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Understanding and measuring psychological consultation with staff working with care experienced young people

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M.A (Hons) Psychology, MSc in Applied Psychology for Children and Young People

Submitted in partial fulfilment of the requirements for the degree of

Doctorate in Clinical Psychology

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Chapter 1 Systematic Review

The experience of receiving psychological consultation within children's social and residential care services: A systematic review of the literature

Prepared in accordance with the author requirements for British Journal of Psychology.
Author Submission Guidelines

Abstract

The overall aim of this review was to systematically review and synthesize the evidence base on the experience of receiving psychological consultation within children's social and residential care services and review it based on its quality. A mixed-methods systematic review was conducted following PRISMA guidelines. Four databases were searched. Seven studies met the inclusion criteria, and their quality was assessed using the Crowe Critical Appraisal Tool (CCAT). Results were synthesised and integrated using a convergent integrated approach. Psychological consultation is viewed as valuable to residential carers and social workers working within children's care services. Three categories were identified as the main functions and outcomes of the consultation experience: 1) accessing independent expertise, 2) developing a new skill, 3) providing a deeper understanding of a young person/family. Three categories were identified that reflect facilitators to the consultation experience, including: 1) provision of a safe space for reflection, 2) the consultant's language, 3) the availability and responsiveness of the consultant. Barriers to the consultation experience were integrated in the following four categories: 1) dedicated time to attending consultation, 2) frequency of consultation, 3) location of consultation, 4) unclear understanding of the role of psychology and purpose of consultation.

Introduction

Due to the increase in the number of referrals to mental health services, consultation is becoming increasingly common as a means of providing intervention to a wide number of people, despite scarce resources (Hibbert & Frankl, 2011). The aim of consultation is to provide a link between psychological theory and practice and is typically defined as working with the system or network around a client to improve the client's psychological wellbeing and outcomes (Dent & Golding, 2006).

Within mental health settings, consultations involve a consultant, consultee and either an issue related to a particular client or a wider work-related problem (Caplan, 1970). In a consultation, the consultant provides guidance and advice, and the consultee then decides whether and how to apply this new knowledge in their own work (Onyett, 2007). Although distinct from clinical supervision, some aspects of consultation are similar to that in supervision, such as the process of reflective practice (Alban and Frankel, 2007). Fredman and colleagues (2018) suggest that the most beneficial model of consultation within mental health settings is a "collaborative consultee-centred" approach, based on the principles of systemic, collaborative, appreciative and narrative models. A systematic review by Ghag and colleagues (2021) identified that cognitive behavioural and cognitive analytic models are the two most frequently used models of consultation within mental health settings. Most studies included in this review explored psychological consultation delivered to other mental health professionals within adult mental health settings, with only two out of the 17 studies exploring consultation delivered from psychologists working within children's mental health services (Ghag et al., 2021).

Psychological consultation is common practice within Child and Adolescent Mental Health Services (CAMHS), particularly from psychology clinicians to staff working within social care services (Dent & Golding, 2006). The interface between CAMHS and social service departments has become increasingly prominent due to care experienced young people (CEYP) being at increased risk of poor mental health outcomes due to the impact of early childhood abuse and neglect, which is often characteristic of the experiences of CEYP before entering care (Tarren-Sweeney, 2017). Maltreatment is also associated with increased risk of having neurodevelopmental disorders (NDDs) such as tics, autism spectrum disorder (ASD) and attention deficit hyperactivity disorder (ADHD)

(Dinkler et al., 2017) and traumatic brain injury (TBI; Gornall & Colleauges, 2021). Furthermore, exposure to maltreatment in childhood has been linked to neurobiological changes which can cause difficulties with cognitive functioning, such as deficits in executive functioning and difficulties with emotion regulation (Matt-Landry et al., 2022).

Considering the complex network of carers and professionals that surround CEYP, consultation can help to create a shared understanding of the young person's difficulties and foster an environment in which the young person feels safe and secure (Dent & Golding, 2006). Furthermore, consultation encourages social workers and residential staff to take a reflective and trauma informed approach to their work, to help them understand the young person's behaviours within the context of their past experiences (Rogers et al., 2011). Although many mental health professionals can provide consultation to staff working with CEYP, Clinical Psychologists are appropriately placed to provide this systemic intervention as their training encourages the implementation of system wide change (Onyett, 2007). Furthermore, delivering psychological theory via consultation to carers and professionals is identified as a core skill required in the training of Clinical Psychologists (British Psychological Society, 2017). In addition, the evidence base for the recovery from maltreatment in CEYP shows that psychological interventions as opposed to pharmacology-based interventions are most appropriate for this population (Rogers et al., 2011). Furthermore, there are instances where direct therapeutic work with a young person in residential care may not be clinically appropriate (Rogers et al., 2011). Therefore, consultation acts as a means of indirectly providing psychologically informed support and intervention when needed, with empirical support for the positive impact of indirect consultation on care experienced young people's mental health (Deuchar and Majumder, 2021).

The theoretical models that underpin consultation to social workers and residential carers differ from those seen within adult mental health settings and are typically based on the principles of Attachment Theory (Draper et al., 2021). Attachment theory posits that early experiences in childhood can impact our understanding of the world and provides a template for future relationships (Bowlby, 1969). Dyadic Developmental Psychotherapy (DDP) is based upon the principles of Attachment Theory and was developed to be used with children who have experienced developmental trauma – trauma experiences that happen early in development and have potential to disrupt relationships (Golding, 2006). DDP is a model that often underpins psychologically based

consultation and focuses on facilitating the relationship between young people and carers (Dent and Golding, 2006).

Staff working within children's social care services are at an increased risk of experiencing secondary trauma compared to staff working within other areas of social work (Armes et al., 2020). Reasons for this include being exposed to children and young people with high levels of child abuse and trauma history and the stressful nature of the work entailed (Armes et al., 2020). Secondary trauma has been found to impact social workers' decision to leave the profession and contribute to feelings of burnout (Quinn et al., 2019). This in turn can have negative consequences for the young people they work with, such as frequent changes in staff and compassion fatigue (Wagman et al., 2015). Factors which have been found to mitigate the impact of burnout and secondary trauma is improved job competency through training and education and higher rates of self-efficacy and empathy (Kulkarni et al., 2013; Wagaman et al., 2015). Due to this, government policies within the United Kingdom, such as Future in Minds (Department of Health, 2015) and The Promise (Independent Care Review, 2021), have highlighted the importance of ensuring that staff who work with CEYP receive specialist training and support to ensure that they are appropriately equipped to meet the needs of this vulnerable population.

Due to the growing evidence base of psychological consultation, there are some factors that have been identified that contribute to the overall success of consultation. For example, the systematic review by Ghag and colleagues (2021) identified that if a consultant is viewed as accessible and skilful by the consultee, this impacts the overall consultation experience. Furthermore, a study by Blinkhorn and colleagues (2021) identified that offering a space for reflection was a key benefit of psychological consultation to probation officers working with adult offenders. There is a growing body of research into the experience of consultation for social workers and residential carers working within children's social care services, with mixed results reported. Some studies found that consultation helps to improve consultees' relationship with young people and improves consultees' confidence (Evans et al., 2011). On the other hand, other studies have identified that consultation can leave consultees feeling confused or anxious about their own competence (Dimaro et al., 2011; Durka & Hacker, 2015).

Despite this growing evidence base, there is not currently an overall understanding of the experience of receiving psychological consultation within children's social care services. In order to make recommendations for psychological consultation in these settings, we would need to understand the existing evidence base. Therefore, the overall aim of this review was to systematically review and synthesize the evidence base on the experience of receiving psychologically informed consultation within children's social and residential care services and review it based on its quality. An additional aim was to identify factors that are helpful in ensuring positive and beneficial experience and factors that may act as barriers to engaging with or benefiting from the consultation. This review provides a greater understanding of consultation within children's social care services and may be beneficial in shaping the implementation, delivery, and evaluation of psychological consultation in those settings.

Research Questions

1. What are the experiences of consultees (social work and residential staff) receiving psychological consultation within children's social care services?
2. What factors/elements contribute to a positive or negative experience of psychological consultation within social care services?

Methods

The PRISMA methodological guidance for systematic reviews was followed (Page et al., 2021). A study protocol was registered with PROSPERO on the 7th July 2023, which can be accessed from the following link: https://www.crd.york.ac.uk/prospero/display_record.php?RecordID=428636.

Search Strategy

An initial scoping search was conducted to identify a relevant research question. A University of Glasgow librarian was consulted in the search strategy development. Thereafter, the following databases were searched on the 10th of October 2023: Cumulated Index to Nursing and Allied Health Literature (CINAHL), PSYCHINFO, Applied Social Science Index & Abstracts (ASSIA), and PubMed. No date restrictions were applied. The following search terms were used:

1. Consultation
2. team-based formulation
3. 1 or 2

4. social work*
5. social service*
6. residential care*
7. looked after
8. accommodated
9. Looked After Children
10. residential staff
11. care experienced
12. residential child?care
13. high?risk youth
14. 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13
15. child*
16. 3 and 14 and 15

Study Selection

All records were imported into EndNote for the removal of duplicates and for screening. Duplicate articles were removed prior to screening. The following criteria were used during the screening and selection process.

Inclusion Criteria

- Studies must have explored the experience of psychological consultation to social work and residential staff working within children's social care services.
- Consultation had to be delivered by a psychological clinician (e.g. Clinical Psychologist or Psychological Therapist).
- Studies need to have explored the experience of receiving psychological consultation from the consultee's perspective, either through qualitative, quantitative or mixed methods approaches.
- Research must be published in English.
- Research must be published in a peer reviewed journal.

Exclusion Criteria

- Studies that do not explore the experience of receiving psychologically informed consultation from the consultee's perspective.
- Studies that are not set in children's social care services.
- Studies not published in English.
- Grey literature

The first phase of screening involved reviewing the title and abstracts of the papers. The second stage involved full text review of the included articles against eligibility criteria to identify the included studies. This process is illustrated in Figure 1. A second reviewer, a Trainee Clinical Psychologist, randomly selected 20% of the articles for title and abstract screening and full text screening to determine whether they met inclusion criteria. Agreement for title and abstract screening was 98.9% and percentage agreement for full text screening was 100%. Disagreements were discussed and decisions were made upon consensus. In addition, a search of all the references of the seven included studies was conducted; this did not yield any additional papers that met inclusion criteria.

Data Extraction and Synthesis

A data extraction tool was developed for this review and can be seen below in Table 1. The primary researcher then extracted the following information from the eligible papers: Author, year of publication, design, aims of the study, participants, sample demographic information (including age, gender, and ethnicity when reported), clinicians providing consultation, consultation model, the frequency of consultation, how consultation was assessed, analytic approach used, and the main findings. The second reviewer randomly selected three of the seven studies and extracted the relevant data to ensure accuracy, with no inaccuracies identified.

To address the aims of this review, a convergent integrated approach was taken to the synthesis as outlined by the Joanna Briggs Institute (JBI) methodology for mixed methods systematic reviews (Stern et al., 2020). Quantitative results were extracted from mixed-methods and quantitative studies and through an iterative process transformed into qualitative stand-alone statements. For example, "97% of participants agreed consultation helped develop new ideas" becomes "consultation helps develop new ideas." This transformed data is then integrated with themes and subthemes that have been directly extracted from the qualitative studies. To identify key components of the consultation

experience and barriers and facilitators, repeated and detailed examination of the pooled data was conducted, and data was clustered into categories based on the similarity of meaning. Through an iterative process of clustering findings, a table of synthesized results was created. To be clustered as a category, the finding had to be present in at least two studies. When findings were unique to individual studies, a descriptive approach was used, whereby the relevant results are summarized and described.

Quality Appraisal

The Crowe Critical Appraisal Tool (CCAT v1.4; Crowe et al., 2013) was used to assess the quality of each of the included studies by the primary reviewer. This tool has been recommended for use in mixed methods reviews and has been found to demonstrate good inter-rater reliability (Crowe et al., 2012). Each of the included studies was scored on a scale from 0-5 across the following eight areas: preliminaries, introduction, design, sampling, data collection, ethical matters, results, and discussion. This resulted in a total score out of 40, with higher scores indicating better quality studies. In accordance with CCAT guidelines, a score of less than 20 (50%) indicates poor quality, between 20-30 (50-75%) is considered moderate quality and 30+ (75% +) is indicative of a high-quality study. The second reviewer randomly selected and reviewed three of the seven studies independently. For two of the studies there was a 100% agreement, however for one study there was discrepancies of one point on two areas which were resolved through discussion and consensus.

