communication would happen with the child, it was not always considered. This appeared to be either through a lack of resources or insight into the importance of it. A GIFT clinician reflected on how the child's needs are met by doing so effectively:

... You have to tell them when you are taking them from their parents to live with somebody else, you have to talk to them, you have to talk to them if they are going to respite, you have to talk to them about what contact is, why they are going, how it might have felt, and I think that's understood for older children and I think things like life-story work happens retrospectively, but actually you wouldn't need to have to do all this big huge life story work if the child was just being told at the time.

GIFT, Case 4: GIFT clinician

A similar reflection occurred with a foster parent who pondered on whether the children were listened to at all. The following extract captures her wonderment about the absence of communication:

I don't think the girls' voices are listened to enough ... it just feels as though are they listened to? What weight is given to it?

FACS, Case 2: Foster parent

Who has the Power?

Lack of communication consequently created a sense of powerlessness. When the key individuals, including the children, felt that they were no longer listened to, they experienced a significant impact. People started to see each other more as external rather than working towards a shared goal. A social worker reflected on how she felt her input was not being acknowledged by the other agencies, due to lack of communication:

We are really, really throwing everything we've got at families to try and keep the child with them, so by the time they are accommodated....there is huge amount of assessment already done before the child is even accommodated... I think there needs to be more trust in that assessment.

FACS, Case 2: Social worker

The sense of powerlessness was apparent with one foster parent who felt that communication often was 'at' her and the children:

The social workers are the ones who have the power and they can come at any time and whatever they want to be saying to you or deciding you are at their behest... to a certain extent as a carer you are vulnerable to the social work department as well and the power of that institution.

FACS, Case 2: Foster parent

Creating barriers

A lack of open communication appeared to create a sense of making the process emotionally more challenging. When informants recalled breakdown in communication, it often was described in emotional terms. An adoptive parent acknowledged how it created frustration for all involved:

I think what happened then was a bit of a breakdown in communication ...we thought we were now just waiting to be matched, so we didn't really anticipate that we had to build a relationship with this new social worker and I think we'd started off on the wrong foot ... a little bit of a breakdown in communication and a bit of frustration on both sides

GIFT, Case 4: Parent

A sense of loss was described by one of the foster parents who reflected on how a break in communication amplified a difficult experience:

... An acknowledgement would have been nice or a note to say 'this is the stage that we are at now' because she had been with us for such a long time, she was family.

GIFT, Case 4: Foster parent

Communication was therefore interpreted to be of great significance for progress to occur and in aiding individuals in dealing with complex emotional experiences. As with the theme of time, difficulties appeared to be easier to deal with if there was a shared understanding of the process.

Impact of Legal Services

I think the major changes I would like to see are definitely in the children's hearing system. I don't think the current system is very good for the under 5s.

FACS, Case 1: FACS social worker

The final theme, but by no means of less significance, is the impact the legal structure had on the assessment process. This theme appears to bring out a multi-layered array of opinions and impacted both practical aspects and was emotionally challenging. There was a sense that it could be a difficult experience rather than aiding progress. A foster mum described a sense that it was something that had to be tolerated by her and the children:

...The hearing system tries to be child friendly, but there is nothing child friendly about a children's hearing...but they don't happen that often, so just sort of tolerate it really.

FACS, Case 1: Foster parent

Prove it

It was felt that there was a need to prove the outcome of the assessment and information provided by childcare professionals was not taken at face value. This led to a number of difficulties, as it became a legal debating forum rather than a space where the complex presentation of the child and their families were considered. As a consequence, the space would not allow for great reflection to occur as more proof was often asked for. A social worker reflected on her experience:

...Does a GIFT or a FACS assessment not hold enough weighting legally at a children's hearing for them to trust that and say 'well I trust that this expert individual has made an assessment over a length of time, with all the information that they have got and their direct observations of people and their children...' but that

doesn't seem to be substantial enough for the legal system, they want more evidence, and more evidence and more evidence..

FACS, Case 2: Social worker

There was an expectation that a legal argument should be put across, rather than a knowledgeable discussion on child welfare outcomes. Extracts from both a FACS and a GIFT practitioner reflect this:

The main problems I think, well we have is with the children's hearing system ... they don't always pay an awful lot of attention to what we write in reports

FACS, Case 1: FACS social worker

... It is not even just you come and you speak to your experience, it has to be a legal argument whether you are a foster carer or whether you are a teacher, social worker ...that's not what it was designed to be.

GIFT, Case 4: GIFT clinician

The informants reported that this was perhaps influenced by how the legal system was structured and the involvement of solicitors in the proceedings.

Where do priorities lie?

I think we all kind of feel that children's hearings are really not about children a lot of the time, they are about the adults in this case, and that's what frustrates us more than anything, it certainly frustrates me.

FACS, Case 1: FACS social worker

The transcripts convey a sense that the focus had been shifted to considering the needs of the birth parents more. This was enhanced by the presence of solicitors and their ability to argue the case in legal terms:

As soon as solicitors start quoting sections of the law panel members will just like ...oh what do we do?

GIFT, Case 4: GIFT clinician

A FACS practitioner reflected on how the input of solicitors' advice impacted parent's abilities and motivation towards engaging in the assessment:

... Solicitors who give their clients bad advice...not to do assessments, not to work with us, not to withhold information, that all impacts on the child. We are asking parents to prioritise their children's needs and they are getting advice that contradicts that, they are getting legal advice, the legal advice is the best thing for them, but it is not for the child. So that's frustrating.

FACS, Case 2: FACS social worker

This created a concern that the child would ultimately lose out with the shift of attention focusing away from them. A sense of frustration from social workers and the assessment teams was felt. A social worker outlined that the panel is set up for the child and therefore their needs need to be paramount:

You get panels saying to you like parental rights, but I always say well what about the child's rights, their rights supersede the parent's rights, you know they are the priority, this is their hearing.

GIFT, Case 3: Social worker

A subtheme was that the experience of the hearing system was dependent on who was on the panel. A GIFT social worker recalled how a panel, who felt pressure from the parent's solicitor, made a decision in the hearing that would have a negative impact on the child. A reflection was that the outcome of this difficult decision is dependent on who was on the panel:

When we left the panel members apologised to us when we were leaving saying 'we are really sorry we had to make that decision because we know if we didn't it would have been appealed' ... that deeply concerns me that the threat of appeal is overriding the needs and welfare of the child in terms of people's decision making and yeah that's a really worrying...and that's not the same for every panel, you know there is so much variability within that.

GIFT, Case 4: GIFT social worker

“Pot Luck” Panel

There was a sense that the experience of the hearing was dependent on who was sitting on the panel on that day, creating a sense of unpredictability. It all came down to luck rather than planning:

It is kind of your luck really on the day about who might be sitting on the panel and what level of understanding...another time you go in and your heart sinks because you just know, you just need to get one person and you can just tell by their tone voice and their attitude and you think ...you know before you even start that it is not going to go well.

FACS, Case 1: FACS social worker

The variation in decision making appeared to be linked to the panel member's own experiences and backgrounds. A GIFT Psychologist reflected on how a panel member handled a complex situation and how professional background could influence this:

... Some reporters are social workers, prior to becoming reporters. I am not a betting woman, but I would imagine if that reporter had been a social worker prior to being a reporter she wouldn't have allowed that to have happened, but this particular reporter had a legal background, so even to that level all your training will influence your decision making, you are a human being... we will all have unconscious bias, won't we?

GIFT, Case 4: GIFT Psychologist

Panel members were not only influenced by professional background, but also their emotional experiences. A FACS worker reflected on how panel members may relate a difficult decision to their own circumstances and feelings of empathy towards the birth family:

There are some really good panel members, but there is a lot that it does evoke that really emotional response, they are maybe relating it to their own circumstances

FACS, Case 1: FACS social worker

The complex nature of a hearing system appeared to be significantly influenced by three factors: vocational background, ability to reflect and training in infant mental health. A lack of training was a theme that was present across several of the key informant's accounts:

I think the panel system has its place and I totally agree with the ethos behind it, but I don't think it is equipped to make the decisions for the cases that we are asking them to make decisions about.

FACS, Case 2: FACS social worker

Panel members ...they are not trained, they are giving some advice and some information but they are not really trained to deal with these difficult situations.

FACS, Case 1: FACS social worker

Professionals expressed that change was essential and that the current set up of competing demands did not met the need.

Need for change

A social worker (GIFT) summed up the complexities well when discussing the multiple demands on panel members:

It is so ridiculously multi-layered that lay people are trying to manage and cope with the complexity of the law and deal with solicitors' view points on the law and interpretations of the law while manage the needs of the child ... It is probably an impossible task for anybody.

GIFT, Case 4: GIFT social worker

Informants reflected on alterations to the current system to support this. A suggestion was that there should be a greater consistency in who facilitates the hearing and a specialist team for permanent placements:

I think it would be nicer if people were following cases... got the same panel ... whereas we've been to cases where it has maybe been to a panel maybe 6, 7 times, it is a different panel every time and they are contradicting each other's decisions.

FACS, Case 1: FACS social worker

... I think there should be more training for panel members and maybe the panels are specifically around permanence and could maybe go to a specialist team, rather than

picking three people at random who don't have any qualifications or a real lack of understanding about child development, and about an adult attachment perspective ...

FACS, Case 2: FACS social worker

A shared ethos was outlined as beneficial as well. A member of FACS discussed how child protection is always paramount in most services surrounding the child, but that this may not be shared within the legal profession:

It would be better if there were maybe closer links with legal representatives and they were all maybe joining training or something to say that actually 'yes you need to represent and advocate for the parent, but actually when you see it is harmful don't ...you know to a child there must be something to say 'where do we draw the line?'

