Summary Report: Evaluation of Dyadic Developmental Psychotherapy/Practice Programme (DDP): An Adoption Support Intervention provided by Adoptionplus

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“Oh I would tell them it’s amazing. I have already recommended it to lots of people! Yeah, I would tell them to do it, that it has been incredible for us.”

Parent’s view of the post-adoption service at Adoptionplus

Summary Report

Overview:

In April 2017, Adoptionplus commissioned UEA to undertake an independent evaluation of its Dyadic Developmental Psychotherapy/Practice therapeutic social work service. The aim was to utilise therapeutically trained social workers to provide a service for adoptive families. However, changes to the Adoption Support Fund in 2017, reduced numbers of referrals to the service, and this significantly affected the numbers of families who were able to take part in the research. This in turn resulted in the decision being made to cease the evaluation in February 2019.

Researchers at UEA collected pre-intervention data from four parents, which indicated that their children had a high level of need at the point they first accessed the service. In-depth interviews carried out with two parents who had partially completed the programme, were positive about the value of the intervention. In-depth interviews were also completed with three members of staff (social workers), who also reported positive experiences of the intervention, both in terms of their own staff development and the impact on families they were working with.

However, the small sample sizes used in this study has affected the robustness of the evaluation. Because of these small numbers, the study is unable to reach any conclusion about whether the intervention makes a significant difference to families. The small amount of data that were collected shows that the children in families referred to the service had high levels of need and gave promising feedback about the service whilst partway through receiving it. Collecting additional data would be useful to help gain a more robust picture of the effects of the intervention, given its intensity and cost.

1. Introduction:

This report summarises the findings of an independent evaluation that was carried out by a team at the University of East Anglia and commissioned by Adoptionplus for their new DDP based therapeutic social work service based in a North London location. The service began operating from April 2017.

Adoptionplus is an adoption agency based in Buckinghamshire, which offers an Adoption Placement Service, a Developmental Trauma and Attachment Therapy Service, a birth relative Counselling Service and a Training and Conference Service. Previously the agency has received Department for Education (DFE) 'National Prospectus Grant' to run a Dyadic Developmental Psychotherapy (DDP) based Nurturing Attachment Group Programme in four locations around the UK, which was evaluated in July 2016 (Selwyn, Golding, Alper, Gurney Smith and Hewitt, 2016). The organisation received a further grant from the DFE (Innovation funding) to develop a therapeutic DDP informed social work service

Dyadic Developmental Psychotherapy is an attachment focussed family therapy approach that is designed to meet the needs of children who have experienced trauma and loss, developed by Dan Hughes (Hughes 2011), and is one of a number of therapy services offered by Adoptionplus. Adoptionplus emphasises research-based practice so is keen to evaluate its work using DDP.

2. Outline of Proposed Study

Proposed evaluation

In 2017 Adoptionplus set up a new therapeutic social work (SW) service for adoptive families comprising of five members of staff (Team Manager, Deputy Team Manager and three Social Workers). The plan was to train and certify all staff in DDP. It was envisaged that the service would offer:

1. Consultation with adopters (and their social workers from the referring Local Authority). This service comprised six sessions [with the possibility of a further sessions if requested]. It was hoped this would encourage local authority social workers to understand how to continue to support the approach once the Adoptionplus DDP consultation service had come to an end.
2. Nurturing Attachment Group and Foundations for Attachment Group Programmes (this part of the service was not included in this research)
3. DDP informed Therapeutic life story work.
4. DDP informed family work adoptive families. Each family was to be offered 32 sessions of DDP based family work.

Aim

The initial aim of the evaluation was to explore the impact on families of the DDP practice based therapeutic approach provided by social workers to assess its potential to help families and to inform any future evaluation planning.

The evaluation would collect data about the three different services available:

- intensive DDP therapy;
- life story work;
- parent consultation.

Research questions

The questions agreed at the beginning of the evaluation were:

1. Are there differences in children's wellbeing and functioning before and after the interventions and are these sustained six months after the interventions?
2. Are there differences in parents' wellbeing and functioning before and after the intervention and are these sustained six months after the intervention?
3. Did the parents feel helped and supported to undertake their parenting tasks?
4. How satisfied were children and parents with the services they received?
5. What were the key issues for the social workers involved in being trained and then delivering DDP?