Results

The searches were completed on 10th October 2023 and imported into EndNote for the removal of duplicates and for screening. A total of 3238 papers were identified following a search of 4 different databases. Following de-duplication, 416 articles were removed, resulting in 2822 unique references. Using the eligibility criteria, first the title and abstract were screened and papers which clearly did not meet criteria were removed. This then yielded a total of 46 papers for full-text screening. Upon full text screening against the inclusion and exclusion criteria, a total of seven included studies met eligibility criteria. All seven studies were retrieved. This process is illustrated in Figure 1 below.

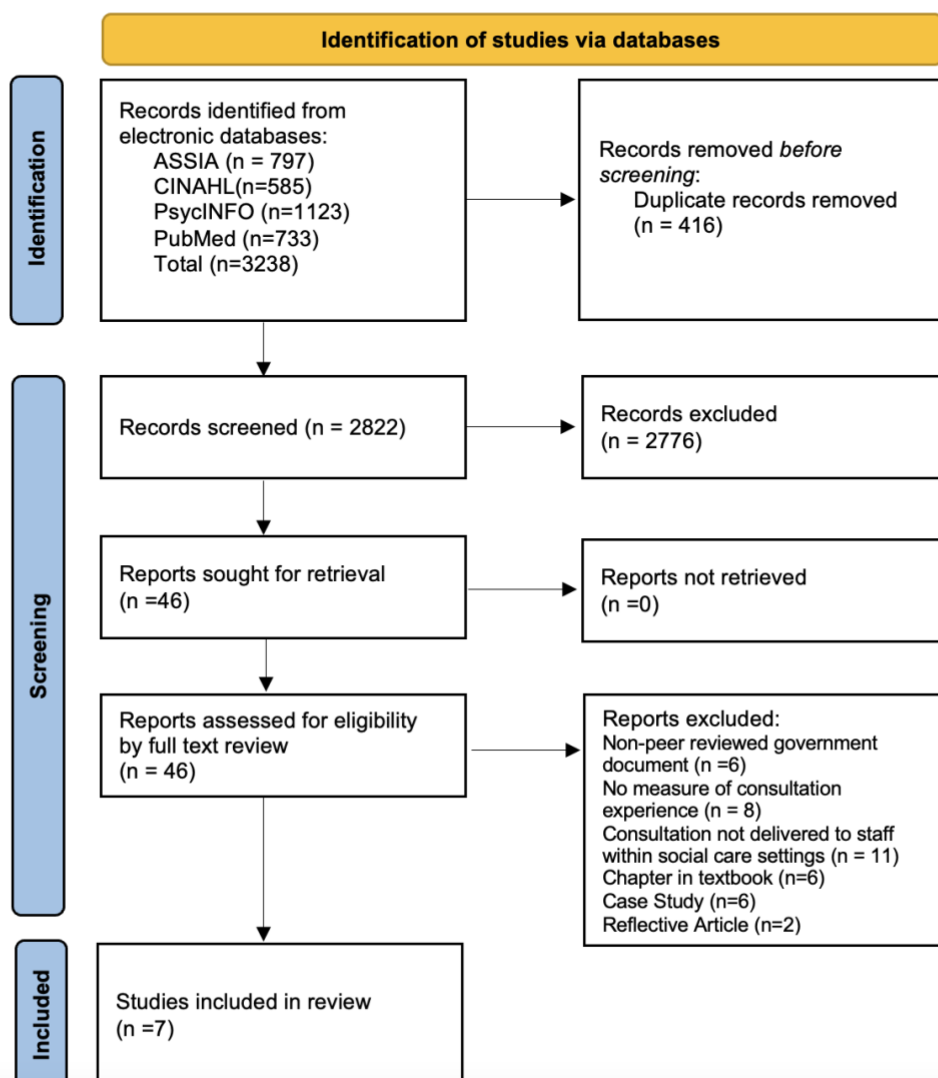

Figure 1: PRISMA Flow Diagram (adapted from Page et al., 2021)

Study Characteristics

Table 1 illustrates key information that was extracted from the included studies, relevant to the aims of this review. Of the seven included studies, all of them were conducted within the United Kingdom, with three of them being conducted in England (Clare & Jackson-Blott, 2023; Dimaro et al., 2014; Hibbert & Frankl, 2011) two in Scotland (Durka & Hacker, 2015; Sproull & Johnson 2023) and two in Wales (Draper et al., 2022; Evans et al., 2014) and were published between 2011 and 2023. Four of the studies were qualitative in design and measured the experience of psychological consultation through semi-structured interviews with participants (Draper et al., 2022; Evans et al., 2011; Sproull & Johnson, 2023.) Two studies were mixed-methods in design (Clare & Jackson-Blott, 2023; Durka & Hacker 2015) and one study utilised quantitative design to measure the experience of

consultation (Dimaro et al., 2022). All the studies that were qualitative in design used thematic analysis to analyse interview data and identify themes.

The total number of participants across the seven studies was 444, with the study by Clare and Jackson-Blott (2023) having a considerably larger number of participants (344) than the other 6 studies. The participants in the studies were predominantly a mixture of social workers and residential carers, except for the study by Clare and Jackson-Blott (2023) that also included early-help residential workers in their sample. This group of participants were defined as voluntary support workers within children's care homes who work within social work services. Demographic information of participants was collected in only three of the studies and this pertained to their gender. Of those studies that reported on gender, there were a total of 12 females and seven males. Draper et al., (2022) was the only study to report on the ethnicity of the participants, as noted in Table 1. No other demographic information was reported in any of the seven studies.

The model that underpinned psychological consultation was reported in four of the included studies. Three studies stated that consultation was based on the principles of attachment theory and the impact of trauma on brain development (Clare & Jackson Blott, 2023; Dimaro et al., 2014; Hibbert & Frankl, 2011). Draper et al., (2022) reported that consultation was based on the principles of DDP which is also theoretically underpinned by attachment theory. The consultants in each study included a Clinical Psychologists, however, three of the studies also included a variety of multi-disciplinary colleagues (Clare & Jackson-Blott 2023; Dimaro et al., 2014; Sproull & Johnson 2023). Five of the included studies reported that all participants had attended at least one consultation previously, with participants in the study by Durka and Hacker (2015) having attended monthly consultation for one year and participants in the study by Hibbert and Frankl (2011) having attended an average of 3.3 consultations in total.

Table 1: Data Extraction

Author Year Country Study Design	Aim	Sample characteristics	Clinicians providing consultation	Consultation Model Frequency of Consultation	Assessment of Consultation	Analysis	Results /outcomes
Clare & Jackson-Blott 2023 UK-England Mixed-Methods	To assess the provision of psychological consultation across community social care and residential care	N=340 social workers, residential carers and early help workers	Clinical Psychologists, Psychiatrist, Assistant Psychologists, Education Advisors	Trauma informed and attachment based All participants had attended at least one consultation Frequency not reported	Pre and post questionnaire Staff rated the impact of consultation on staff confidence, motivation, knowledge and understanding using a quantitative rating scale. Open-ended questions asked for qualitative feedback.	Quantitative: test of normality, non-parametric Wilcoxon Signed Rank Test. Qualitative: Thematic Analysis	**Quantitative Results** • Significant improvements in staff knowledge of the family post consultation (pre Mdn=7, post Mdn=8, W=1088.5, p<.001). • Confidence to work with the family (pre Mdn=7, post Mdn=8, W=2219.5.5, p<.001). • Motivation to work with the family improved (pre Mdn=7, post Mdn=8, W=2474.5, p<.001). **Qualitative Themes** • Enriching Assessments • Developing formulations • Informing interventions • Broadened understanding of the family within psychological models and approaches • Supporting reflective practice and feeling validated

							• The process of consultation • Wanting more time • Wanting to change the content to be more solution focused
Dimaro et al., 2014 UK-England Quantitative	To what extent did psychological consultation meet social workers goals and in what way did it make a difference to social workers.	N= 48 Social workers	Clinical psychologists, specialist social workers, mental health nurses, art psychotherapists and psychiatrist. Each consultation is delivered by two clinicians from different disciplines.	Attachment theory and a trauma informed framework. Frequency not reported	Questionnaire which asked participants to quantitatively rate to what extent their goals were achieved.	Quantitative-descriptive statistical analysis.	**% to which goal was met** • 92% agreed consultation assessing concerns about a child's behaviour or development. • 77% reported an increased understanding the possible effect of a child's experiences. • 78% reported consultation helped to know how to manage a child's behaviour. • 63% largely agreed that it helped consider effect ways to parent/form a relationship with the child. • 83% rated that consultation helped think through what to do next with a child. • 85% rated "time and opportunity to discuss

							relevant issues in depth" positively. • 70% agreed that it clarified their own service practices. • 59% agreed it helped work effectively with staff/agencies and links with local services. • 67% stated it did not help assess contact with family members.
Durka & Hacker 2015 UK-Scotland Mixed-Methods, Sequential	What are the perceived benefits and limitations of consultation? What is the perceived role of the consultant? What are the relevant aspects of the consultation relationship?	Residential Carers N=30 completed the survey in phase 1, N=13 in the interview in phase two.	Clinical Psychologists	Model not reported. Participants had attended monthly consultation for approximately one year	Phase one: Quantitative questionnaire Phase two: Qualitative semi-structured interview	Phase One-Frequency statistical analysis Phase Two-Thematic Analysis	**Positive** • 97% stated consultation was helpful. • 97% developing new ideas and 97% understanding feelings of young people. • 90% agreed that it helped develop a new skill. • 100% staff reported consultation was useful. • 87% were satisfied with consultation. • 97% indicated they would recommend to others. **Negative** • Staff requested more time during consultation. • more frequent consultation Focus Group Themes

							• The value of consultation - confusion about what it can offer and role of Psychologist. • A new way of working- knowing where to signpost and what to do next and developing new skills. • Building the consultation relationship- power dynamic and the consultant not providing solutions.
Draper et al., 2022 UK-Wales Qualitative	Explore how consultation was experiences by social workers and psychologists. Characterise the consultation in terms of the therapeutic models used by psychologists and explore whether social workers find consultation useful	N= 6 social workers. Female N=5 Male N=1 British, 1 Welsh, 1 English, 1 Romanian, 1 British Romanian	Clinical Psychologists	Model was Dyadic Developmental Psychotherapy Frequency not reported	Qualitative, semi-structured interview	Thematic Analysis	Overall found consultation to be useful. Themes **Highly emotive work with scarce resources.** • The scarcity of consultation • Emotionally demanding work **Consultation experienced as valuable despite challenges**. • Provides a safe space for reflection, containment and reassurance. • Broadening consultantees skills • Provides a language for consultantees to explain trauma and attachment.

							• Positioning Psychologists as experts and this as valuable **Challenges** • Lack of time to attend consultation or prepare appropriately.
Evans et al., 2011 UK-Wales Qualitative	Preliminary evaluation of a mental health consultation process	N=6 Residential carers Female, n=4 Male, n=2	Clinical Psychologists	Model not reported. All participants had attended at least one consultation. Frequency not reported	Qualitative, semi-structured interview	Thematic Analysis	Themes **Initiating consultation** • Consultees doubt about their own competencies and feeling a lack of confidence in their abilities. • The dynamic of the consultant-consultee relationship • Preconceptions about consultation and the role of Clinical Psychology **Building the consultative relationship** • Importance of consultant being on the same level and staff feeling familiar with them. • The consultant being perceived as part of the team.