FACS, Case 2: FACS social worker

This would allow for the focus to be centred on the child, whilst also acknowledging the needs of the birth parents. The need to recognise the complex nature of children's internal world is another aspect that was outlined to be important. This would ensure that attention would remain on the child:

For everyone involved around the child so whether it is birth parents and their lawyers, the children's hearing system, social workers and team leaders, and all of the other organisations that are on the periphery to have as much education and training about children ... understanding more about attachment, and trauma, and the children's developmental needs, would mean that there is maybe better hope for children that should be maybe kept at the centre of all of the decision making processes.

GIFT, Case 3: GIFT Psychologist

All roads lead back to time

The importance of change to the current system links to the familiar theme of time and the need to avoid drift. The delay caused by the legal structures appeared to impact both the beginning:

...It was 18 months it took for the grounds to be established at the sheriff court ...it is a whole period of time where that could have been done much quicker and in that period of time because there was no assessment the area team were saying 'well we are not attempting rehab, we don't know enough... '.

FACS, Case 2: FACS social worker

and once the assessment is completed:

With some cases you can wait, we could wait 4,5 months for a permanence review, which is not ideal...we would want one within, I would say 6 weeks max really after we're finished, but we don't have any control over that bit.

FACS, Case 1: FACS social worker

This could have an impact on the support that a family could receive to prevent further maltreatment. The informants reflected how it could impact the recommendations of the assessment:

... I think the standard at the moment is now years down the line before things are progressed and therefore our assessment becomes less helpful in the system or less used, so that's a big issues in terms of processing how things are managed and responded to....

GIFT, Case 4: GIFT clinician

The following extract outlines well how the assessment procedure is not ideal for any of the parties involved, but how care and mindfulness, open communication and clear outcomes could minimise drift and make the whole experience more acceptable:

...The hearing ...like it is still sad, but it doesn't have to be horribly confusing and giving you a sense of yourself as someone that things just happen to ... it could be something that was still very sad but at least made sense and was respectful ... it is not ideal for any child having to come into care, but it doesn't have to be as damaging as it is.

GIFT, Case 4: GIFT clinician

DISCUSSION

The aim was to gain an insight into the perspectives of stakeholders from FACS/GIFT and the assessment system as a whole. A major theme was that the time taken for outcomes to be reached was perceived to be too lengthy. This is interesting as the trial set out to minimise delay in decision-making, whilst providing best service (Minnis et al., 2015). It is not known yet how long it takes to produce the best outcome and the completion of the trial will provide insight into this. Numerous reasons were highlighted as an influence on time taken, with informants highlighting different aspects, but it appeared that the complexities of the wider system played a major part. Informants reflected that all parts of the child assessment system are interlinked, creating a dependence on other services for outcomes to be reached. It was highlighted that society did not place enough importance on resources for social work services, thus putting it under significant strain. This consequently caused frustration at the obstruction it caused in providing best care for the child. Some participants also reported that it felt acceptable that the assessment proceedings took longer. This was when it was felt that longer time periods contributed to better decision making for the child at the centre.

A theme that appeared in the response provided by several informants was that effective communication was highlighted as important in aiding joint working. Hudson et al (1999) outlined the importance of a shared sense of purpose through communication. This is of interest as research has indicated that conflicting opinions in the children's assessment systems can cause drift (Johnson et al., 1995) and therefore impact the assessment procedure. For outcomes to be reached, collaborative working is essential especially when dealing with complex situations (Hudson et al., 1999). This was reflected in participants' accounts, where they frequently reported that communication was essential in making difficulties more manageable. Open communication brought people together, working collaboratively towards a shared outcome. When absent, it was often felt that things were '*done to*' someone.

Where there was less communication, it appeared easier to point the '*finger of blame*'. Turner-Halliday et al (2017) reported that social workers felt that GIFT appeared '*external*'. It was seen to cause drift due to the treatment phase. The participants' accounts of the current research reported similar experiences. GIFT was originally developed in New Orleans, USA, and this change of environment may be influencing how the framework is perceived. Incorporating an infant mental health model in a social work setting may contribute to a sense of uncertainty (Turner-Halliday et al., 2017). Change, even if it is occurring with the aim of bettering outcomes, can be difficult to embrace.

There was a sense that the panel system was not providing the intended service and that child care professionals were not having their opinions valued. Informants reported focus shifting away from the children and the frustration this caused. A reason given for this was the increased presence of law representatives. This theme had previously been highlighted (Tuner-Halliday et al. 2017). The presence of lawyers has significantly increased over recent years in the children's hearing system (Porter et al., 2016). This focused attention on the legal aspect, rather than the child welfare knowledge, creating a court like environment. A lawyer's ability to confidently put forward their professional expertise of the law appears to sway the decision making of panel members. This may be due to them not feeling as confident on the law (Greiner et al., 2016). Informants reported that solicitors may not be fully understanding of the mental well being of children and at times gave advice to a parent that was not in the best interest of the child. This led to panel members being faced with conflicting messages from solicitors which at times did not reflect recommendations from the assessment team. This created a risk for adversarial outcomes. Informants reflected that change is pivotal in order to put children's needs first. They also acknowledged that there is a place for the hearing system, but that the task at hand for the panel was difficult and therefore further support was needed.

A subtheme was that there was no consistence within the panel and that their decision-making could be influenced by their own vocation, training and their ability to reflect within a complex structure. Safe, predictable environments are essential for any child, particular those who have experienced adversities (Zeanah, 2009). Creating a consistent stress-free environment in the hearing system is therefore essential, as described by numerous informants.

The theme of time appearing in all superordinate themes is interesting. The process has been perceived as linear rather than parallel. This delays outcomes and impacts children being placed with their long-term carer and being '*claimed*' by a family.

Implications and Future Research

Legal concerns that were highlighted (Tuner-Halliday et al., 2017) appear to enhance drift within a system that already is under significant strain. It would be of interest to see how this is reflected in the quantitative outcomes of the trial and to revisit perceptions on what causes delay in future. The legal structures in Scotland are different to England and it would be of interest to complete research with key participant surrounding LIFT, to see if similar themes emerge. Additionally, evaluating training and links with the legal professions would be

beneficial for future research. It would also be interesting to conduct research with lawyers and advocates to gain an insight into their perceptions of the assessment process.

Limitations

The key informants were a heterogeneous group and therefore provided an insight into their unique experiences. Due to this, future research may find different themes to be more prevalent. However, the aim of the research was to gain in-depth insight into the complex issues in assessing cases of maltreatment, which case studies allow for. There were some difficulties in re-establishing contact with the birth parents. Only one birth mother was interviewed. It would have been beneficial to acquire the views of more birth parents for a holistic insight. There were subthemes that the current research paper did not have capacity to address, which may would have shown greater themes of inconsistency in informants reports. Though the current study did not have capacity to address this, this can be reviewed at a later date. The key researcher role as a Trainee Clinical Psychologist may have impacted on what the informants chose to disclose, due to preconceptions of the role and experiences of sharing information.

CONCLUSION

The study set out to gain an insight into what it was like being part of the assessment process in the child welfare system in Scotland. Overarching concerns always linked back to the welfare of the children. Frustration around lack of communication, time taken for final decisions and legal requirements all link back to the primary concern about a child having to wait for their permanent long-term home. It was therefore deemed essential that these aspects are addressed through training and resources to support the process. When joint working occurred, with clear communication and reflection, a difficult process was made easier for everyone. Crucially, it allowed for all parties to be mindful that they were working towards the best outcome for the child. This highlights that effective communication and understanding of one another are essential in making complex decisions to support children to be provided with a responsive and warm care provider.

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APPENDIXES

Appendix 1.1 Instruction for authors from the selected journal



Manuscript preparation and submission

Papers should be submitted online. For detailed instructions please go to: http://mc.manuscriptcentral.com/jcpp_journal. Previous users can check for an existing account. New users should create a new account. Help with submitting online can be obtained from the Editorial Office at publications@acamh.org

1. The manuscript should be double spaced throughout, including references and tables. Pages should be numbered consecutively. The preferred file formats are MS Word or WordPerfect, and should be PC compatible. If using other packages the file should be saved as Rich Text Format or Text only.
2. Papers should be concise and written in English in a readily understandable style. Care should be taken to avoid racist or sexist language, and statistical presentation should be clear and unambiguous. The Journal follows the style recommendations given in the *Publication manual of the American Psychological Association* (5th edn., 2001).
3. The Journal is not able to offer a translation service, but, authors for whom English is a second language may choose to have their manuscript professionally edited before submission to improve the English. A list of independent suppliers of editing services can be found [here](#). All services are paid for and arranged by the author, and use of one of these services does not guarantee acceptance or preference for publication.

Layout

Title: The first page of the manuscript should give the title, name(s) and short address(es) of author(s), and an abbreviated title (for use as a running head) of up to 60 characters.

Abstract

The abstract should not exceed 300 words and should be structured in the following way with bold marked headings: Background; Methods; Results; Conclusions; Keywords; Abbreviations. The abbreviations will apply where authors are using acronyms for tests or abbreviations not in common usage.

Key points and relevance

All papers should include a text box at the end of the manuscript outlining the four or five key (bullet) points of the paper. These should briefly (80-120 words) outline what's known, what's new, and what's relevant.

Under the 'what's relevant' section we ask authors to describe the relevance of thier work in one or more of the following domains - policy, clinical practice, educational practice, service development/delivery or recommendations for further science.

Headings

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

Acknowledgements

These should appear at the end of the main text, before the References.