							• The manner of the consultant and them using accessible language that was jargon free. • The availability and responsiveness of consultant created a sense of safety. **Overcoming obstacles** • The environment of consultation impacted their experience-lack of quiet, confidential space. • A lack of time to dedicate to consultation. **Seeing the value of consultation** • Linking theory to the background of young people to help make sense of their difficulties. • Consultation as a method of clarification and validation in decision making processes
Hibbert & Frankl 2011 UK-England Qualitative	How accessible is consultation, does it improve knowledge and understanding, does it improve communication in the network.	N=7 Social Workers	Clinical Psychologists	Model underpinned by attachment theory. Mean number of consultations	Qualitative, semi-structured interview	Thematic Analysis	<u>**Themes**</u> **Ease of Access** • Quick access to psychological support • The comfort of the environment is important. **Support**

				attended, n=3.3, range 1-6. Frequency not reported			• Offering alternative perspectives, • Skill enhancement in consultees • Supportive with decision making and planning. • Support within the wider professional system. • Accessibility of service-provided easier access to specialist support.
Sproull & Johnson 2023 UK-Scotland Qualitative	Social Workers experience of consultation in the context of working with high-risk youth. What elements do they find helpful and unhelpful.	N=7 Social workers Male, N=4, Female, N=3	Forensic Psychologists and CAMHS clinicians	Model not reported. All participants had attended at least two consultations. Frequency not reported	Qualitative, semi-structured interviews	Thematic Analysis	**Helpful Themes** • Value of independent expertise. • Shared understanding/formulation of young person • Safe space where they felt comfortable sharing ideas. **Unhelpful Themes** • Consultee anxiety - concerns about their practice being judged. • Unheard young person-their voice was lost **Mediating Themes** • Feasibility of recommendations-if they were not deemed feasible this would damage the credibility of the consultation as a whole.

Quality Assessment

As shown in Table 2, six studies (Clare & Jackson-Blott, 2023; Dimaro et al., 2014; Draper et al., 2022; Durka & Hacker, 2015; Evans et al., 2011; Sproull & Johnson, 2023)were of “medium” quality, which is an overall score of 50-74% on the CCAT and one study (Hibbert & Frankl, 2011), was deemed to be of low quality, which is an overall score of 35-49% on the CCAT. None of the studies were deemed to be of “good” quality on the CCAT, which requires an overall score of above 75%.

Methodological limitations were present in all studies in relation to the sampling design. None of the included quantitative studies conducted an a-priori calculation to establish the necessary sample size. The studies which employed qualitative design did not provide a justification for the chosen sample size. In the study by Hibbert and Frankl (2011), interviews were conducted over the telephone, and they reported that they lasted on average 10 minutes, which may limit the extent to which their experience of consultation was explored. The three studies that assessed consultation using surveys all had methodological issues (Clare & Jackson-Blott, 2023; Dimaro et al., 2014; Durka & Hacker, 2015), as seen in Table 2. The questionnaires used to assess the experience of consultation had been designed specifically for their studies and there was no exploration of the validity or appropriateness of the measure or the reliability of its scores. Furthermore, Durka and Hacker (2015) only reported a partial list of items participants were asked. Dimaro et al., (2014) asked participants to rate what their goals were pre consultation and how much these had been achieved post consultation. The authors noted issues highlighted by the clinicians who delivered the consultation in which they criticised the questionnaire for being administered too early in the consultation process and wording that was positively biased (Dimaro et al., 2014). In Clare and Jackson-Blott (2023), the full items on the questionnaire were not reported or made available. This study also did not report on what percentage of the participants were employed as either social workers, residential carer or an early year’s helper.

All seven studies scored poorly on ethical issues and possible sources of bias. Dimaro et al., (2014) and Clare and Jackson-Blott (2023) did not report on issues relating to consent, confidentiality or report on ethical approval. Dimaro et al., (2014) also did not report on any conflict of interests. Durka and Hacker (2015) and Evans et al. (2011) both noted that researchers involved in the study were also the clinicians who had delivered the consultation and Sproull and Johnson (2023) reported

that the researcher who interviewed the consultees was a senior manager in the service that the consultees were employed by.

Table 2: Quality Assessment of Studies using the CCAT (Crowe et al., 2013)

Article	Preliminaries	Introduction	Design	Sampling	Data Collection	Ethical Matters	Results	Discussion	Total (%)
Clare & Jackson-Blott (2023)	3	5	2	2	2	1	4	4	23 (55%)
Dimaro et al., (2014)	3	5	2	3	2	0	2	5	22 (55%)
Draper et al., (2022)	4	5	4	1	3	3	4	5	29 (72.5%)
Durka and Hacker (2015)	3	5	2	2	3	4	3	4	26 (65%)
Evans et al., (2011)	4	4	2	3	3	3	3	5	27 (67.5%)
Hibbert & Frankl (2011)	3	4	2	1	2	1	3	3	19 (47.5%)
Sproull & Johnson (2023)	4	5	3	2	4	3	4	4	29 (72.5%)

Synthesis of Results

The key findings from the seven studies can be seen in Table 1. Due to the aims of the studies varying, the aspects of the consultation experience that were measured differed between studies. Most studies assessed and reported on the consultation experience through its perceived outcomes and functions. All the studies found psychological consultation was useful to social work staff working within children's services. For example, Draper et al., (2022) found that all participants in their study commented on the highly emotive nature of working with CEYP and the lack of supervision this staff group received, and how psychological consultation can help support them with this emotionally demanding work. Based on information reported across the seven studies, Table 3 illustrates the main results of the synthesis including the main elements of the consultation experience which included outcomes and functions of the consultation in addition to process-based factors that acted as facilitators and barriers to the consultation experience.

The Consultation Experience in Terms of its Perceived Outcomes and Functions.

There was a total of three outcomes of the consultation process that were reported in two or more studies. As seen in Table 3, the two most common outcomes of the consultation process were "developing skills and new ideas," which was identified in 6 of the studies (Clare and Jackson-Blott 2023; Dimaro et al., 2014; Draper et al.,2022; Durka & Hacker 2015; Hibbert & Frankl 2011; Sproull & Johnson 2023) and "providing a deeper understanding of the young person or family" which was identified in 6 studies as well (Clare & Jackson-Blott, 2023; Dimaro et al., 2014; Draper et al., 2022; Durka & Hacker., 2015; Evans et al., 2011; Sproull & Johnson, 2023). For example, Dimaro et al., (2014) found that consultation increased understanding of the possible effects of a child's early life experiences, and Evans et al. (2011) reported that consultation helped consultees to understand a young person's behaviour in the context of psychological theories. Three studies (Draper et al., 2022; Hibbert & Frankl 2011; Sproull & Johnson 2023). identified that consultation provided the opportunity to have independent expertise and perspectives. For example, social workers positioned psychologists as having "expertise" in the study by Draper and colleagues (2022) and reported that this was valuable when relaying information gained in the consultation process to the families they were working with. Similarly, Sproull and Johnson (2023) identified that social workers consistently referred to the benefits of having "objective independent expertise" as it provided a different perspective to a case. In the study by Hibbert and Frankl, (2011), social workers reported that consultation allowed for a space to get professionals' perspective on a situation which helped with decision making.

Facilitators

Aspects which facilitated the consultation experience were identified across the studies and clustered into a total of three categories. Four studies (Clare & Jackson-Blott, 2023; Draper et al., 2022; Sproull & Johnson 2023) identified that a key beneficial component of consultation was "providing a safe space," which included providing a space for consultees to reflect on their experiences of working with young people and a space where they could be validated and listened to. Characteristics of the consultant were also found to facilitate the experience of the consultation process. For example, "the consultant's language" was a category that was identified in a total of three studies (Durka & Hacker., 2015; Draper et al., 2022; Evans et al., 2011) which impacted the overall experience of the consultation process. Durka and Hacker (2015) found that when consultants used jargon-free language it promoted a sense of collaborative understanding, and the content of consultation was deemed more accessible, whereas Evans et al. (2011) identified that if the language was too scientific it became difficult to understand. Draper et al. (2022) also reported that the language used by consultants was helpful in explaining ideas about attachment and trauma in a way that was easy to understand. The "availability and responsiveness of the consultant" was a category that was present across two studies (Durka & Hacker., 2015; Evans et al., 2011). Both studies found that when the consultant was deemed to be approachable and available when needed, this improved the overall relationship between the consultee and consultant and impacted how supported they felt (Durka & Hacker., 2015; Evans et al., 2011).

Barriers

Barriers to the consultation experience were identified across the studies and clustered into four categories, as seen in Table 3. Four studies (Clare & Jackson-Blott 2023; Draper et al., 2014; Durka and Hacker 2015; Evans et al., 2011). reported that consultees did not have enough time to dedicate to preparing for and attending consultations, despite also finding that the consultation was overall useful. The physical location of the consultation was also identified as a barrier to the consultation experience (Durka & Hacker, 2015; Evans et al., 2011; Hibbert & Frankl.,2011). Some consultees found it a barrier to have consultation sessions in their place of work as they had no private space and would often be interrupted (Durka and Hacker, 2015; Hibbert & Frankl., 2011), whereas Evans et al., (2011) identified that participants in their study preferred consultation to be conducted at their place of work as it made it easier to attend. An additional barrier that was identified by Draper et al., (2014) and Durka and Hacker (2015) was that consultation was not frequent enough. The frequency of consultation was only measured and reported in the study by Durka and Hacker (2015) who reported that residential carers had attended consultation monthly

for approximately one year. Furthermore, two studies found that a lack of understanding of the purpose and role of psychological input and consultation also impacted negatively on the overall consultation experience (Durka & Hacker 2015; Evans et al., 2011).

Summary of Remaining Unique Findings

Two studies (Dimaro et al., 2014; Durka & Hacker 2015), explored whether consultation resulted in a reduction in anxiety in the consultee and presented conflicting results. In the study by Durka and Hacker (2015) almost all the residential carers reported that consultation reduced their anxiety and concern about a young person. In contrast, Dimaro et al (2014) found that two thirds of participants did not agree that consultation reduced their anxiety. Sproull and Johnson (2023) found that social workers worried about being judged and feeling inferior in the context of a hierarchical consultee-consultant relationship and that the consultee level of anxiety could act as a barrier to the consultation process. Furthermore, Sproull and Johnson (2023) was the only study to identify a mediating factor that impacted the consultation experience, which was the perceived feasibility of the recommendations from the consultation. If the recommendations were unrealistic to implement, this impacted the overall credibility of the consultant (Sproull & Johnson, 2023). Clare and Jackson-Blott (2023) assessed consultation using mixed-methods and was the only study to ask participants whether consultation improved consultees' motivation to work with a family, with a significant proportion of participants reporting that it did. Related to this, the majority of participants in Dimaro and colleagues' (2014) study noted that consultation did not help with "assessing/managing contact with family members". Dimaro et al. (2014) was the only study which asked consultees whether the consultation process "helped agencies and staff work together," whether it supported staff in "being able to consider effective ways to parent a child" and whether consultation "clarified their own service practices." Although more than half the respondents agreed consultation helped with the aforementioned areas, these areas were less commonly supported than other aspects of consultation measured in the study, and similar themes were not identified in other studies.

Table 3: Key Categories of the Consultation Process

Main elements of the consultation	Contributing Studies
Outcomes and Function of Consultation	
Independent expertise/perspectives	Draper et al., (2022); Hibbert & Frankl (2011); Sproull and Johnson (2023).
Developing new skills and ideas	Clare & Jackson-Blott (2023); Dimaro et al., (2014); Draper et al., (2022); Durka & Hacker (2015); Hibbert & Frankl (2011); Sproull and Johnson (2023).
Providing a deeper understanding of the young person/family	Clare & Jackson-Blott., (2023); Dimaro et al., (2014); Draper et al., (2022); Durka & Hacker, (2015); Evans et al., (2011); Sproull & Johnson (2023)
Facilitators to the Consultation Experience	
Providing a safe space for reflection	Clare & Jackson-Blott (2023); Draper et al., (2022); Evans et al., (2011); Sproull & Johnson (2023)
The consultant's language	Draper et al., (2022); Durka and Hacker., (2015) Evans et al., (2011)
Availability and responsiveness of consultant	Durka & Hacker., (2015); Evans et al., (2011)
Barriers to the Consultation Experience	
A lack of time for consultees to dedicate to consultation.	Clare & Jackson-Blott (2023); Draper et al., (2014); Durka & Hacker (2015); Evans et al., (2011)
Consultation as not frequent enough	Draper et al., (2014); Durka & Hacker (2015)
The location of consultation	Durka & Hacker (2015); Evans et al., (2011); Hibbert & Frankl., (2011)
Unclear understanding of the role of psychology and the purpose of consultation	Durka & Hacker (2015); Evans et al., (2011)

Discussion

The purpose of this mixed-methods systematic review was to explore social work and residential staff's experience of psychological consultation within children's social care services and identify what factors, if any, consultees found helpful and unhelpful to the consultation process. Psychologically informed consultation to the networks surrounding care experienced young people is increasingly commonplace due to limited resources in CAMHS (Hibbert & Frankl, 2011). This review provides understanding and clarity around how this is experienced by consultees. Across the seven included studies, data synthesis yielded three categories that were reported as main functions and outcomes of the consultation experience, three categories that reflect facilitators to the consultation experience and four categories that reflect barriers to the consultation experience. The findings have both clinical and organisational implications for social work and residential staff within children's care services and clinicians providing psychological consultation.

Overall, this review identified that social work and residential staff working within children's care services experience psychological consultation as useful with notable positive outcomes for staff. The main aspects of the consultation experience identified across studies are categorized in three perceived outcomes and functions of the consultation: 1) developing new skills and ideas, 2) accessing independent expertise and perspectives and 3) providing a deeper understanding of the young person/family. These results are consistent with a study by Blinkhorn et al., (2021) that explored the experiences of managers working with adult offenders with consultation and identified that consultees appreciated access to independent expertise. Supporting staff (social work and residential cares) in developing their skills and expertise in turn helps promote their self-efficacy, which is an important caregiving domain associated with positive outcomes in CEYP (Cherry, 2014). Indeed, a systematic review found that mental health consultation in early education settings improved staff's self-efficacy and their perception of their ability to manage challenging behaviour (Brennan et al., 2008). In addition, category three reflects some of the principles of the attachment-based models of consultation that aim to promote an understanding of the emotional, psychological and developmental impact of maltreatment in CEYP (Dent & Golding, 2006). Having a greater understanding of why a young person or family is behaving in a particular way has been found to improve the overall quality of the relationship between carers and young people in care settings (Rogers et al., 2011). This is also in keeping with the results of a systematic review by Ghag and colleagues (2021) which found that staff had an increased understanding of patients across mental

health services as a result of consultation. Taken together, these three categories can be viewed within two overarching domains: psychological consultation supports the consultees' understanding of the people they are working with and facilitates consultees' own professional development.

Facilitators to the Consultation Experience

This systematic review identified that the relationship between the consultant and consultee is an important factor that can facilitate the overall experience of consultation. The elements that categorise this dynamic include: 1) providing a safe space for reflection, 2) the consultants language, and 3) the availability and responsiveness of the consultant. Taken together, these categories can broadly be understood as the consultant-consultee dynamic. Reflective practice has been identified as an important tool for residential carers and social work staff working with CEYP (Golding and Dent, 2006). Furthermore, Rogers et al., (2011) state that social workers and residential carers should engage in regular reflective practice as it is necessary to support any therapeutic intervention that is being offered directly to a young person. The importance of safety found in this review is in keeping with previous literature which has identified that for effective reflection to occur in social work settings, staff must not fear repercussion about expressing their thoughts and feelings (Ryding et al., 2018). If consultees are anxious about being judged or do not feel safe, this could limit what they are willing to share, and the overall effectiveness of the consultation process as highlighted by findings from Sproull and Johnson (2023). The consultees language was also identified as a factor that can facilitate the consultation experience. This finding has also been evidenced in educational psychology consultation to schools. For example, Newman and colleagues (2015) identified that when psychological consultants used terms such as "we, us and our" during the consultation session, consultees rated the overall collaboration of consultation more positively. Similar to research on psychological consultation in different settings (Murphy et al., 2013), this review identified the importance of personal qualities of the consultant on the overall consultation experience. Nonetheless, consultation is a collaborative two-way process (Caplan, 1970) and psychologists delivering consultation are also faced with competing work demands in their roles, which may impact on their availability and responsiveness. The findings of this review illustrate the importance of consultants being aware of their interaction style and relationship with consultees due to the influence it has on the overall experience of the consultation.

Barriers to the Consultation Experience

This systematic review identified four categories which act as barriers to the consultation experience, these are as follows: 1) limited time for consultees to dedicate to attending consultation, 2) frequency of consultation, 3) location of consultation, 4) an unclear understanding of the role of psychology and purpose of consultation. It is notable that social work and residential staff working within children's services report that they do not have enough time to prepare and attend consultation. Due to the emotionally and physically demanding nature of this work, social care workers and residential carers are particularly vulnerable to experiencing higher levels of burnout which can lead to frequent staff turnover (Maddock, 2023). It is therefore important to explore what factors would allow staff more time to engage in the consultation process due to the benefits for them and the CEYP they work with. Consultation not being frequent enough was highlighted as a barrier, which suggests that consultees find it a valuable resource and would find it beneficial to have it offered to them more frequently. Yet, the frequency of consultation was not consistently measured across the included studies, similar to findings from previous reviews (e.g., Ghag et al., 2021). The physical location of consultation was identified as a possible barrier to the consultation process. Conflicting findings were present, with some studies finding that participants would rather have consultation away from their work and other finding they would rather consultation took place at their work. This suggests that it is important for consultants to explore this with individual staff groups to identify what would be preferable for their needs as inadequate therapeutic space will likely impact feelings of safety to engage meaningfully in the consultation process.

An unclear understanding of the purpose of consultation and clinical psychology was also categorised as a barrier to the consultation process. Clearly defined roles within the team and goals of the consultation process have been identified as important factors in improving the overall experience of consultation, and it is recommended this is contracted at the beginning of the consultation relationship (Caplan, 1970). Furthermore, realistic expectations of what can be offered from consultation has been identified as an important aspect to clarify with consultees, before engaging in consultation, as it can mitigate consultees' feelings of anxiety or frustration (Southall, 2005). These seem to apply to social work and residential staff within children's settings as well and should be taken into consideration when developing guidelines for psychological consultation in these settings.

Implications of Findings

The findings of this systematic review have important implications for research, clinical practice and policy. Firstly, this review has evidenced that psychological consultation is deemed valuable to staff working within children's social work and residential services. This is important given the vulnerability to secondary trauma and bunout of this staff group and the challenges they face when working with CEYP. This review has added to the literature in this area by identifying what elements are considered the key outcomes/functions of psychological consultation to staff working with CEYP. Furthermore, it has also identified what elements facilitate the consultation process and the elements that can act as barriers. Successful psychological consultation is a multi-faceted process that is dependent upon numerous factors, such as the inter-personal skills of the consultant and service level factors, such as staff having enough time to engage in consultation. When psychological consultation is experienced positively, it can change staff's perception of CEYP and increase their skills and expertise in working with them. These factors together will help guide future implementation and evaluation of consultation in this setting. Along with other professionals, Clinical Psychology has expertise within the field of child development, mental health and systemic models of working and therefore can be positioned to support residential carers and social workers working with CEYP. A partnership approach is essential for this type of work and this review has highlighted the importance of collaborative working between the professional groups to maximise the experience of consultation. Although there are likely different types of consultation models that can be offered to residential carers and social workers working with CEYP, and they may have their own unique benefits, this systematic review was specifically focused on psychologically informed consultation, typically with input from Clinical Psychology. This does not take away from other consultations and the role of other professionals in supporting these staff groups.

Future Directions

To further understand the impact of psychological consultation, there needs to be consistency in the measurement of the consultation experience and the reporting of studies within this field. The identification of a standardised measure of the consultation experience would allow for greater consistency in research and could advance the evidence base of this field. This review has identified the key elements that capture the consultation experience, and this could inform the development of a tool to measure the consultation experience.

It is important to consider the findings of this review in the context of the quality of the studies included. None of the studies included were rated as "good" as measured by the CCAT and therefore this limits the generalisability of the findings. The majority of studies did not collect demographic information about participants and did not report how many consultations were attended. There were also issues regarding possible bias in studies due to purposive sampling and the researchers being involved in the delivery of consultation. This could have impacted the responses the consultee gave and impaired their ability to openly reflect on their experience, particularly about any criticisms of the consultation experience. Future research in this field should ensure that the frequency and number of consultations attended is recorded and explore whether this impacts on the overall consultation experience. Notably, all the included studies were conducted within the United Kingdom (UK), and therefore the findings may be limited in terms of generalisability to other countries and contexts. Similarly, all the studies in the systematic review by Ghag and colleagues (2021) which explored consultation within mental health settings, were also all conducted within the UK. It would be important to explore reasons for the evidence base for psychological consultation being UK specific in future work, which could in part be influenced by mental health and social care policy. It is also possible that due to consultation being identified as a key role for Clinical Psychologists by the British Psychology Society (BPS), learning, teaching, and research around consultation within UK-based training programmes is especially prominent (BPS, 2021).

Strengths and Limitations

By design, this study was focussed on psychological consultation and consultation from non-psychologists to social workers and residential carers was not captured. It is certainly likely that other types of consultation from different professions may have their own unique benefits in supporting this staff group. The decision to exclude grey literature may have impacted the scope of this review. Additionally, only studies that were published in English were included which may have meant that valuable research published in other countries has been missed. A strength of this review is the decision to include both quantitative and qualitative methodology, allowing for a greater number of studies to be reviewed and their results synthesized. Further, a second reviewer participated in the screening and selection processes to ensure rigour and accuracy.

Conclusion

This systematic review has highlighted the limited research that has been conducted on social work staff and residential carers experience of receiving psychological consultation within children's social services. Despite the limited research in this field and inconsistencies in the reporting of these studies, this review identified the key elements that capture the consultation experience. It identified three main categories that reflected the functions and outcomes of the consultation experience and several important processes that reflected facilitators and barriers to the consultation experience. These findings are essential for shaping frameworks for psychological consultation within children's care settings and guiding their measurement.

Statements and Declarations

There was no funding associated with this review and the authors have no competing interests to declare.

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Chapter 2 Major Research Project

Measuring Residential Carers' Experience of Psychological Consultation within Children's Homes: Implications for Caregiving

Prepared in accordance with the author requirements for Child Abuse & Neglect.

Author Submission Guidelines

Plain Language Summary

Title: Measuring Residential Carers' Experience of Psychological Consultation within Children's Homes: Implications for Caregiving.

Background: Children who are accommodated in residential homes are at increased risk of poor mental health (Deuchar and Majumder, 2021). Psychological consultation to the systems around care experienced young people (CEYP) is meant to provide indirect support to improve children's mental health. Although consultation is commonplace within this population, there is a lack of empirical research on the benefits of consultation to staff, this is partly due to the lack of a tool to evaluate the consultation process.

Aims and Questions: The main aim was to create a questionnaire which captures the perceived benefits and limitations of consultation for residential carers. The secondary aim was to explore whether the consultation process is associated with improved outcomes on care giver domains which are reflective capacity, self-efficacy and burnout.

Methods: A preliminary tool to measure the experience of receiving psychological consultation, The Experience of Consultation Questionnaire (ECQ), was co-developed with input from Clinical Psychologists who were experienced in delivering consultation. This was done by extensive review of the literature which identified the main aspects of the consultation experience. A total of 22 items were generated and separated into questions that asked about the experience "during the consultation" and questions which asked about their experience as a result of attending the consultation, named the "after consultation" domain. Following on from this, a survey was given to 61 carers who work within residential homes for children in Scotland. The survey included the ECQ and items measuring key care giver domains. The results of this survey were analysed using quantitative methodology, with item and total score summary statistics, correlations and multiple regression analysis.

Main Findings and Conclusions: The ECQ was found to have overall reliable scores. The After Consultation domain of the ECQ was significantly correlated with self-efficacy, even after controlling for levels of work-related burnout. There was no significant association between domains of the ECQ and reflective capacity. This study offers preliminary support for the ECQ as an appropriate tool to assess the experience of psychological consultation. This study provides valuable insight into the experience psychological consultation and its relation to key caregiver domains in residential carers

working with CEYP. Limitations of this study and challenges with conducting research with residential carers is explored.

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Deuchar, S., & Majumder, P. (2021). Mental health services for children in care: investigation to elicit outcomes of direct and indirect interventions. *BJPsych Bulletin*, *45*(5), 264-271.

Abstract

Background: Psychological consultation to the systems around care experienced young people (CEYP) aims to provide indirect support to improve children's mental health. There is limited empirical research on the benefits of consultation, partly due to the lack of a tool to evaluate the consultation experience.

Objective: To develop a tool that captures the multifaceted experience of consultation and to assess its preliminary psychometric properties. The secondary aim was to explore whether the consultation experience is associated with three key caregiving-related domains: reflective capacity, self-efficacy, and levels of burnout.