Correspondence to

Full name, address, phone, fax and email details of the corresponding author should appear at the end of the main text, before the References.

References

The JCPP follows the text referencing style and reference list style detailed in the *Publication manual of the American Psychological Association* (5th edn.)i.

References in text

References in running text should be quoted as follows:

Smith and Brown (1990), or (Smith, 1990), or (Smith, 1980, 1981a, b), or (Smith & Brown, 1982), or (Brown & Green, 1983; Smith, 1982).

For up to five authors, all surnames should be cited in the first instance, with subsequent occurrences cited as et al., e.g. Smith et al. (1981) or (Smith et al., 1981). For six or more authors, cite only the surname of the first author followed by et al. However, all authors should be listed in the Reference List. Join the names in a multiple author citation in running text by the word 'and'. In parenthetical material, in tables, and in the References List, join the names by an ampersand (&). References to unpublished material should be avoided.

Reference list

Full references should be given at the end of the article in alphabetical order, and not in footnotes. Double spacing must be used.

References to journals should include the authors' surnames and initials, the year of publication, the full title of the paper, the full name of the journal, the volume number, and inclusive page numbers. Titles of journals must not be abbreviated and should be italicised.

References to books should include the authors' surnames and initials, the year of publication, the full title of the book, the place of publication, and the publisher's name.

References to articles, chapters and symposia contributions should be cited as per the examples below:

Kiernan, C. (1981). Sign language in autistic children. *Journal of Child Psychology and Psychiatry*, 22, 215-220.

Thompson, A. (1981). *Early experience: The new evidence*. Oxford: Pergamon Press.

Jones, C.C., & Brown, A. (1981). Disorders of perception. In K. Thompson (Ed.), *Problems in early childhood* (pp. 23-84). Oxford: Pergamon Press.

Use Ed.(s) for Editor(s); edn. for edition; p.(pp.) for page(s); Vol. 2 for Volume 2.

Tables and Figures

All Tables and Figures should appear at the end of main text and references, but have their intended position clearly indicated in the manuscript. They should be constructed so as to be intelligible without reference to the text. Any lettering or line work should be able to sustain reduction to the final size of reproduction. Tints and complex shading should be avoided and colour should not be used unless essential. Authors are encouraged to use patterns as opposed to tints in graphs. In case of essential colour figures, authors are reminded that there is a small printing charge. Authors will be contacted during the proofing stage of their accepted paper. Figures should be originated in a drawing package and saved as TIFF, EPS, or PDF files. Further information about supplying electronic artwork can be found in the Wiley electronic artwork guidelines [here](#).

Nomenclature and symbols

Each paper should be consistent within itself as to nomenclature, symbols and units. When referring to drugs, give generic names, not trade names. Greek characters should be clearly indicated.

Supporting Information

Examples of possible supporting material include intervention manuals, statistical analysis syntax, and experimental materials and qualitative transcripts.

1. If uploading with your manuscript please call the file 'supporting information' and reference it in the manuscript.
2. Include only those items - figures, images, tables etc that are relevant and referenced in the manuscript.
3. Label and cite the items presented in the supplementary materials as - FigS1, FigS2 etc and TableS1, TableS2 etc (as the case maybe) in their order of appearance.
4. Please note supporting files are uploaded with the final published manuscript as supplied, they are not typeset and not copy edited for style etc. Make sure you submit the most updated and corrected files after revision.
5. On publication your supporting information will be available alongside the final version of the manuscript online.
6. If uploading to a public repository please provide a link to supporting material and reference it in the manuscript. The materials must be original and not previously published. If previously published, please provide the necessary permissions. You may also display your supporting information on your own or an institutional website. Such posting is not subject to the journal's embargo data as specified in the copyright agreement. Supporting information is made free to access on publication.

Full guidance on Supporting Information including file types, size and format is available on the [Wiley Author Service](#) website.

For information on Sharing and Citing your Research Data see the [Author Services website here](#).

Appendix 1.2 Outline of search terms in databases

Embase (Ovid)

1. (child* or infan*).ti,ab.
2. exp child/
3. 1 or 2
4. ((child* adj3 (abuse* or neglect* or mistreat* or maltreat* or (sex* adj3 abus*) or (physical* adj3 (abuse* or neglect* or violent*)) or (emotion* adj3 (abuse* or neglect*)))) or adverse child* experienc* or (child* adj5 ACE*)).ti,ab.
5. exp child abuse/
6. 4 or 5
7. (video* interact* guid* or psychother* or attachm* bio* behavio?ral* or abc or circle of security or cbt or cognitive behavio?r therap* or intervent*).ti,ab.
8. 3 and 6 and 7
9. limit 8 to english language
10. limit 9 to (infant <to one year> or preschool child <1 to 6 years>)

Medline (Ovid)

1. (child* or infan*).ti,ab.
2. exp Child/
3. 1 or 2
4. ((child* adj3 (abuse* or neglect* or mistreat* or maltreat* or (sex* adj3 abus*) or (physical* adj3 (abuse* or neglect* or violent*)) or (emotion* adj3 (abuse* or neglect*)))) or adverse child* experienc* or (child* adj5 ACE*)).ti,ab.
5. exp Child Abuse/
6. 4 or 5
7. (video* interact* guid* or psychother* or attachm* bio* behavio?ral* or abc or circle of security or cbt or cognitive behavio?r therap* or intervent*).ti,ab.
8. 3 and 6 and 7
9. limit 8 to english language
10. limit 9 to ("all infant (birth to 23 months)" or "newborn infant (birth to 1 month)" or "infant (1 to 23 months)" or "preschool child (2 to 5 years)")

Psyinfo (EBSCO)

1. ((child* or infan*))
2. DE "Child Abuse" OR DE "Battered Child Syndrome"
3. (((child* adj3 (abuse* or neglect* or mistreat* or maltreat* or (sex* adj3 abus*) or (physical* adj3 (abuse* or neglect* or violent*)) or (emotion* adj3 (abuse* or neglect*)))) or adverse child* experien* (child* adj5 ACE*)) OR (DE "Child Abuse")
4. (video* interactive* guide*) or (psychother*) or (attachm* bio* behavior* or abc) or (circle of security) or (cbt or cognitive behavior* therap* or intervent*)
5. 1 and 2 and 3 and 4

Cochrane

1. (child* or infan*)
2. (((child* near/3 (abuse* or neglect* or mistreat* or maltreat* or (sex* near/3 abus*) or (physical* near/3 (abuse* or neglect* or violent*)) or (emotion* near/3 (abuse* or neglect*)))) or adverse child* experienc* or (child* near/5 ACE*))
3. ("video* interact* guid*" or psychother* or "attachm* bio* behavior*" or abc or "circle of security" or cbt or "cognitive behavior* therap*" or intervent*)
4. #1 and #2 and #3

Grey Literature

OpenGray

Search term: Child Abuse intervention

The Social Science Network

Search term: Child Abuse intervention

Hand search

Journal of Child Psychology and Psychiatry

In abstract

1. child? OR infant

AND

2. child? Abuse

AND

3. intervention

University of Glasgow Library

Search terms

- "Circle of Security" randomised
- "Attachment and Bio-behavioural Catch-up" randomised
- "Video interactive guidance" randomised
- "Child-Parent Psychotherapy" randomised

Appendix 1.3 Data Extraction Sheet

Data Extraction Sheet

- Identification Number:
- Author(s):
- Year of Publication:
- Study Design:
- Inclusion Criteria:
- Participants

Age range:

Ethnicity:

LAAC:

- Intervention:
- Comparator:
- Outcome:
- Effect size:
- Analyses:
- **C-TAM Score**

Appendix 1.4 Clinical Trials Assessment Measure (CTAM)

Trial design area	Item	Score
Sample two questions: maximum score = 10	Q1: is the sample a convenience sample (score 2) or a geographic cohort (score 5), or highly selective sample, e.g., volunteers (score 0) Convenience sample—e.g., clinic attenders, referred patients or Geographic cohort—all patients eligible in a particular area	
	Q2: is the sample size greater than 27 participants in each treatment group (score 5) or based on described and adequate power calculations (score 5)	
Allocation three questions: maximum score = 16	Q3: is there true random allocation or minimisation allocation to treatment groups (if yes score 10)	
	Q4: is the process of randomisation described (score 3)	
	Q5: is the process of randomisation carried out independently from the trial research team (score 3)	
Assessment (for the main outcome) five questions: maximum score = 32	Q6: are the assessments carried out by independent assessors and not therapists (score 10)	
	Q7: are standardised assessments used to measure symptoms in a standard way (score 6), idiosyncratic assessments of symptoms (score 3)	
	Q8: are assessments carried out blind (masked) to treatment group allocation (score 10)	
	Q9: are the methods of rater blinding adequately described (score 3)	
	Q10: is rater blinding verified (score 3)	
Control groups one question: maximum score = 16	Q11: TAU is a control group (score 6) and/or a control group that controls for non-specific effects or other established or credible treatment (score 10)	
Analysis two questions: maximum score = 15	Q12: the analysis is appropriate to the design and the type of outcome measure (score 5)	
	Q13: the analysis includes all those participants as randomised (sometimes referred to as an intention to treat analysis) (score 6) and an adequate investigation and handling of drop outs from assessment if the attrition rate exceeds 15% (score 4)	
Active treatment two questions: maximum score = 11	Q14: was the treatment adequately described (score 3) and was a treatment protocol or manual used (score 3)	
	Q15: was adherence to the treatment protocol or treatment quality assessed (score 5)	

Where the criterion is not reached for any question score = 0, Total maximum score = 100