Participants and Setting: Participants were 61 residential carers working in children's homes across Scotland**.**

Methods: A preliminary tool was developed to measure residential carers experience of psychological consultation. This was done by extensive review of the literature which identified the main aspects of the consultation experience. A total of 22 items were generated and separated into questions that asked about the experience "during the consultation" and questions which asked about their experience as a result of attending the consultation, named the "after consultation" domain. Descriptive statistics were used to investigate the measurement properties of the Experience of Consultation Questionnaire (ECQ). Correlations and multiple regression analysis were used to investigate associations with other domains.

Results: Most item-level responses on the ECQ showed appropriate variation and the ECQ yielded overall reliable scores. The After Consultation domain of the ECQ was significantly correlated with self-efficacy, even after controlling for levels of work-related burnout. There was no significant association between domains of the ECQ and reflective capacity.

Conclusion: This exploratory study offers preliminary support for the ECQ as an appropriate tool to assess the experience of psychological consultation. This study provides valuable insight into the experience psychological consultation and its relation to key caregiver domains in residential carers working with CEYP. Limitations of this study and challenges with conducting research with residential carers is explored.

Keywords: Residential care, psychological consultation, young people

Introduction

A key aspect of child and adolescent psychological services is the provision of consultation to parents, carers and other professionals (BPS, 2021). Consultation is typically defined as working with the system or network around a client to improve the client's psychological wellbeing and outcomes and is especially important when working with care experienced young people (CEYP) (Dent & Golding, 2006). This is because CEYP are at higher risk of experiencing mental health and interpersonal difficulties than the general population (Deuchar & Majumder, 2021) and require supportive systems to mitigate these difficulties. An existing limitation in the literature is the scarcity in studies examining the experience of consultation for carers in residential children's settings and associated clinical outcomes, with a systematic review finding that studies exploring the impact of consultation rarely used valid and reliable measures (Ghag et al., 2021). The main objective of this study was to develop a consultation tool that can be used with carers within residential children's settings and establish its preliminary psychometric properties.

CEYP and Child-Carer Relationship

Research has consistently found that CEYP within kinship, foster or residential care, are at higher risk of poorer mental health outcomes than children who are not involved with the social care system (Turner et al., 2019). This is in part due to early experiences of maltreatment that lead to disruptions in their caregiving system and attachment security (Vasileva & Petermann 2018). Attachment security typically develops in early infancy, with children developing different attachment styles in response to their caregiver's availability and attunement to their physical and emotional needs (Ainsworth, 2015). Secure attachment typically develops when a carer is warm and responsive to an infant's needs and behaves in a predictable manner (Ainsworth, 2015). Secure attachment is characterised by the infant viewing their primary caregiver as a secure base, with the infant showing appropriate distress when separated from their primary caregiver and displaying pleasure when reunited (Ainsworth, 2015). The quality of this carer-infant relationship has been found to impact upon the infant's later socioemotional development (Turner et al., 2019). Therefore, CEYP who have experienced interpersonal trauma are at risk of experiencing disrupted attachment. In addition, maltreated children are at an increased risk of having neurodevelopmental disorders (NDDs) and difficulties (Dinkler et al., 2017). Although having NDDs does not necessarily mean a young person will have poorer outcomes, they have been identified as risk factors for both poorer mental health and physical outcomes if they are not given the appropriate support (Gallant and Good, 2022).

Children who are accommodated in residential settings are at even higher risk of adverse outcomes, including maladaptive coping mechanisms and attachment-related disorders than those accommodated in foster care (Li, et al., 2017). Only 35% of children accommodated in residential settings met the criteria for secure attachment, and they presented with more cognitive impairments and internalising and externalising problems compared to those in kinship care (Vasileva & Petermann; 2016). A systematic review by Wright and colleagues (2019) identified that the quality of the child-carer relationship, within residential settings, plays an important role in impacting physical, cognitive, emotional and behavioural outcomes in CEYP. Furthermore, personal qualities and characteristics of carers within residential settings are among those key caregiving factors that are associated with positive outcomes in CEYP (Porter et al., 2020). Higher quality care is characterised by carer's ability to be warm and sensitive towards children and to engage with them in a developmentally appropriate manner (Porter et al., 2020).

Caring-related factors that impact CEYP recovery.

There are a number of factors that might impact on the child-carer relationship and in turn on CEYP's recovery. CEYP can present with a variety of maltreatment-related interpersonal difficulties that carers may find challenging to manage, and which can act as a barrier to forming quality relationships with carers (Tarren-Sweeney, 2008). Carers' own caregiving system – a set of behaviours that the caregiver displays which ensure the child is looked after and their needs are met (Solomon & George, 1999) – is a key consideration when caring for CEYP. Adult caregiving systems function to provide protection and comfort to a child and to support autonomy in the child (Solomon and George, 1999). The behaviours that a carer exhibits towards a child are expressions of the carer's caregiving security (Bowlby, 1969). These caregiving behaviours impact on the relationship between carer and child, with a study by Virat and Dubreil (2020) finding that adolescents with insecure attachment reported that the availability, accessibility, encouragement and validation of social carers played an important role in strengthening the relationship between carers and young people. Although important, it is recognized that the expectation to consistently engage in these caregiving behaviours presents as a heavy psychological load on carers working within residential children's homes (Virat & Dubreil, 2020).

Key caregiver domains that have been identified in the literature as important factors that positively impact on CEYP's wellbeing and mental health are reflective capacity (Midgley et al.,2021; Pascuzzo et al., 2021) and perceived self-efficacy (Golding, 2019). Parental self-efficacy refers to an individual's belief about their competency and skill in a parenting capacity (Bandura, 1977). Higher

levels of parental self-efficacy have been found to be related to the quality of parenting and level of behavioural problems in children (Hamovitch et al., 2019). Furthermore, high levels of self-efficacy in staff working with CEYP have been associated with increased job satisfaction, increased staff retention and more positive beliefs about their ability to positively influence a young person's life (Cherry et al., 2014). Reflective capacity refers to the ability to understand the internal experiences of oneself and others and has been shown to be integral to sensitive caregiving (Fonagy & Target, 1997). A study by Pascuzzo and colleagues (2021) found that higher levels of reflective capacity in residential carers was associated with lower externalising and internalising behaviours in the youth they supported.

An additional domain that is associated with improved outcomes for CEYP in residential care is staff levels of burnout (Porter et al., 2020). Due to the challenging nature of working with CEYP in residential homes, levels of burnout are elevated in this population, with burnout having been found to impact staff retention and job satisfaction in residential carers (Fong et al., 2022; Poter et al., 2020). Carer burnout has an impact on outcomes for CEYP as burnout is related to both the emotional attunement and availability of carers (Seti, 2008). Furthermore, high levels of staff turnover are disruptive for young people who have already experienced previous breakdowns in key caregiver relationships (Parry et al., 2021). Taken together, levels of staff burnout are an important domain to consider when examining caregiving capacity when working with CEYP in residential settings.

Psychological consultation

Research has shown that consultation with a network of individuals, including carers, social workers and teachers, can positively impact the outcomes for CEYP (Callaghan et al., 2004). This is because children's development and wellbeing is partly contingent on the interaction with the systems that surround them (Bronfenbenner, 1992; Minnis et al., 2024). Psychological consultation can help enhance the quality of the relationship between carers and young people by providing training and support to carers (Callaghan et al., 2004). Furthermore, it can help carers to understand the context surrounding challenging behaviour displayed by CEYP and mitigate challenges posed to their own caregiving security. Empirical findings support the positive impact of indirect consultation on CEYP's mental health (Callaghan et al., 2004; Deuchar & Majumder, 2021), with four domains identified as reflecting the process of successful psychological consultation: "initiating consultation, building the

consultation relationship, overcoming obstacles and seeing the value in consultation" (Evans et al., 2011).

Psychological consultation to residential carers is typically rooted in attachment theory (Draper et al., 2021), social learning theory (Bandura, 1977) and Dyadic Developmental Psychotherapy (DDP) (Hughes et al., 2015). The premise being that the carers' manner of communication impacts on the child's feelings of security and safety, allowing the child to connect emotionally with their carer (Wingfield & Gurney-Smith, 2018). It is expected that focusing on the relationship and communication between carer and child within the consultation process, would impact on their caregiving abilities and practice.

Despite the expected benefits of consultation to carers, caregiving-related outcomes are not routinely collected, and consultation evaluation tools are underdeveloped, limiting our understanding about the consultation experience and its impact on care within residential settings. Dimaro et al. (2014) evaluated the impact of psychological consultation with social workers who supported foster carers. They noted limitations with the overall implementation and wording of items used to assess the consultation as expressed by social workers. In another study, Durka and Hacker (2015) measured the value of consultation as reported by residential carers. However, only some of the items from this tool were published. Furthermore, none of these studies explored the degree to which the consultation experience is associated with key caregiving domains that are important indicators of the consultation's success (i.e., outcome). Overall, there has been preliminary research into whether consultation is beneficial for carers in residential settings with children, however due to underdeveloped tools to evaluate the benefit of consultation, the evidence base is lacking.

Aims and Research Questions

The overall aim of this study was to develop a preliminary consultation tool for residential carers that captures their experience with and perceptions of consultation and assess its preliminary psychometric properties and associations with caregiving-related domains. The primary exploratory research questions are as follows:

Primary Exploratory Research Question

- Does the consultation experience tool yield reliable total and/or subscale scores?
- Is the consultation experience, or specific aspects of the consultation, associated with caregiving-related domains in residential carers?

Secondary Exploratory Research Question

- Is the consultation experience (or specific aspects) uniquely associated with caregiving-related domains in residential carers, after controlling for sociodemographic and work-related factors?

Method

Ethical Approval

Ethical approval was granted from the University of Glasgow's college of Medical Veterinary and Life Sciences (MVLS) ethics committee on March 17th, 2023, project number: 200220207 (Appendix 2). Management approval was obtained from NHS Highland Research and Design on the 18th May 2023 (NHS Highland RD&I Ref: HIGHLAND 1869) (Appendix 4).

Phase 1: Co-development of Experience of Consultation Questionnaire

The first phase involved developing the Experience of Consultation Questionnaire (ECQ). This tool was co-developed with input from two Clinical Psychologists working in the NHS Care Experienced Young People (CEYP) team in NHS Highland, both of whom have considerable experience in delivering psychological consultation to residential carers. Item generation, refinement, and piloting with experts by experience (i.e., residential carers) were conducted as per scale development guidance (Boateng et al 2018).

Initially, relevant domains were identified through literature review and identification of pre-existing measures of psychological consultation. The domains that were identified are the value of consultation, overcoming obstacles, attitudes towards consultation and relationship with consultant, all of which have been found to be associated with successful consultation. The ECQ includes items adapted from pre-existing measures of psychological consultation used by Durka and Hacker (2015)

and Dimaro and colleagues (2014). Additional items were generated by identifying domains that were not appropriately measured in other tools and through discussion with the clinicians in the CEYP who deliver consultation. Both researchers and clinicians contributed to item generation and refinement through a series of online meetings. A final list of 22 items was agreed upon and it was determined that the items were captured by two domains, the experience during the consultation and the experience as a result of the consultation, these were named the “During” and “After” domains of the ECQ. To ensure that the ECQ accurately captured the needs of service users, two residential carers were consulted in the development stage of the tool and with whom the tool was piloted. Their role involved reviewing the items to ensure that the items measured key components of the consultation process from their point of view and to ensure that the language was accessible and free of jargon. The final items used in the research can be seen in Table 1 and can be accessed from the link in Appendix 6. A description of the measure is included in the Measures section below.

Phase 2: Online Survey

Design and Participants

Phase 2 consisted of a cross-sectional observational design with residential staff, utilising a quantitative methodology. Participants were residential staff working in children’s homes run by the Highland Council and Argyll and Bute Council. There are 10 children’s homes run by the Highland Council, with an estimated 100 residential carers employed. There are three children’s homes run by Argyll and Bute Council, with an estimated 45 carers employed across these homes. To increase the number of possible participants, an amendment was made to include the third sector organisations in the research (see Appendix 3 for amendment ethical approval). Third sector participants were from Aberlour Childcare Trust which has seven children’s homes across Scotland and has an estimated 85 members of staff employed as carers. This gave an estimated possible pool of 230 carers. These homes provide residential care to young people between the ages of 7–19 years. Psychological consultation delivered by these services is based on the principles of Attachment Theory (Bowlby, 1969) and DDP (Hughes et al., 2015).

Those participants who were employed by Highland Council and Argyll and Bute Council received psychological consultation from the NHS Highland Care Experienced Team. This team is made up of three Clinical Psychologists, five Psychological Therapists, and two Trainee Clinical Psychologists, all of whom provide consultation. Those staff who were employed by Aberlour Childcare Trust received

their consultation from freelance Clinical Psychologists, one of whom was also the Clinical Psychologist who assisted in the co-development of the tool. The inclusion criteria to complete the online survey was that the participants were over the age of 18, employed as a residential carer in a children's home and had attended at least one previous consultation.

There was a total of 61 participants included in this study, of which 45 were female, 15 were male and 1 person did not disclose their gender. The mean age of the overall sample was 40.68 years (SD =10.88), and the range was from 23-63 years. The approximate number of consultations attended by the overall sample ranged from 1-60, with the mean being 17.5.

Measures

The Experience of Consultation Questionnaire (ECQ). The ECQ was used to assess experience of consultation. The initial questions asked about whether psychological consultation was provided by the NHS or third-party, an estimate of how many consultations had been attended, and whether the frequency of consultation was sufficient. The ECQ is then split into two sections, with seven items related to participants' experience "during the consultation process" and 15 items related to their experience "as a result of the consultation" which is captured as the "During" and "After" domains of consultation. Participants rate how much they agree with statements on a 6-point scale ranging from strongly disagree to strongly agree.

***The Copenhagen Burnout Inventory (CBI*; Kristensen, 2005).** This measure was used to assess levels of burnout in residential carers. This 19 item inventory measures both the physical and emotional exhaustion staff experience across three domains: personal burnout (six items), work burnout (seven items) and client burnout (six items). A total of 12 items have response categories along a five-point Likert scare ranging from "always" to "never/seldom." Seven of the items require participants to rate how much they agree with a statement on a five-point Likert scale ranging from "to a very high degree" to "to a very low degree". Cut-offs for the CBI are as follows; a total score of below 50 indicates low levels of burnout, 50-74 indicates moderate burnout, 75-99 is considered high burnout and a score of 100 is considered severe (Kristensen, 2005). This inventory has been validated for use with child welfare workers (Leake et al., 2017).

***The Brief Parental Self-Efficacy Scale (BPSES*; Woolgar et al., 2013).** Levels of self-efficacy within carers was measured by the BPSES. This short 5 item scale measures self-efficacy and can be used with carers as well as parents and has been used in studies with adoptive parents (Midgely et al., 2018). Respondents rate how much they agree with statements along a 5-point Likert scale ranging from "strongly disagree" to "strongly agree". It has a minimum score of 5 and a maximum score of 25, with higher scores indicative of higher levels of self-efficacy. For this study the word "child" was changed to "young person."

***The Reflective Practice Questionnaire (RPQ;* Priddis and Rogers., 2017).** This measure was used to assess participants' levels of reflective functioning. This 40 item self-report questionnaire was developed to be used in a variety of health and social care settings to measure the reflective capacity of staff who interact with service users/patients. In this present study, the subscales Reflective-in-Action (RiA), which comprises of 4 items assessing participants thoughts, feelings and beliefs about their clients and Reflective-on-Action (RoA) which comprises 4 items assessing the participants' reflections on how the client found the interaction were included in the survey. Participants were asked to rate how much they agree or disagree with a statement on a 6-point Likert scale ranging from "not at all" to "extremely" with higher scores being indicative of higher reflective capacity. The word "client" was changed to "young person" for the purposes of this study.

Procedure

Residential care home managers were informed about the research by the Clinical Psychologists who provided consultation to their staff team. An email was sent to the managers which included the link to the survey and the participant information sheet (Appendix 5), and they were asked to share this with their staff. The main researcher offered to meet with care home managers to discuss the project further if required, and one care home out of the 10 in Highlands opted for this. The area manager for the three homes in Argyle and Bute and the manager for the five homes run by Aberlour both attended a meeting with the main researcher to discuss the project further. Monthly emails were sent over an 8-month period, from both the main researcher and the Clinical Psychologists who provided the consultation, prompting care home managers to share the link with their staff teams.

Qualtrics software was used to administer the online survey (Qualtrics, Provo, Utah, 2023). Participants were presented with the participant information sheet and privacy notice online and provided online consent within the survey. If they did not consent to participate or did not meet the inclusion criteria, the survey would terminate, and no responses would be registered. Those who consented to participate and met the inclusion criteria were then presented with the following questionnaires: the ECQ, CBI, BPES and the RiA and RoA domains of the RPQ (Appendix 6).

Data Analysis

Quantitative analysis was used in this study to examine preliminary psychometric properties of the ECQ and its association with caregiving-related domains. The data were analysed using IBM SPSS Statistics version 29.0.1.0 (SPSS Inc., Chicago, IL USA). To address research question 1, ECQ item-level descriptive statistics including item-level response rates, mean, standard deviation, skewness and kurtosis and internal consistency of the ECQ subscale scores were calculated and reported. Then, the distribution of the total subscale and total scores of all the measures used were visually inspected using histograms and descriptive statistics including mean, standard deviation, and observed range were generated and reported. To answer research question 2, initially scatterplots were visually inspected among pairs of variables to assess linearity. Correlational analysis was used to measure associations among all variables measured, including age, work-related, consultation experience, and caregiving domains. To answer research question 3, Multiple regression was used to test whether the consultation experience is uniquely associated with the caregiving domains of self-efficacy and reflective capacity, while controlling for work-related burnout and gender. Separate multiple regression models were estimated for each of the caregiving domains. A pairwise approach was taken to handling missing data for the correlation and regression models, whereby data available for each pair of variables are retained and used in the analysis.

Sample Size and Power Analysis

This is an exploratory study as there have been no previous quantitative studies which have looked at the association between psychological consultation and caregiving domains. Nonetheless, a priori sample size analysis was conducted using G*Power (Faul et al., 2009) for a correlational analysis. Originally, power was set at 0.8, alpha set at 0.05 and a small to moderate effect size (i.e., correlation) of 0.3, with results indicating that a minimum of 84 participants would be required for

this study. This sample size was not achieved in the current study and therefore post-hoc power analysis was conducted based on the existing sample size. For a sample of 61 participants with an alpha set to .05 and effect size (i.e., correlation) of 0.3 power detected was 0.66. When the effect size estimated is set to 0.35, with the same sample size, power detected was 0.8. The correlation analysis results are supplemented with confidence intervals and small associations (i.e., .30 and below) are interpreted with caution, commenting on strength, direction, and width of confidence interval instead of significance. A post-hoc power analysis was also conducted for the regression analysis used to address the second question. The achieved power detected for an effect size F2 of .02 alpha .05, in a model with three predictors and our existing sample size was 0.82 which is sufficient to run the analysis and interpret the results with confidence.

Results

Research Question 1: Experience of Consultation Questionnaire: Item Level and Total Score Descriptives and Reliability.

Table 1 has the item level descriptive statistics and shows the response rates across the rating scale for each of the items of the ECQ. As displayed in Table 1, at least four of the response categories were used in 14 of the 22 items in the scale. Across the remaining 8 items the response categories of “disagree” and “somewhat disagree” were not used. This may indicate an overall positive experience in relation to these items. For item-level skewness and Kurtosis (descriptive indices of a distribution relative to a normal distribution), acceptable values can range between -3 and +3 for skewness -10 and +10 for kurtosis values (Kline, 2011). Skewness and Kurtosis for all items are within the acceptable range, except for item 18 which has a kurtosis value of 12.58. This means that responses for this item have a heavy-tailed distribution possibly due to extreme values.

Table 1: Item Level Descriptive Statistics for the ECQ.

	Strongly Disagree % (n)	Disagree % (n)	Somewhat Disagree % (n)	Somewhat Agree % (n)	Agree %(n)	Strongly Agree % (n)	Mean	SD	Skewness (z-score)	Kurtosis (z-score)
ECQ- During the Consultation										
1. I feel respected by the facilitators (n=61)	-	-	-	6.6 (4)	20.8 (14)	62.5 (43)	5.64	.61	-1.49	1.17
2. I feel comfortable discussing my concerns (n=61)	-	-	-	14.8 (9)	27.9 (17)	57.4 (35)	5.43	.74	-.88	-.61
3. There is usually enough time to discuss my concerns in depth (n=61)	-	4.9(3)	4.9(3)	18.0 (11)	37.7 (23)	34.4 (21)	4.92	1.09	-1.05	.77
4. I feel I have a space to discuss difficult things (n=60)	-	1.7 (1)	3.3(2)	11.7 (7)	35.0 (21)	48.3 (29)	5.25	.914	-1.35	1.94
5. The language used is usually easy to understand (n=61)	-	1.6 (1)	1.6 (1)	4.9 (3)	39.3 (24)	52.5 (32)	5.39	.80	-1.85	4.95
6. I have space to practice communicating a young person's needs (n=61)	-	1.6 (1)	-	16.4 (10)	32.8 (20)	49.2 (30)	5.28	.86	-1.23	1.93
7. I have a space to reflect on personal and organisational factors impacting my caring capacity (n=61)	-	3.3 (2)	4.9 (3)	9.8(6)	31.1 (19)	50.8 (31)	5.21	1.04	-1.47	1.83

ECQ-As a Result of the Consultation										
8. Staff and other agencies work together in meaningful ways (n=61)	-	1.6 (1)	4.9 (3)	24.6 (15)	41.0 (25)	27.9 (17)	4.89	0.94	-0.66	.32
9. I feel more confident in communicating a young person's needs to other agencies (n=61)	-	3.3 (2)	-	15.0 (9)	46.7 (28)	35.0 (21)	5.10	0.87	-1.37	2.96
10. I have a better understanding of how to apply theoretical knowledge in my work (n=61)	-	-	1.6 (1)	21.3 (13)	50.8 (31)	26.2 (16)	5.02	.741	-.28	-.39
11. I am confident in dealing with challenges that come up at work (n=60)	1.7 (1)	-	-	15.0 (9)	51.7 (31)	31.7(19)	5.10	.86	-1.86	7.53
12. I think about ways of doing things differently at work (n=60)	-	-	-	10.0 (6)	48.3 (29)	41.7 (25)	5.32	.65	-.42	-.67
13. I feel less stuck when challenging situations come up at work (n=61)	-	-	1.6 (1)	21.3 (13)	50.8 (31)	26.2 (16)	5.02	.74	-.28	-.39
14. I know what to do next to support the young people I care for (n=60)	-	-	-	20.0 (12)	58.3 (35)	21.7 (13)	5.02	.65	-.02	-.55
15. I have gained practical solutions to handle difficult situations at work (n=61)	-	-	1.6 (1)	24.6 (15)	37.7 (23)	36.1 (22)	5.08	.82	-.34	-.55
16. I am able to contain the distress a young person experiences (n=60)	-	-	-	30.0 (18)	53.3 (32)	16.7 (10)	4.87	.67	.17	-.94

17. I am able to provide a safe space whilst a young person is in distress (n=60)	-	-	-	8.3(5)	65.0 (39)	26.7 (16)	5.18	.57	.02	-.08
18. I understand the relational safety and security needs of the young people I support (n=61)	1.6 (1)		-	4.9 (3)	52.5 (32)	41.0 (25)	5.03	.80	-2.59	12.58
19. I understand how a young person's past experience may influence their current relationships (n=60)	-	-	-	3.3 (2)	25.0(15)	71.7 (43)	5.68	.54	-1.47	1.31
20. I am confident in my caring abilities (n=61)	-	-	-	1.6 (1)	39.3 (24)	59.0 (36)	5.57	.53	-.65	-.86
21. I approach my work differently than I used to (n=60)	-	-	3.3 (2)	25.0 (15)	40.0 (24)	31.7 (19)	5.00	.84	-.35	-.72
22. I have an increased understanding of the young people that I care for (n=61)	-	-	3.3 (2)	6.6 (4)	34.4 (21)	55.7 (34)	5.43	.76	-1.37	1.75

Note. - Indicates no endorsement in that response category.

Reliability of the ECQ scores was measured using McDonalds Omega co-efficient (McDonald, 1999). During consultation and after consultation scores had strong internal reliability .90 and .89 respectively. When the reliability of the scores was further examined by deleting items sequentially to assess whether reliability of the score would improve upon the removal of specific items, the reliability did not improve, suggesting that all items are worthy of retention.