Appendix 1.5 CTAM Scores

STUDY	SAMPLE	ALLOCATION	ASSESSMENT	CONTROL GROUPS	ANALYSIS	ACTIVE TREATMENT	TOTAL
01. Dozier, M. et al. 2006	7	13	16	16	15	11	78
02. Dozier, M. et al. 2008	7	9	6	16	15	11	64
03. Dozier, M. et al. 2012	7	13	32	16	15	11	94
04. Lind, T. et al. 2017	7	13	6	16	15	11	68
05. Bernard, K. et al. 2015	10	13	26	16	15	11	91
06. Lind, T. et al. 2014	7	13	32	16	15	11	94
07. Cassidy, J. et al. 2017	7	13	12	6	15	11	64
08. Cicchetti, D. et al. 2006	10	13	32	16	9	11	91
09. Stronach E.P. et al 2013	10	13	32	16	9	11	91
10. Fonagy, P. et al. 2016	10	16	12	16	15	11	80
11. Lieberman, A. F. et al. 2005	7	10	6	6	11	6	46
12. Ippen, C. G. et al. 2011	5	10	6	6	15	11	53
13. Pereira, M. et al. 2014	5	10	32	6	15	6	74
14. Negrão, M. et al. 2014	10	10	6	6	15	6	53
15. Casonato, M. et al. 2017	2	10	29	6	15	3	75
16. Steele, H. et al. 2019	10	13	32	16	15	11	97

Appendix 2.1 Instruction for authors from the selected journal



CHILD ABUSE & NEGLECT

The International Journal

GUIDE FOR AUTHORS

Types of contributions

1. **Research Article:** Child Abuse and Neglect publishes quantitative, qualitative, and mixed-method research. Particular focus will be placed on thorough and appropriate methods, strong data analysis and discussion of implications for the field.

2. **Reviews:** Authors with plans for proposed review articles (systematic, meta-analytic, scoping) are invited to first submit a draft outline to the Editor-in-Chief for review. Please send proposals to chiabu@elsevier.com. The editors may also commission reviews on specific topics. Reviews submitted without invitation or prior approval may be returned.

3. **Medical Report:** Child Abuse and Neglect publishes clinically-relevant original research using a more structured medical format. Medical Reports should include a structured abstract of no more than 250 words including the following sections: Background, Objective, Participants and Setting, Methods, Results (giving specific effect sizes and their statistical significance), and Conclusions. Manuscript length is limited to 3,000 words (excluding the abstract, tables and figures, and references or appendices) and up to 5 figures or tables (additional figures or tables may be considered as online appendices). Medical reports should include the following sections: Introduction: In 1-2 pages, state the objective of the study and provide adequate background that a reader can determine whether they should read the paper in its entirety. Methods: Provide sufficient detail that the study could be repeated by another investigator. Results: Provide main and secondary results. Discussion: Summarize the most important results and provide the authors interpretation of relevance in the context of any relevant prior literature. The discussion section should include a section on the articles strengths and limitations, and suggested next steps. Conclusion: In 1-2 sentences, summarize the authors final conclusions. Medical Reports should include 2 sections highlighting the importance of the paper; What is known and What this study adds. Each section is limited to 40 words.

4. **Discussion Article:** Plans for proposed critical review discussion articles are invited to first submit a draft outline to the Editor-in-Chief. Please send proposals to chiabu@elsevier.com. These articles may discuss a policy or legal / philosophical framework or a brief data report. The article must present a critical analysis of areas of gap in practice or research, current critical or emergent issues, with an expectation of utilizing an integration and discussion of empirical research.

Child Abuse and Neglect does not publish case reports or small case series in any of its article types.

Length and Style of Manuscripts

Full-length manuscripts should not exceed 35 pages total (including abstract, text, references, tables, and figures), double spaced with margins of at least 1 inch on all sides and a standard font (e.g., Times New Roman) of 12 points (no smaller).

Instructions on preparing tables, figures, references, metrics, and abstracts appear in the [Publication Manual of the American Psychological Association](#) (6th edition).

For helpful tips on APA style, [click here](#).

Article structure

Subdivision

Divide your article into clearly defined sections. Three levels of headings are permitted. Level one and level two headings should appear on its own separate line; level three headings should include punctuation and run in with the first line of the paragraph.

Introduction

State the objectives of the work and provide an adequate background, avoiding a detailed literature survey or a summary of the results.

Essential title page information

- **Title.** Concise and informative. Titles are often used in information-retrieval systems. Avoid abbreviations and formulae where possible.

- **Author names and affiliations.** Please clearly indicate the given name(s) and family name(s) of each author and check that all names are accurately spelled. You can add your name between parentheses in your own script behind the English transliteration. Present the authors' affiliation addresses (where the actual work was done) below the names. Indicate all affiliations with a lower-case superscript letter immediately after the author's name and in front of the appropriate address. Provide the full postal address of each affiliation, including the country name and, if available, the e-mail address of each author.

- **Corresponding author.** Clearly indicate who will handle correspondence at all stages of refereeing and publication, also post-publication. This responsibility includes answering any future queries about Methodology and Materials. **Ensure that the e-mail address is given and that contact details are kept up to date by the corresponding author.**

- **Present/permanent address.** If an author has moved since the work described in the article was done, or was visiting at the time, a 'Present address' (or 'Permanent address') may be indicated as a footnote to that author's name. The address at which the author actually did the work must be retained as the main, affiliation address. Superscript Arabic numerals are used for such footnotes.

Abstract

Abstracts should follow a structured format of no more than 250 words including the following sections: Background, Objective, Participants and Setting, Methods, Results (giving specific effect sizes and their statistical significance), and Conclusions.

Keywords

Immediately after the abstract, provide a maximum of 6 keywords, using American spelling and avoiding general and plural terms and multiple concepts (avoid, for example, 'and', 'of'). Be sparing with abbreviations: only abbreviations firmly established in the field may be eligible. These keywords will be used for indexing purposes.

Formatting of funding sources

List funding sources in this standard way to facilitate compliance to funder's requirements:

Funding: This work was supported by the National Institutes of Health [grant numbers xxxx, yyyy]; the Bill & Melinda Gates Foundation, Seattle, WA [grant number zzzz]; and the United States Institutes of Peace [grant number aaaa].

It is not necessary to include detailed descriptions on the program or type of grants and awards. When funding is from a block grant or other resources available to a university, college, or other research institution, submit the name of the institute or organization that provided the funding.

If no funding has been provided for the research, please include the following sentence:

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Footnotes

The use of footnotes in the text is not permitted. Footnoted material must be incorporated into the text.

Table footnotes Indicate each footnote in a table with a superscript lowercase letter.

Tables

Please submit tables as editable text and not as images. Tables can be placed either next to the relevant text in the article, or on separate page(s) at the end. Number tables consecutively in accordance with their appearance in the text and place any table notes below the table body. Be sparing in the use of tables and ensure that the data presented in them do not duplicate results described elsewhere in the article. Please avoid using vertical rules and shading in table cells.

References

Citation in text

Please ensure that every reference cited in the text is also present in the reference list (and vice versa). Any references cited in the abstract must be given in full. Unpublished results and personal communications are not recommended in the reference list, but may be mentioned in the text. If these references are included in the reference list they should follow the standard reference style of the journal and should include a substitution of the publication date with either 'Unpublished results' or 'Personal communication'. Citation of a reference as 'in press' implies that the item has been accepted for publication.

Web references

As a minimum, the full URL should be given and the date when the reference was last accessed. Any further information, if known (DOI, author names, dates, reference to a source publication, etc.), should also be given. Web references can be listed separately (e.g., after the reference list) under a different heading if desired, or can be included in the reference list.

Data references

This journal encourages you to cite underlying or relevant datasets in your manuscript by citing them in your text and including a data reference in your Reference List. Data references should include the following elements: author name(s), dataset title, data repository, version (where available), year, and global persistent identifier. Add [dataset] immediately before the reference so we can properly identify it as a data reference. The [dataset] identifier will not appear in your published article.

References in a special issue

Please ensure that the words 'this issue' are added to any references in the list (and any citations in the text) to other articles in the same Special Issue.

Reference management software

Most Elsevier journals have their reference template available in many of the most popular reference management software products. These include all products that support [Citation Style Language styles](#), such as [Mendeley](#). Using citation plug-ins from these products, authors only need to select the appropriate journal template when preparing their article, after which citations and bibliographies will be automatically formatted in the journal's style. If no template is yet available for this journal, please follow the format of the sample references and citations as shown in this Guide. If you use reference management software, please ensure that you remove all field codes before submitting the electronic manuscript. [More information on how to remove field codes from different reference management software](#).

Users of Mendeley Desktop can easily install the reference style for this journal by clicking the following link:

<http://open.mendeley.com/use-citation-style/child-abuse-and-neglect>

When preparing your manuscript, you will then be able to select this style using the Mendeley plug-ins for Microsoft Word or LibreOffice.

Reference style

Text: Citations in the text should follow the referencing style used by the American Psychological Association (view the [APA Style Guide](#)). You are referred to the Publication Manual of the American Psychological Association, Sixth Edition, ISBN 978-1-4338-0561-5.

List: references should be arranged first alphabetically and then further sorted chronologically if necessary. More than one reference from the same author(s) in the same year must be identified by the letters 'a', 'b', 'c', etc., placed after the year of publication.

[dataset] Oguro, M., Imahiro, S., Saito, S., Nakashizuka, T. (2015). Mortality data for Japanese oak wilt disease and surrounding forest compositions. Mendeley Data, v1. <http://dx.doi.org/10.17632/xwj98nb39r.1>.