Histograms to inspect the distribution of subscale scores were visually inspected. The During Consultation score was slightly negatively skewed whereas the After Consultation score looked approximately normally distributed. None of the scale scores showed evidence of floor effects (i.e., having the minimum possible score on a scale) however there was evidence of a ceiling effect in the During Consultation score. Ceiling effect is observed when participants score the highest possible value on a test/measure. In other fields of research, studies have defined a ceiling and floor effect as 15% or more of participants scoring either the minimum or maximum on a scale (Lim et al., 2015). In this sample, 51% of the participants scored the maximum total During Consultation score, which means that this domain likely cannot accurately differentiate between high scoring participants (i.e., those reporting extremely positive experience during consultation).

Research Question 2: Descriptive Statistics and Correlations Among all Variables

Table 2 shows descriptive statistics for each variable for the overall sample of participants as well as separated by those carers who received NHS based consultation and those that received private based consultation. Based on established cut-offs, the levels of burnout in the sample of residential carers was characterized. For personal burnout 39.1 % of participants scored in the moderate range and 8.5% were within the high range, for work related burnout, 34.5 % of participants were within the moderate range and 1.7% were within the high range and only 4.8% of participants scored within the moderate range for client related burnout. When divided by group, those carers who received consultation via the NHS rated high levels of work-related burnout, with 54.2% being within the moderate range and 4.2% in the high, compared to those carers employed by private homes, where 22.3% were in the moderate range and none scored within the high range. For personal burnout, scores were high in carers who received consultation from the NHS, with 45.8% within the moderate range, 12.5% in the high range, compared to carers in private homes, where 34.4% scored within the moderate range and 5.7% were within the high range. Neither group scored within the high category for client burnout. Of staff who received NHS based consultation, 12.5% scored moderately for client burnout compared to 2.9% of carers in privately run homes.

Regarding the frequency of consultation, 82% of the total sample rated the frequency as “about right” and 18% stated that consultation was “not frequent enough.” When broken down by group, carers who received consultation by NHS clinicians, 33.3% of those carers who received consultation from NHS clinicians rated consultation as not frequent enough, compared to only 8.1% of carers who received consultation from private sector clinicians.

Table 2: Descriptive Statistics of Key Variables

	Total Sample				NHS Based Consultation				Private Based Consultation			
Variable Name	N	Mean	SD	Range	N	Mean	SD	Range	N	Mean	SD	Range
Approximate Consultations Attended	59	17.15	14.63	1-60	24	14.75	13.73	1-50	35	18.80	15.19	1-60
During Consultation	60	37.2	4.76	19-42	24	38.25	4.17	30-42	36	36.50	5.06	19-42
After Consultation	60	77.67	6.94	61-90	24	79.33	6.77	70-90	36	76.56	6.92	61-90
Personal Burnout	59	276.27	101.18	50-450	24	298.96	90.13	125-450	35	260.71	106.46	50-450
Work Related Burnout	60	295.83	111.91	50-550	24	337.50	112.53	125-550	36	268.06	103.96	50-475
Client Related Burnout	59	128.81	88.43	0-325	24	162.50	97.52	0-325	35	105.71	74.53	0-300
Self-Efficacy	59	20.07	2.12	15-25	24	20.21	1.56	18-25	35	19.97	2.44	15-25
RIA	60	18.67	3.78	8-24	24	18.5	3.86	8-24	36	18.78	3.78	12-24
ROA	59	20.81	2.46	14-24	24	21.13	2.38	17-24	35	20.60	2.52	14-24

The relationship between consultation experience (During and After domains) and key caregiving domains, age, number of consultations, and burnout factors were explored using Pearson correlations, as displayed in Table 3. Upon visual inspection of the scatterplots, no issues with linearity were observed. The three domains of burnout were moderately to strongly positively correlated with one another ranging between r =.39 and r =.74, all *ps* < .01, meaning that higher levels of burnout in one domain are associated with higher levels in other domains. The two domains of reflective capacity, RIA and ROA, were also moderately to strongly positively correlated with one another, *r*=.47, *p*<.01, meaning higher reflective capacity in one domain is associated with higher capacity in the other domain. Self-efficacy was moderately positively correlated with After Consultation score, *r*=.38, *p*< .01, meaning that higher levels of self-efficacy were related with higher scores on the After Consultation domain. The remaining correlations are of a small to moderate effect size (.30 and below), and this study is not well powered to detect significance for such values. All associations appear in the direction expected albeit small. Of those, there are some notable correlations between self-efficacy and ROA (r = .25, CI [-.43, .06], p > .05), client burnout (r =-.26, CI [-.49, .00], p >.05), and number of consultations attended (r=.28, CI [-.02, .50], , *p* < .05). The ECQ During Consultation and After Consultation scores had small correlations with all other variables with wide confidence intervals as shown in Table 3.

Table 3: Correlation Matrix with confidence intervals

Variable Name	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.
1.During Consultation	1									
2.After Consultation	.59** .40, .74	1								
3.Personal Burnout	-.17 -.41 .09	-.09 -.34 .17	1							
4.Work Burnout	-.12 -.37 .14	-.16 -.40 .10	.74** .60 .83	1						
5.Client Burnout	-.05 -.30 .21	-.11 -.35 .15	.39** .15 .59	.58** .38 .73	1					
6.Self-efficacy	.18 -.08 .41	.37** .12 .57	.01 -.25 .25	.01 -.25 .26	-.26 -.49 .00	1				
7.RIA	.13 -.13 .37	.19 -.07 .43	-.00 -.26 .25	-.06 -.31 .20	-.18 -.41 .08	.16 -.10 .40	1			
8.ROA	.05 -.21 .31	.14 -.13 .38	.11 -.15 .34	.08 -.18 .33	-.20 -.43 .06	.25 -.00 .48	.47** .24 .65	1		
9. Age	.19 -.70 .43	.12 -.14 .36	.10 -.16 .35	.08 -.18 .33	.17 -.10 .41	.16 -.11 .40	-.041 -.29 .22	.16 -.10 .40	1	
10. No. Consultations Attended	.13 -.14 .37	.15 -.11 .39	.00 -.26 .260	.04 -.22 .30	-.02 -.28 .24	.28* .02 .50	.07 -.19 .32	.15 -.12 .40	.05 -.21 .30	1

** Correlation is significant at the 0.01 level (2-tailed)

* Correlation significant at the 0.05 level (2-tailed)

Note. With this sample size and an alpha level of .05 the achieved power detected is .80 with correlations of .35.

Research Question 3: Multiple Regression

The unique association between the consultation experience (During Consultation and After Consultation domains) and self-efficacy and reflective capacity were explored using multiple linear regression, while controlling for the effect of gender and work-related burnout[1]. As seen in the correlation table, there were no concerns about multicollinearity among the predictor variables. As seen in Table 4, after consultation was uniquely and significantly correlated with self-efficacy, with a moderate effect: $b= .38$, $t\ (56) =2.92$ $p<.01$. There were no other unique associations detected between the domains of consultation experience and caregiving domains.

[1] Although not part of the a priori hypothesis, client burnout was a stronger correlate with self-efficacy, RIA and ROA domains than work burnout. Therefore, the same regression models were run while controlling for levels of client burnout instead of work burnout, however, the results remained the same.

Table 4: Multiple Linear Regression

	Unstandardised B	Standardised beta	SE	P value	95% CI for B	
					LL	UL
Outcome: Self-efficacy						
Model 1						
Gender	.19	.04	.69	.79	-1.21	1.58
Work burnout	.00	.04	.00	.79	-.01	.01
During consultation	.08	.18	.06	.19	-.04	.20
Model 2						
Gender	-.19	-.04	.66	.78	-1.52	1.14
Work burnout	.00	.06	.00	.67	-.00	.01
After consultation	.12*	.38	.04	.01	.04	.20
Outcome: ROA						
Model 1						
Gender	.24	.20	1.21	.16	-1.39	1.88
Work Burnout	.00	.01	.01	.94	-.00	.01
During Consultation	.04	.14	.11	.32	-.11	.18
Model 2						
Gender	.07	.01	.82	.93	-1.57	1.72
Work Burnout	.00	.11	.00	.45	-.01	.01
After Consultation	.05	.15	.82	.29	-.50	.15
Outcome: RIA						
Model 1						
Gender	1.75	.20	1.21	.16	-.69	4.18
Work Burnout	.00	.02	.01	.94	-.01	.01
During Consultation	.11	.14	.11	.32	-.11	.32
Model 2						

Gender	1.43	.16	1.23	.25	-1.02	3.90
Work Burnout	.00	.01	.01	-.95	-.01	.01
After Consultation	.09	.16	.07	.25	-.06	.23

Discussion

In this study, a preliminary tool was developed to evaluate residential carers' experience of psychological consultation within residential settings for CEYP, focussing on the experience during and after consultation, and assessed its preliminary psychometric properties and associations with key caregiving and work-related domains. Overall, this exploratory research advances the study of psychological consultation by offering an accessible tool with preliminary support for the reliability of its scores. Furthermore, the results speak to the association between the consultation experience and key caregiving outcomes, especially the domain of self-efficacy. Implications for caring practices with CEYP are discussed.

The ECQ yielded overall reliable scores for both During and After consultation domains and all items in the ECQ were found to be worthy of retention. There was no evidence of a floor effect in the During Consultation domain of the ECQ, however there was evidence of a ceiling effect. Ceiling effects occur when a considerable proportion of the participants score the highest possible rating on a scale, limiting the ability of the tool to distinguish meaningful differences between those participants who score at the higher end (Lim et al., 2015). A possible reason for finding this ceiling effect might be that this domain captures variation primarily as a result of carers' experience of the consultant (e.g., how respectful they perceived the consultant to be, how comfortable the consultant made them feel and whether the consultant used easy to understand language). Therefore, it is encouraging that the carers have rated the consultants highly on this domain and could reflect the overall positive relationship the participants in this study have with the clinicians' providing consultation. It also may be the case that when the clinicians are consistent across the consultation sessions, there will be little expected variation if they consistently offer high quality sessions. This may

differ when using this tool across other health boards or regions, whereby consultations would be offered by a larger number of clinicians and possibly capture wider variation in session experience.

There was no evidence of ceiling or floor effects in the After Consultation domain of the ECQ, suggesting that the tool has the potential to reliably measure wide variation in experiences after consultation. This domain of the ECQ measures carers' perception of their ability to apply the knowledge and skills gained during consultation in their caring practice. Specifically, it assesses how well the consultation has supported them in understanding and responding to young people's behaviours and distress and in connecting these psychological reactions to their attachment history. This domain has important implications for caregiving practices and is expected to show more variation than the During Consultation domain as it is expected to be more dependent on carers than consultants, especially in carers making the link between the consultation and their practice.

Burnout was prevalent within this sample, with higher rates of burnout observed in the carers in local authority run homes than carers in third sector run homes. However, overall, levels were lower than rates reported in previous research with residential carers in children's homes (Seti, 2008; Parry et al., 2021). Only a small proportion of the participants scored within the "high" range of burnout in the work and personal domains. Regarding client burnout, no participant scored within the high range and only a small proportion scored within the moderate range. This means that this sample of participants do not report burnout from their interactions with CEYP. Nonetheless, there are aspects of their work that contribute to moderate feelings of work burnout and with some to high levels of work-related burnout. This is in keeping with the findings from Leake and colleagues (2017) which explored burnout in 2302 child welfare workers using the CBI and identified that staff are more likely to attribute burnout to work related factors, rather than client related. When examining associations between the burnout domains and experience of consultation and key caregiving domains, for the most part correlations were small with wide confidence intervals. The correlation between levels of client burnout and self-efficacy, however, indicates that there is a negative relationship between the two variables. This is consistent with what we know about the challenges of working with CEYP and the protective impact of self-efficacy in carers.

Overall, the results build on previous work indicating that burnout is prevalent in residential carers, but that this is not necessarily due to working with CEYP and may be because of "agency related factors" (Leake et al., 2017), including lack of managerial support or negative work culture. The observed differences in levels of burnout reported by carers working with local authority homes and those working within private/third sector run homes require further research to properly examine differences and understand the possible factors that may contribute to these differences.