Examples:

Reference to a journal publication:

Van der Geer, J., Hanraads, J. A. J., & Lupton, R. A. (2010). The art of writing a scientific article. *Journal of Scientific Communications*, 163, 51–59.

Reference to a book:

Strunk, W., Jr., & White, E. B. (2000). *The elements of style*. (4th ed.). New York, NY: Longman.

Reference to a chapter in an edited book:

Mettam, G. R., & Adams, L. B. (2009). How to prepare an electronic version of your article. In B. S. Jones, & R. Z. Smith (Eds.), *Introduction to the electronic age* (pp. 281–304). New York, NY: E-Publishing.

Appendix 2.2 MRP Proposal



DOCTORATE IN CLINICAL PSYCHOLOGY

Major Research Project (MRP) Proposal

Qualitative investigation into approaches to maltreated pre-school children in care

Matriculation number

0308000

Date of Submission

17th May 2018

Version Number

7

Actual Word count

2890

Maximum Word Count

3000

For Office Use Only

Date Received:

--

Abstract

Early intervention with children who experience neglect and abuse is important for both their physical well-being and their current and long-term mental health. Historically children who were being assessed for care in Scotland experienced a lengthy process of drifting between birth families and foster parents, prior to a decision being reached about their permanent placement. This pattern increases the risk of repeated episodes of maltreatment and poor attachment that can lead to negative long-term consequences for the child. Glasgow is currently undertaking a randomised controlled trial (RCT) named the Best Services Trial (BeST?) comparing the effectiveness of two assessment frameworks for cases of maltreatment in children under the age of five: 1. A new multidisciplinary infant mental health approach, and 2. the usual approach to assessing families by social work services. Whilst the main trial is ongoing, the aim of this sub-study is to gather qualitative data about the experiences and processes of families going through both assessment approaches. To give an in depth perspective of such cases, the aim is to explore how key stakeholders involved in a case of maltreatment perceive the process and experience. This includes the perceptions of the parent(s), foster carer(s), social worker(s) and clinician(s) involved in each case. Qualitative data was gathered in 2015 and the transcripts will be analysed to provide a topic guide for further interviews with carers, both birth and foster, and focus groups with professionals. The focus will be on the same four cases to ensure triangulation by gathering information at different points in time and through different means. A Thematic Analysis (TA) approach will be applied across the two data sets. The aim is to build a picture of specific cases in order to learn about aspects of personal experience as well as perspectives of system-level processes.

Introduction

The early years of a child's life are important and research indicates a significant link between early adverse life experiences and a range of mental and physical health difficulties in later life (Felitti et al, 1998, van der Kolk, 2005, Pritchett et al, 2013, Bellis et al, 2014). Research on attachment has found that a responsive and warm care provider plays a significant protective role in the development of a child. Insecure attachment can influence the development of mental health difficulties (Sroufe et al, 2005), and a lack of positive parenting experiences have been linked to an increased risk of psychiatric disorders, higher rates of hospitalisation and increased rates of premature mortality (Furlong et al, 2012). It is therefore important to ensure that a child is supported from the onset to provide them with the best possible start. Providing early intervention can have a significant impact on a child's emotional and social development and increases the chance of recovery from the effects of maltreatment (Fox et al, 2011). Children who are already in care or entering into care are among the most vulnerable in society (Minnis & Del Priori, 2001). Prompt and effective decision-making about their placement is important to ensure that a child is provided with a permanent place with a secure base and positive parenting experiences (Pritchett et al, 2013). In spite of this, decisions about a permanent placement for the child have historically not been made in Scotland until around the age of four, which means potentially several years of drifting between numerous care providers (Pritchett et al, 2013). This is known to put their mental wellbeing at further risk. It is therefore paramount that there is an effective assessment framework in place to make the key decision of whether the child should be reunified with their birth parents as early as possible.

The BeST? study aims to compare two different services to identify the most efficacious, and cost effective, way of assessing whether a child should return home or not after maltreatment. One of the assessment frameworks is provided by the Glasgow Infant and Family Team (GIFT). The approach is adopted from the New Orleans intervention model (NIM), which emphasises the importance of infant mental health and follows a structured attachment-based assessment framework (Walker et al 2013). Post-assessment, a multi disciplinary team of Clinical

Psychologists, Therapists and Social Workers, tailor a therapeutic intervention for the child and their carer(s), such as biological and foster parents. At the end of the intervention the GIFT team provide a recommendation about the appropriate permanent placement of the child, based on parental capacity and the child's mental health (Minnis et al 2015, Turner-Halliday, 2015). GIFT is being compared to the enhanced control intervention of the Family Assessment and Contacts Service (FACS), which is being provided by a team of Social Workers employed by Glasgow City Council. The assessment consists of monitored naturalistic episodes of arranged contact between the child and their birth parent(s) and the final recommendation for the permanent placement of the child is based on the social work team's assessment of the parenting capacity (Minnis et al 2015).

With a trial of any complex intervention, a qualitative approach to information gathering is important in order to be able to provide explanatory power to the eventual quantitative results of the study. The Medical Research Council framework on complex interventions states that to evaluate the change process, service users should be included in all stages (MRC, 2006). Conducting qualitative research provides information on why a framework may be effective and how it impacts those involved in it. Families are not passive recipients of an intervention and contextual settings can all impact outcomes (Turner-Halliday, In Press). Qualitative research can provide information on the contextual nuances that quantitative research may miss. Previously the majority of studies focusing on children's care experiences have applied quantitative research methods and used samples of children older than five years of age and past infancy (Glass et al 2016). This study aims to support the evaluation of the two assessments framework through qualitative methods, to identify the most effective assessment process for recommending the best place for a child.

Aims

The aim of this study is to explore the experience and perceptions of those involved in the assessment phase of cases of maltreatment in Glasgow, Scotland. To achieve this, cases that have previously been assessed by GIFT and FACS will be examined. The study aims to gather information on participants' perceptions of the processes that ensued whilst being involved in the assessment of maltreatment. A secondary focus will be on their perceptions of the child welfare system as a whole.

Plan of Investigation

Participants

Children were initially recruited for the BeST? trial between December 2011 and October 2013, with a total of 92 children recruited overall (Glass et al, 2016). All children were between the ages of 0 and 60 months and were removed from their parents or guardians care for further assessment after child protection concerns were raised (Pritchett et al, 2013). The participants in this study were purposively selected as they represent the key figures surrounding the children of 4 families that have been part of the trial. Participants will consist of at least 4 birth parents/carers, 4 foster carers, a minimum 4 social workers and minimum of 2 clinicians across the four cases. The aim will be to have an even distribution of participants across the cases and assessment frameworks. The study will not directly interview any of the children involved.

Inclusion and Exclusion Criteria Recruitment Procedures Measures

The inclusion criteria will be specific individuals who have been involved in four selected cases of maltreatment. The cases have been selected for follow up, as they have previously been part of qualitative research in 2015. The parents and foster carers have consented to the BeST? trial and consented to be interviewed as part of the qualitative component of the study. The clinicians and social workers that are part of GIFT and FACS have consented to giving their views on cases of maltreatment that are the focus of this study. Overall exclusion criteria for the trial were

children who had a severe learning disability and if the primary care giver would have been unavailable to take part in the intervention.

Design

This will be a qualitative study using interviews and focus groups.

Research Procedures

To explore the aims, qualitative transcripts gathered in June 2015 from 4 cases of maltreatment, two that were assessed by GIFT and two by FACS, will be analysed for recurring themes. The case studies consist of 4 families with a total of 7 children (Case 1: 2 children, Case 2: 3 children, Case 3: 1 child & Case 4: 1 child). A researcher associated with the trial conducted a total of 18 individual interviews and their assessment process is now complete. The transcripts are available for analysis and will be analysed by the researcher.

Following analysis, follow-up qualitative data will be gathered; this will entail focus groups with the clinicians and social workers that were involved with each family and individual interviews with parents and foster carers. This is to gather qualitative information about the perception of the process so far since the initial interviews. The themes from the analysis of the data from 2015 will provide a topic guide to the focus groups and interviews. This process of triangulation will occur through the gathering of information at multiple points in time and through different means. This is to provide a 'richer' insight into the participant's experiences and perceptions. Any consistencies across the two data sources could indicate reliability. The aim of using triangulation is not necessary to provide this, but to increase the level of understanding, which is reflected in the aim of this study (Barbour, 2001).

It is expected that each case study will have a minimum of 4 participants consisting of a Foster parent, Social Worker, Clinician (where involved) and parents, both adoptive or birth. A total of 4 focus groups are planned for each case involving all professionals and between 6 and 10

individual interviews with parents, foster parent and any clinicians unable to attend a focus group. The number of individual interviews is dependent on whether the child has been adopted, reunified with their parents or is still in foster care.

Data Analysis

The transcripts from the initial interviews are available and will be analysed once approval has been granted, which will be part of the initial phase (Table 1). The data from the follow up focus groups and interviews will be audio recorded and transcribed verbatim by an administrator associated with the trial (Table 2). To facilitate interpretation of the data a Thematic Analysis (TA) approach will be applied across the two data sets.

The rationale for a TA approach is that this approach focuses on gathering an understanding of the experience and perception of the participants in the samples. It allows for themes to be developed from small homogenous groups and for the research to look for patterns across the datasets, leading to identifying themes and meaning (Braun & Clarke, 2006). Analysis can be shaped by a bottom up approach lead by the experiences of the participants rather than assumptions held by the researcher and the teams associated with the assessment processes. Braun & Clarke (2006) recommend that for a thematic analysis around 6 to 10 interview should occur, with 2 to 4 focus groups and a minimum of 6 participants. It is expected that this minimum will be achieved. If the saturation of themes is not achieved, a review will occur to consider further recruitment, if deemed necessary.

Table 1. Initial phase of data Analysis

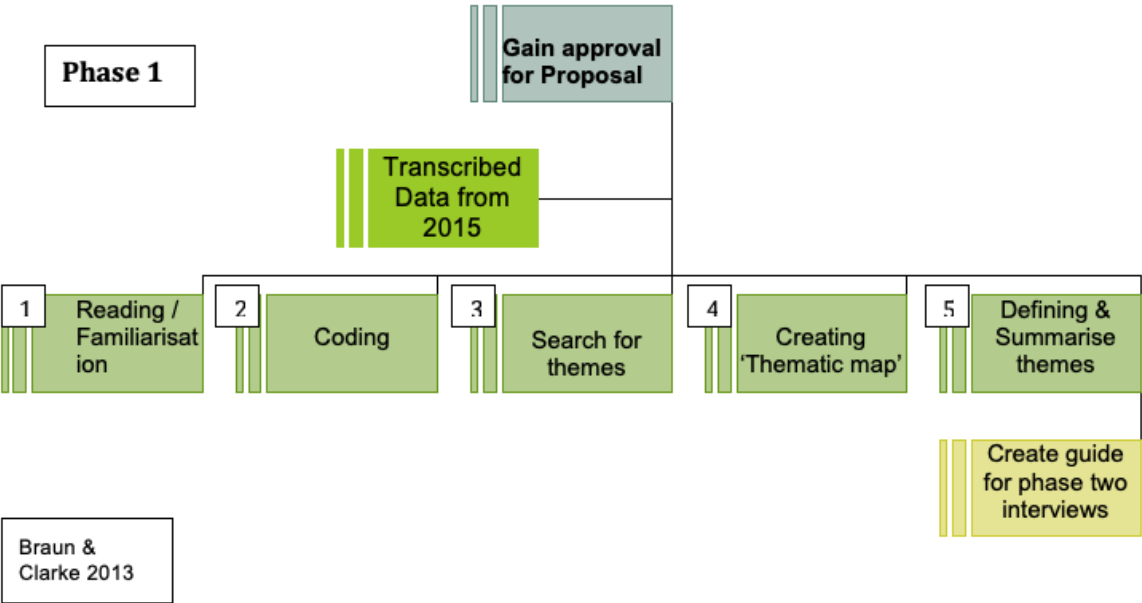
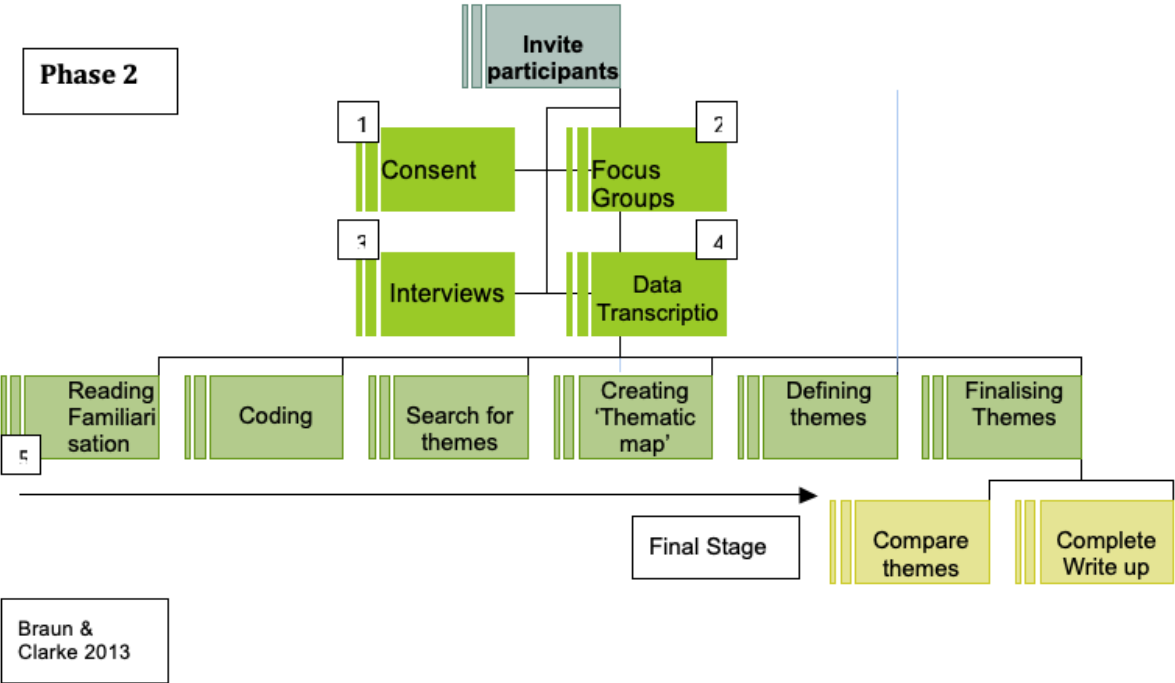


Table 2. Second phase of data Analysis



Health and Safety Issues

The aim is that the focus groups will be undertaken in a research or clinical setting. In the unlikely event of the need to conduct a home visit, a researcher associated with the BeST? trial will be present alongside the researcher to avoid lone working and adhere to NHS Greater Glasgow & Clyde lone working policy .

Ethical Issues

As the study will be gathering and storing confidential information, the researcher will ensure to adhere to relevant guidelines such as the Caldicott Principle (1997) and GDPR legislation (2018). Any identifiable information will be removed once the data is written up and no identifiable data will be stored outwith an NHS setting. Prior to participants taking part in the focus groups and interviews a consent form will be provided. Information will be given on the study and outline rights to withdraw their involvement.

The BeST? trial has received full ethical approval from the West of Scotland Research Ethics Committee and all qualitative research is covered in this, including the proposed research project. The researcher has made contact with the R&D sponsor of the trial and is waiting for confirmation on the approval being granted.

Clarification has been sought from Dr Alison Jackson (MRP Research coordinator, Doctorate in Clinical Psychology, Glasgow University) in regard to the need of having to seek additional ethical approval as part of the Doctorate in Clinical Psychology training process on the 17th November 2017. The researcher was informed that this would not be needed.

Financial Issues

Each participant that takes part in the research is offered a £20 voucher and his or her travel expenses are covered by the trial. A budget is available for this. Any travelling costs that arise for the researcher to facilitate the focus groups will be covered by the trial as well.

Timetable

The aim is to start analysing the existing data from 2015 as soon as the proposal has been approved. Once this is completed the focus groups and individual interviews will be arranged and it is expected that the data will be collected in summer of 2018.

Practical Applications

The results of the study will gather an insight into how the assessment frameworks are perceived by individuals who are part of it. The implications will impact the overall evaluation of the trial and influence the future assessment methods of children who experience maltreatment in Scotland. The MRC guidelines (2006) outline that publication of research is essential, for these reasons, the findings will be presented and published where possible to support the implementation of the most effective framework.

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**WEST OF SCOTLAND/ UNIVERSITY OF GLASGOW
DOCTORATE IN CLINICAL PSYCHOLOGY**

HEALTH AND SAFETY FOR RESEARCHERS

1. Title of Project	Qualitative investigation into approaches to maltreated pre-school children in care
2. Trainee	Removed for anonymisation
3. University Supervisor	Professor Helen Minnis Professor Hamish McLeod
4. Other Supervisor(s)	Dr Fiona Turner-Halliday
5. Local Lead Clinician	Professor Helen Minnis Dr Fiona Turner-Halliday
6. Participants: (age, group or sub-group, pre- or post-treatment, etc)	<p>The participants of the focus groups and interviews will all be of adult age (18 years and older). The participants in this study were purposively selected as they represent the key figures surrounding the children of 4 families that have been part of the trial.</p> <p>Participants will consist of at least 4 birth parents/carers, 4 foster carers, a minimum 4 social workers and minimum of 2 clinicians across the four cases. The aim will be to have an even distribution of participants across the cases and assessment frameworks. The study will not directly interview any of the children involved in the trial.</p>
7. Procedures to be applied	The aim of the research is to gather information in

(e.g., questionnaire, interview, etc)	focus groups and individual interviews following a topic guide. The themes will be taken from the analysis of previous qualitative transcripts gathered in June 2015.
8. Setting (where will procedures be carried out?) i) Details of all settings	The setting for the focus groups and interviews will take place in buildings operated by the NHS.
ii) Are home visits involved	Not expected



<p>9. Potential Risk Factors Considered (for researcher and participant safety):</p> <p>i) Participants</p> <p>ii) Procedures</p> <p>iii) Settings</p>	<p>i. Participants</p> <p>No dangerous or unpredictable behaviours have been associated with any of the participants.</p> <p>ii. Procedure</p> <p>The participants taking part in the study may experience some distress whilst discussing their involvement in the trial. The birth parents and carers will be discussing their child(ren's) long term permanent placement after child welfare concerns were highlighted. There is a possibility that their child may have been removed from their care. The clinicians involved in the focus group could experience some distress when discussing their involvement or experience some disagreement with other members of the focus group.</p> <p>iii. Settings</p> <p>The interviews will occur in clinical or research settings and no home visits are anticipated. In the</p>
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	unlikely event of a home visit needing to occur, a researcher associated with the trial will accompany the researcher.
<p>10. Actions to minimise risk (refer to 9)</p> <p>i) Participants</p> <p>ii) Procedures</p>	<p>i. Participants</p> <p>The participants are the key figures of four cases that have been part of the BeST? service trial. They have agreed to take part in the study and relevant risk assessments have previously been conducted when they engaged in the initial information gathering in June 2015. The participants will consist of at least four birth parents/ carers, four foster carers, a minimum four social workers and minimum of two clinicians. Prior to the interviews the risk assessments will be reviewed.</p> <p>ii. Procedure</p> <p>Due to the sensitive nature of the birth parents and carers involvement with the study their interviews will occur in individual interviews. This is to provide an environment where the parents and carers feel they can discuss their experiences freely without professionals involved in the assessment process being present.</p> <p>The professionals involved in the four cases will be interviewed in focus groups.</p> <p>To minimise any discomfort that any participants may experience they will be informed at the onset of the interviews that they are free to take breaks or stop their participation at any time without providing a reason. They will also be informed that at the end the researcher will stay in the setting</p>