When examining the associations between the experience of consultation and the caregiving domains of self-efficacy and reflective capacity, self-efficacy was found to be positively associated with the After Consultation domain. This association remained even when controlling for levels of work-related burnout and gender in the multiple regression model. Further, the number of consultations received was also positively moderately associated with levels of self-efficacy. Self-efficacy is an important domain of caregiving, with higher levels of self-efficacy in foster carers being related to improved wellbeing of CEYP (Golding, 2019). It has also been shown to have protective effects by mediating the effect of challenging behaviour displayed by young people on the emotional wellbeing of foster carers (Morgan & Baron, 2011). To the authors knowledge, this is the first study which has evidenced the link between psychological consultation and self-efficacy in residential carers. It would be valuable for consultants delivering psychological consultation to assess self-efficacy in carers as an important caregiving outcome. This finding adds to the evidence base that psychological consultation may have indirect benefits to CEYP outcomes by supporting caregiving, however, further research is required to explore this association further as no causal inferences can be made from this study.

Collaborative reflection is considered a key component, and therefore an expected outcome domain, of psychological consultation to social work services supporting CEYP (Dent and Golding, 2006). Despite this, there was no association found between levels of reflective functioning in residential carers and the domains of consultation experience in this study. Dimaro and colleagues (2014) evaluated psychological consultation to social workers supporting CEYP and found that 62% of the 48 participants reported that the purpose of consultation was to facilitate reflection on their own practice. Similarly, "supporting reflective

professional practice" was identified as a key beneficial theme of psychological consultation, as reported by social workers, in a study by Clare and Jackson-Blott (2022). While these studies explored views of reflective practice in consultation, they did not measure reflective capacity to determine whether it is associated with the consultation experience. It may be that the carers in this study valued the space for reflection, however, due to a variety of factors, such as already being highly reflective, this did not translate to an association between consultation and reflective capacity. Reflective practice is one of the core components of social work (Ferguson, 2018), and therefore it may be that the carers in this study routinely thought about their own mental states and the mental states of the young people they were working with and how this may impact on their behaviour. Given the evidence that reflective capacity is associated with important aspects of caregiving behaviour, including higher sensitivity, increased understanding of challenging behaviour and overall higher quality of the carer-child relationship (Parry et al., 2021; Pascuzzo et al., 2021), it is still an important quality to assess and support in residential carers working with CEYP.

Limitations and Future Directions

There are several limitations with the present study. This is a preliminary study with exploratory analysis, no causal inference can be made from correlational and cross-sectional analysis and therefore the findings would benefit from being explored further with prospective designs. The small sample size due to low survey response rates, meant that the study was underpowered to detect significant correlations of .30 and smaller. Further, the sample size limits the representatives of the sample, especially to carers receiving consultation through other health boards. Nonetheless, this study has one of the higher sample sizes compared to other published research with this population (see Chapter 1). For example, Durka and Hacker (2015) had 34 residential carers complete their survey, and Evans and colleagues (2011) had 6 residential carers in their study. There was an estimated participant pool of 145 residential carers who receive psychological consultation from NHS Highland and approximately 85 carers employed by the third sector charity approached within this study for recruitment. Despite multiple pathways to recruitment extended over an eight-month period, which included monthly reminder emails sent to care home managers, attending care home team meetings both in person and online to explain the rationale of the study and regular reminders from the Psychologists who provided the consultation, recruitment proved challenging. Several care homes were also nonresponsive. Therefore, it is concluded that recruitment is a challenge for research within this field and is worthy of re-

evaluation through participatory and partnership approaches to understand barriers and facilitators to engagement in research.

It is important to ensure that the consultation that is being provided to this staff group is effective and rooted in evidence and to do so we need to be able to measure and assess the impact of consultation. This is in keeping with relevant policies such as “The Promise” (Independent Care Review, 2020), which identified the need for significant change in residential care through five priority areas, one of which being supporting the workforce around CEYP. However, it is critical to consider how feasible it is to conduct research with this staff group due to difficulties with recruitment in research. Cyhlarova and colleagues (2020) conducted a methods review to explore the challenges in recruiting participants for adult social care studies. They identified that one of the main barriers was that each organisation within social care had different organisational structures and many lacked the capacity to be able to allow staff time to commit to research. They also found that organisations may gatekeep possible research from participants due to not understanding how the research would benefit both individuals and the wider organisation (Cyhlarova et al., 2020). This review identified several factors that could improve engagement, including: providing participants with a financial incentive to participate in research; ensuring that researchers build adequate relationships with potential research sites; involving research sites throughout the research design process; reporting recruitment difficulties so that future research can try to mitigate them (Cyhlarova et al., 2020). Although this review was not specifically related to residential carers working within CEYP settings, it is possible that the barriers to recruitment could be similar due to similarities in staffing groups and thus worthy of considering in future research in such settings. It is vital to ensure consultation provided to residential carers is collaborative and viewed as a partnership between consultants and consultees as this will likely not only improve the overall consultation experience, but also encourage residential carers to participate in research.

The structure of residential homes within Scotland can vary, ranging from individual homes with one child, to much larger residential homes which care for many children. There has been an 133% increase in the number of private sector providers of residential care within Scotland, increasing from 61 in 2010 to 142 in 2020, whereas the number of local authority care homes

has remained relatively stable during this time (Scottish Social Services Council, 2022). Overall, there has been an increase of 16% in the workforce of residential carers within Scotland from 2010 to 2020 (Scottish Social Services Council, 2022). The aim of this present study was not to compare psychological consultation delivered by NHS clinicians and that delivered by privately employed psychologists, however it is interesting to note that in this study, 33.3% of carers who were employed by local authority homes reported that they did not think consultation was frequent enough compared to only 8.1% of carers employed by private sector homes. This could suggest that NHS clinicians are not able to provide as frequent consultation as privately employed clinicians and/or that staff in local authority care homes are not able to attend as frequently. If residential carers do not have enough protected time during their working day to attend consultation sessions it could further compound the difficulties with researching the effectiveness of consultation with this staff group. Due to the large increase in privately run children's homes across Scotland, comparisons across these groups of carers is an area that could be explored further in future research.

Conclusion

It is important to improve the evidence base of psychological consultation to the systems around CEYP, given the vulnerability of this population to adverse outcomes. To do this, this exploratory study has developed a preliminary tool to evaluate residential carers' experience of psychological consultation within residential settings that is short and freely available. Reported burnout levels were generally highest within the work domain, and even when taking those into account, self-efficacy remains an important caregiving outcome to consider in relation to the consultation experience. Future research is needed to further examine the exact role of the consultation experience in carers' reflective capacity.

Statements and Declarations

There was no funding associated with this study and the authors have no competing interests to declare.

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Appendices

Appendix 1: PRISMA Checklist

PRISMA 2020 Checklist

Section and Topic	Item #	Checklist item	Location where item is reported
TITLE			
Title	1	Identify the report as a systematic review.	Page 7
ABSTRACT			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	Page 8
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	Pages 9-11
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	Pages 12
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	Page 13-14
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	Page 12
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	Pages 13-14
Ge	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.	Pages 15-16

Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	Page 16
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	Pages 16, 20-26
	10b	List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	Pages 20-26
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.	Page 16-17
Effect measures	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	N/A
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)).	Page 16
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions.	Page 16
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	Page 16
	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	Page 16
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression).	N/A
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.	N/A
Reporting bias assessment	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	Pages 16-17
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	N/A

PRISMA 2020 Checklist

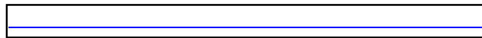
Section and Topic	Item #	Checklist item	Location where item is reported
RESULTS			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	Pages 17-18
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	N/A
Study characteristics	17	Cite each included study and present its characteristics.	Pages 20-26
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	Pages 27-28
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	Pages 20-26
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	Pages 27-32
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	N/A
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	N/A
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	N/A
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	Page 28
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	N/A
DISCUSSION			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	Pages 33-35

	23b	Discuss any limitations of the evidence included in the review.	Pages 36-37
	23c	Discuss any limitations of the review processes used.	Page 37
	23d	Discuss implications of the results for practice, policy, and future research.	Page 36-37
OTHER INFORMATION			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	Page 14
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	Page 14
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	In protocol
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review.	N/A
Competing interests	26	Declare any competing interests of review authors.	Page 37
Availability of data, code and other materials	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	Pages 20-26

From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71

For more information, visit: http://www.prisma-statement.org/

Appendix 2: Ethical Approval



Ethical Approval form removed due to confidentiality issues

Appendix 3: Ethical Approval for Amendment

Ethical approval for amendment removed due to confidentiality issues

Appendix 4: NHS R&D Approval

TEMP009 Version 7   April 2023

Headquarters: Assynt House, Beechwood Park, INVERNESS IV2 3BW

Chair: Sarah Compton-Bishop
Chief Executive: Pam Dudek

NHS R&D Approval removed due to confidentiality issues

Appendix 5. Participant Information Sheet

Accessible from this link: https://osf.io/wa2m7

Appendix 6: Copy of Survey

Accessible from this link: https://osf.io/c5mxz

Appendix 7. Final Approved Major Research Project Proposal

Accessible from this link: https://osf.io/ye7jc

Appendix 8: STROBE Checklist

STROBE Statement—checklist of items that should be included in reports of observational studies.

	Item No	Recommendation	Page No
Title and abstract	1	(*a*) Indicate the study's design with a commonly used term in the title or the abstract	45
		(*b*) Provide in the abstract an informative and balanced summary of what was done and what was found	45
Introduction			
Background/rationale	2	Explain the scientific background and rationale for the investigation being reported	46-49
Objectives	3	State specific objectives, including any prespecified hypotheses	49-50
Methods			
Study design	4	Present key elements of study design early in the paper	50
Setting	5	Describe the setting, locations, and relevant dates, including periods of recruitment, exposure, follow-up, and data collection	53
Participants	6	(*a*) Give the eligibility criteria, and the sources and methods of selection of participants	51
Variables	7	Clearly define all outcomes, exposures, predictors, potential confounders, and effect modifiers. Give diagnostic criteria, if applicable	48-51
Data sources/ measurement	8*	For each variable of interest, give sources of data and details of methods of assessment (measurement). Describe comparability of assessment methods if there is more than one group	50-53
Bias	9	Describe any efforts to address potential sources of bias	53
Study size	10	Explain how the study size was arrived at	54

Quantitative variables	11	Explain how quantitative variables were handled in the analyses. If applicable, describe which groupings were chosen and why	54
Statistical methods	12	(*a*) Describe all statistical methods, including those used to control for confounding	55-66
		(*b*) Describe any methods used to examine subgroups and interactions	55-66
		(*c*) Explain how missing data were addressed	54
		(*d*) If applicable, describe analytical methods taking account of sampling strategy	
		(*e*) Describe any sensitivity analyses	
Results			
Participants	13*	(a) Report numbers of individuals at each stage of study—eg numbers potentially eligible, examined for eligibility, confirmed eligible, included in the study, completing follow-up, and analysed	55-66
		(b) Give reasons for non-participation at each stage	N/A
		(c) Consider use of a flow diagram	N/A
Descriptive data	14*	(a) Give characteristics of study participants (eg demographic, clinical, social) and information on exposures and potential confounders	51, 54
		(b) Indicate number of participants with missing data for each variable of interest	55-66
Outcome data	15*	Report numbers of outcome events or summary measures	56-58
Main results	16	(*a*) Give unadjusted estimates and, if applicable, confounder-adjusted estimates and their precision (eg, 95% confidence interval). Make clear which confounders were adjusted for and why they were included	64-66
		(*b*) Report category boundaries when continuous variables were categorized	

		(*c*) If relevant, consider translating estimates of relative risk into absolute risk for a meaningful time period	N/A
Other analyses	17	Report other analyses done—eg analyses of subgroups and interactions, and sensitivity analyses	55-66
Discussion			
Key results	18	Summarise key results with reference to study objectives	66
Limitations	19	Discuss limitations of the study, taking into account sources of potential bias or imprecision. Discuss both direction and magnitude of any potential bias	68-71
Interpretation	20	Give a cautious overall interpretation of results considering objectives, limitations, multiplicity of analyses, results from similar studies, and other relevant evidence	66-71
Generalisability	21	Discuss the generalisability (external validity) of the study results	69-71
Other information			
Funding	22	Give the source of funding and the role of the funders for the present study and, if applicable, for the original study on which the present article is based	71