<p>iii) Settings</p>	<p>until all participants have left if they would like to discuss any concerns that arose from the participation of the interviews. If concerns are raised the researcher will ensure to signpost or refer to relevant services for further support. This will occur for both the individual interviews and focus groups.</p> <p>iii. Settings</p> <p>Participants attending a clinical or research setting will be informed about the fire safety procedure at the onset of the meeting.</p>
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Trainee signature: Removed for anonymisation

Date: 26th January 2018

University supervisor signature:

Date: 28 January 2018

Appendix 2

RESEARCH EQUIPMENT, CONSUMABLES AND EXPENSES

Trainee Removed for anonymisation

Year of Course 2nd Year

Intake Year 2016

Item	Details and Amount Required	Cost or Specify if to Request to Borrow from Department
Stationary	None required	Subtotal: N/A
Postage	None required	Subtotal: N/A
Photocopying and Laser Printing	None required	Subtotal: N/A
Equipment and Software	Any software cost will be covered by the trial i.e. voice recorder for interviews. No materials are needed to transcribe due to it being covered by an administrator.	Subtotal: N/A
Measures	None required	Subtotal: N/A
Miscellaneous	No costs are anticipated, but any cost involving the facilitation of the focus groups will be covered by the Best trail.	Subtotal: N/A
Total		-

For any request over £200 please provide further justification for all items that contribute to a high total cost estimate. Please also provide justification if costing for an honorarium:

Trainee Signature

Removed for anonymisation

Date 26th January 2018



Supervisor's Signature ...

Date ...28 January 2018

Plain English Summary

Word Count: 498

Title

Qualitative investigation into approaches to maltreated pre-school children in care

Background

The early years of a child's life are important and research indicates a link between early harmful life experiences with a range of mental and physical health difficulties in later life (Bellis et al, 2014). Historically children who were being assessed for care in Scotland experienced a lengthy process of drifting between birth families and foster parents. This increases the risk of repeated episodes of maltreatment. Glasgow is currently undertaking a randomised controlled trial (RCT) called Best Services Trial (BeST?) comparing the effectiveness of two assessment frameworks for children under the age of five. It compares a new multidisciplinary infant mental health approach facilitated by the Glasgow Infant and Family Team (GIFT). This is contrasted to the Family Assessment and Contacts Service (FACS) facilitated by social work services. At the end of an assessment each team makes recommendations about the appropriate permanent placement (Minnis et al 2015). Previously studies have used mainly quantitative methods and focused on children past infancy (Glass et al 2016).

Aims & Questions

The study aims to gather participants lived experiences of the assessment process and the child welfare system as a whole. This is to provide insight on why an approach may be effective.

Methods

Participants

The participants are individuals who are involved in the care of children from four families going through the assessment process. They consist of birth parents/carers, foster carers, social workers and clinicians and they were initially interviewed in June 2015. The study will not interview any children.

Recruitment

All participants have already been recruited to take part in the research.

Design

The design of the study will be Qualitative and the data will be collected using semi structured interviews and focus groups. A thematic analysis will be applied to identify recurrent themes in the data initially focusing on the transcripts from interviews conducted in 2015. Thereafter the participants will be invited to take part in further interviews.

Ethical Issues

All guardians and professionals provided initial consent to opt in to the trial and to be interviewed. To ensure confidentiality is maintained all information will be held within an NHS building and identifiable information will be removed.

Practical applications

The findings will be feedback into the trial and if possible presented at relevant events and published.

References

Bellis, M.A., Hughes, K., Leckenby, N., Perkins C. & Lowey, H. (2014) National household survey of adverse childhood experiences and their relationship with resilience to health-harming behaviors in England. *BMC Medicine*, 12:72

Glass, S., Gajwani, R. & Turner- Halliday, F. (2016) 'Does Quantitative Research in Child Maltreatment Tell the Whole Story? The Need for Mixed-Methods Approaches to Explore the Effects of Maltreatment in Infancy.' Research Article, *Hindawi Publishing Corporation The Scientific World Journal Volume 2016, Article ID 1869673*

Minnis, H., Turner- Halliday, F., Boyd, K., Trevor, M. & Watson, N. (2015) 'Process and Economic Evaluation of the New Orleans Intervention Model for Infant Mental Health in Glasgow'. NSPCC Funder report.

Questions guide

All questions are asked as an open question

1. Update since 2015, what has occurred, been the outcome since then?
 - Since person has become involved in case
i.e. new carer or social worker
2. Thoughts around the individual assessment process, pro's and con's
3. Particular concerns around
 - Communication
 - Relationships
 - Outcomes
4. Thought around the child assessment system as a whole
5. Child's / Children's current presentation
6. Individual concerns of child / children
7. Thoughts around future outcomes of system

Appendix 2.4 NHS GGC ethical approval for Best trial



Coordinator/administrator: J McGarry/ R Syed
Telephone Number: 0141 232 1817
E-Mail: ray.syed@ggc.scot.nhs.uk
Website: www.nhsggc.org.uk/r&d

Clinical Research & Development
West Glasgow ACH
Dalnair Street
Glasgow G3 8SJ
Scotland, UK

17.11.17

Professor Helen Minnis
Greater Glasgow and Clyde
University of Glasgow, Level 4 Academic CAMHS
West Glasgow Ambulatory Care Hospital
Glasgow
G3 8SJ
Scotland

NHS GG&C Board Approval

Dear Professor Helen Minnis

Study Title:	The Best Services Trial (BeST): Effectiveness and cost-effectiveness of the New Orleans Intervention Model for Infant Mental Health.
Principal Investigator:	Professor Helen Minnis
GG&C HB site	Royal Hospital for Children
Sponsor	NHS Greater Glasgow & Clyde
R&D reference:	GN14CO183P
REC reference:	15/WS/0280
Protocol no: (including version and date)	Version 3.0 (27.03.2017)

I am pleased to confirm that Greater Glasgow & Clyde Health Board is now able to grant **Approval** for the above study.

Conditions of Approval

1. **For Clinical Trials** as defined by the Medicines for Human Use Clinical Trial Regulations, 2004
 - a. During the life span of the study GGHB requires the following information relating to this site
 - i. Notification of any potential serious breaches.
 - ii. Notification of any regulatory inspections.

It is your responsibility to ensure that all staff involved in the study at this site have the appropriate GCP training according to the GGHB GCP policy (www.nhsggc.org.uk/content/default.asp?page=s1411), evidence of such training to be filed in the site file.

2. **For all studies** the following information is required during their lifespan.
 - a. Recruitment Numbers on a quarterly basis
 - b. Any change of staff named on the original SSI form
 - c. Any amendments – Substantial or Non Substantial
 - d. Notification of Trial/study end including final recruitment figures
 - e. Final Report & Copies of Publications/Abstracts

Please add this approval to your study file as this letter may be subject to audit and monitoring.

Your personal information will be held on a secure national web-based NHS database.

I wish you every success with this research study

Yours sincerely,

Joanne McGarry
Research Co-ordinator

PP: Ray Syed

Professor Helen Minnis
Professor of Child and Adolescent Psychiatry
University of Glasgow
Department of Mental Health and Wellbeing
University of Glasgow, Caledonia House,
Yorkhill Hospital, Dalnair Street
Glasgow
G3 8SJ

Date 23rd December 2015
Your Ref
Our Ref
Direct line 0141 232 1805
E-mail WOSREC3@ggc.scot.nhs.uk

Dear Professor Minnis

Study title:	The Best Services Trial (BeST?): Effectiveness and cost-effectiveness of the New Orleans Intervention Model for Infant Mental Health
REC reference:	15/WS/0280
IRAS project ID:	178440

Thank you for responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered in correspondence by a Sub-Committee of the REC. A list of the Sub-Committee members is attached.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact the REC Manager, Mrs Liz Jamieson, wosrec3@ggc.scot.nhs.uk.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for NHS permission for research is available in the Integrated Research Application System, www.hra.nhs.uk or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

The Committee has not yet completed any site-specific assessment (SSA) for the non-NHS research site(s) taking part in this study. The favourable opinion does not therefore apply to any non-NHS site at present. We will write to you again as soon as an SSA application(s) has been reviewed. In the meantime no study procedures should be initiated at non-NHS sites.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Covering letter on headed paper [Cover letter]		
GP/consultant information sheets or letters [GP Information Sheet]	1.0	11 November 2015
Interview schedules or topic guides for participants [Disturbances of Attachment Interview]		
Interview schedules or topic guides for participants [This is My Baby]		
IRAS Checklist XML [Checklist_11112015]		11 November 2015
Letters of invitation to participant [New Parent Letter of Invitation]	1.0	11 November 2015
Letters of invitation to participant [Kinship Carer Letter of Invitation]	1.0	11 November 2015
Non-validated questionnaire [Additional Service User Questionnaire - 1 year follow up]		
Other [Potential Child Development Concern Letter]	1.0	11 November 2015

Other [Potential Child Protection Concern Letter]	1.0	11 November 2015
Other [Missed contact letter]	1.0	11 November 2015
Other [Baseline Research Assessment Letter]	1.0	11 November 2015
Other [Letter confirming research assessment visit]	1.0	11 November 2015
Other [Child's guidance for study visit]	1.0	11 November 2015
Other [Birth Parent/Kinship Carer Research Assessment Letter]	1.0	11 November 2015
Other [Missed appointment/questionnaire letter]	1.0	11 November 2015
Other [Questionnaire letter after telephone call]	1.0	11 November 2015
Other [Example of translated information leaflet]	1.0	11 November 2015
Other [Measures Table]		20 October 2015
Other [Email from CI re Measures etc]		13 November 2015
Other [consent for routine data]	1	21 December 2015
Other [recruitment guidance for professionals]	1	07 December 2015
Other [ethics response cover letter]		
Participant consent form	2.0	21 December 2015
Participant consent form [consent tracked]	2.0	21 December 2015
Participant information sheet (PIS) [Professional Information Leaflet]	2.0	21 December 2015
Participant information sheet (PIS) [PIS tracked]	2.0	21 December 2015
REC Application Form [REC_Form_11112015]		11 November 2015
Research protocol or project proposal [BeST Protocol]	1.0	11 November 2015
Summary CV for Chief Investigator (CI) [Prof H. Minnis CV]		
Validated questionnaire [Strengths and Difficulties]		
Validated questionnaire [PIR-GAS]		
Validated questionnaire [Rough Descriptions for Emotional Signalling Scale Modified]		
Validated questionnaire [ITSEA]		
Validated questionnaire [WPPSI-III Record Form]		
Validated questionnaire [PedsQL]		
Validated questionnaire [RPQ]		
Validated questionnaire [Observational Schedule for Reactive Attachment Disorder]		

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports

- Notifying the end of the study

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

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 R&D staff at our training days – see details at

<http://www.hra.nhs.uk/hra-training/>

15/WS/0280

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely

Liz Jamieson
REC Manager
On behalf of Eoin MacGillivray, Vice Chair

Enclosures: List of names and professions of members who were present at the meeting

"After ethical review – guidance for researchers"

*Copy to: Mrs Lynn McMahon, Senior Trials Manager
 Mr Paul Dearie, NHS Greater Glasgow and Clyde*

West of Scotland REC 3

**Sub-Committee of the REC meeting held in correspondence between 18th and 23rd
December 2015**

Committee Members:

<i>Name</i>	<i>Profession</i>	<i>Present</i>	<i>Notes</i>
Dr Anja Guttinger	Consultant in Sexual & Reproductive Health	Yes	
Mr Eoin MacGillivray	Retired Dentist - Vice Chair	Yes	
Mrs Rosie Rutherford	Volunteer - Lay Plus Member and Alternate Vice Chair	Yes	

Also in attendance:

<i>Name</i>	<i>Position (or reason for attending)</i>
Mrs Liz Jamieson	REC Manager

Appendix 2.5 Researcher added to ethical approval



Coordinator/Administrator: JMcGarry/ RSyed
Telephone Number: 0141 232 1817
E-Mail: ray.syed@ggc.scot.nhs.uk
Website: www.nhsggc.org.uk/r&d

Research & Development
West Glasgow ACH
Dalnair Street
Glasgow G3 8SW

18 June 2018

Maria Spedsberg

Level 4,
Academic CAMHS,
Yorkhill Hospital,
Dalnair Street,
Glasgow
G3 8SW

Dear Dr Maria Spedsberg,

Letter of Access for Research

This letter confirms your right of access to conduct research through **NHS Greater Glasgow and Clyde** for the purpose and on the terms and conditions set out below. This right of access commences **18/06/2018** and ends on **01/02/2021** unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving permission to conduct the project.

The information supplied about your role in research at **NHS Greater Glasgow and Clyde** has been reviewed and you do not require an honorary research contract with this NHS organisation. We are satisfied that such pre-engagement checks as we consider necessary have been carried out.

You are considered to be a legal visitor to **NHS Greater Glasgow and Clyde** premises. You are not entitled to any form of payment or access to other benefits provided by this NHS organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research through **NHS Greater Glasgow and Clyde**, you will remain accountable to your employer **The University of Glasgow** but you are required to follow the reasonable instructions of **Professor Helen Minnis** in this NHS organisation or those given on her behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with **NHS Greater Glasgow and Clyde** policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with **NHS Greater Glasgow and Clyde** in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care

for the health and safety of yourself and others while on **NHS Greater Glasgow and Clyde** premises. You must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of any other contract holder and you must act appropriately, responsibly and professionally at all times.

If you have a physical or mental health condition or disability which may affect your research role and which might require special adjustments to your role, if you have not already done so, you must notify your employer and the health board's HR department prior to commencing your research role at the Health board.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (<http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf>) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. You must not undertake regulated activity if you are barred from such work. If you are barred from working with adults or children this letter of access is immediately terminated. Your employer will immediately withdraw you from undertaking this or any other regulated activity and you **MUST** stop undertaking any regulated activity immediately.

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

NHS Greater Glasgow and Clyde will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

If your current role or involvement in research changes, or any of the information provided in your Research Passport changes, you must inform your employer through their normal procedures. You must also inform your nominated manager in this NHS organisation.

Yours sincerely

Joanne McGarry
Research Co-ordinator



An Invitation

We would like to invite you to give us your views on the services that you have experienced as part of the *Best Services Trial (BEST?)*. As a parent or foster carer, you are already taking part in the trial and we are very interested in your views about the services (GIFT or FACS) that you have received. If you are a social worker, health professional or children's hearing member, we are very interested in your views about the services in terms of the work you are doing with children and families. Before deciding, it is important that you understand what is being done and why. Please take the time to read the following information. Please phone us (contact number below) if you have any questions.

What is the trial?

In Glasgow, health and social work services are working together to try to improve services for children who come into foster care, and their families. The *Best Services Trial (BEST?)* aims to find out which of two new services that have recently been introduced works best for children's development. One of the new services has already been used successfully in New Orleans, USA, and when it was used there, children's development improved whether they went back to their birth families or remained in foster care. But the USA is very different to Scotland: there is much less of a welfare state and families with difficulties usually don't have access to free healthcare. We think it is very important to find out whether the new service, developed in New Orleans, is any better than our own services when those services work the way they are supposed to. We want to compare the New Orleans service with a streamlined version of the service provided in Glasgow where we employ staff to ensure that families get the services they are entitled to.

Why is the trial important? We want to make sure that the new services in Glasgow are the very best for children and their families.

What is this part of the trial about?

If you are a parent or carer, you have already given consent to take part in the trial. As you will be aware, all families with a child aged 6 months to 5 years who have been referred to Glasgow child care services for foster care are being invited to take part in an assessment of their child's development as the child comes into foster care and also 1 year later. Each family who takes part will be offered either the new version of the service in Glasgow or the New Orleans model. Because we don't know

which will be best, and to be as fair as possible, families will be allocated at random to one of the two new services. This is a bit like tossing a coin.

At this stage of the research, we are also conducting case studies, where we will gather the views of parents, foster carers, health professionals, social workers and representatives from the children's hearing system about a small group of children involved in the trial. The purpose of this will be to compare the experiences of the two different services, to track the journey of children and families through the services and to find out what it is like to be part of either service if you are a parent or foster carer. It is really to gather your views about the services and how they affect you or the work that you are doing.

What would be your involvement?

If you are a parent or foster carer, we are hoping that you would be able to tell us what you think about the service that you are part of, and what it is like from your experience so far. If you are a health professional, social worker or children's hearing representative, we would be looking for your opinions about how the new services are working out and what impact you think they are having on your practice, decision-making and on the children and families you work with. This would involve taking part in a one-to-one interview with the researcher on this study, or taking part in a focus group where this might be more suitable. Because we want to study your views in a lot of detail, so as to inform the development of the new services, we would like to audio-record the discussion that takes place in each group. These audio-recordings would then be transcribed verbatim, but all identifying information (such as names and work-places) will be removed so that you cannot be identified.

How much of your time will this take?

An interview or focus group will take around an hour of your time. Refreshments will be provided and we hope the experience will be rewarding for all involved. We would arrange to meet you at a time and place that is convenient to you.

Confidentiality

All information will be stored according to the Data Protection Act and kept in strict confidence within the research and clinical team, except in the unlikely event of concerns about safety of the child or of others in which case NHS Greater Glasgow & Clyde child protection procedures would be followed.

Do I have to take part?

You do not have to take part in the study and your decision to participate or not participate will not be communicated to anyone outwith the research team. In addition, you are free to withdraw from the research at any time without giving a reason.

Feedback

At the end of the study, we will provide you with a summary of the findings of the study and, if you want more detailed feedback, we will also send you copies of any

published papers.

Any Questions? Please contact our research team on 0141 201 9239 and ask to speak to Helen Minnis.

Consent

► Make sure you understand and are happy with everything about the project before you sign the consent form. If you have any questions, please contact **Dr. Helen Minnis** on:

► **0141 201 9239**

				Please initial box
► I have read and understood the information sheet and have had the chance to ask questions.				
► I understand that I do not have to take part, <u>that</u> I am free to withdraw at any time without giving any reason.				
► I agree to an audio-recording being made of an interview or focus group				
► I am happy to take part in an interview or focus group for the BEST? Study.				
► I would be happy to be contacted for future research studies.				
Name of participant	<u>date</u>		<u>signature</u>	
Name of researcher	<u>date</u>		<u>signature</u>	