Potential Sample

All parents (mothers and fathers) using the consultation or clinical service over a six month period (June 2017-November 2017) were invited to participate. An estimate of the sample size of the evaluation was 40 families. The completion of questionnaires was voluntary.

These estimates were based on Adoptionplus' forecasts of the numbers of adopters who could be seen in consultation sessions and clinical work sessions. The service aimed to offer up to 14 session slots with families per week [each session lasting 1.5 hours]. It was anticipated that the service would provide 8 of these session slots as either DDP based therapeutic life story work sessions or DDP family work, whilst 6 session slots would provide DDP informed parent consultation work.

Funding for the project

The project was part funded by the Department for Education (DfE) Innovations Grant. Services were to be provided from an office in North London, which contained three therapy rooms as well as office space for staff. The therapeutic work was part funded by the grant and part funded by commissioning local authorities. Local authorities obtained the majority of the funding for this service from the Adoption Support Fund, although some also provided match funding as well.

Changes that affected the evaluation after it began

At the time the service was established, the ASF did not have a cap on how much money could be allocated to each child/young person following a referral. However, as the level of demand for the ASF was higher than anticipated, in October 2016 the DfE introduced a Fair Access Limit of £5,000 per child for therapy per financial year, as well as a separate amount of up to £2,500 per child if a specialist assessment was needed. This meant that therapy and assessment above those amounts required match funding from the local authority. Alongside this, the timescales for the ASF agreeing specialist assessments and funding for therapeutic support increased. Both these issues affected the rates of referrals to the Adoptionplus service. This impacted on the evaluation as it meant that a lower number of families were able to contribute to the study than was originally planned.

Timescales

The initial timescales agreed for the project were that it was going to be an 18-month project, beginning in April 2017.

In April 2018 the sample size of families was revised from 40 to between 10 and 15, because numbers of families being seen by the project were considerably less than initial projections. In addition, the evaluation was 'paused' from May 2018 to February 2019 because of the low referrals to the project and low numbers of participants in the evaluation. Ultimately the reduction in numbers resulted in Adoptionplus notifying UEA in February 2019 that it wanted to bring the evaluation to an end and instead to review the data collected to date. The contract officially ended in February 2019.

Work was undertaken by both parties to gather as much information from participants who had agreed to take part in the research and from staff who had been involved in providing services to families. This revised approach was adopted to try and extract some useful learning from the small numbers of families and workers who had participated in the project up until it ceased.

The rest of this report provides an overview of the data gathered by the point the contract ended.

3. Method

The evaluation comprised quantitative and qualitative methods.

Quantitative measures:

Parents and young people were asked to complete a pack that contained a number of standardised measures at three different time points - before using either the consultation or clinical services (Time 1 – T1), at the end of the service (Time 2 – T2) and 6 month follow up (Time 3 – T3).

These measures included the following:

Parents:
1. Strengths and Difficulties Questionnaire (Goodman 1997) *
2. Assessment Checklist for Children (short version) (Tarren Sweeney 2007) *
3. Parenting stress index (Abidin 2012)
4. parental reflective functioning questionnaire (Fonagy) *
5. Brief Parental Self-Efficacy Scale (Woolgar)*
6. Parenting Sense of Competence Scale (Gibaud-Wallston & Wandersman, 1978)
7. Thinking about your child (Adoptionplus, modified from Golding and CPLAAC)
8. Parents well being - the Warwick-Edinburgh well-being scale. *

A number of these measures (indicated by * in the list above) had been used by Selwyn et al (2016) in the Nurturing Attachments evaluation. Please see appendix 2 for a brief overview of each of the chosen measures above.

Young people:

1. SDQ self-report version (from age 11) (Goodman 1997)
2. The Inventory of Parent and Peer Attachment, Revised (Armsden & Greenberg, 1987; Gullone & Robinson, 2005)
3. Experience of Service Questionnaire (ESQ) (Brown et al., 2014).

Please see appendix 2 for a brief overview of each of the chosen measures above. The measures were discussed and agreed with Adoptionplus prior to the start of the evaluation. However, because recruitment to the service was significantly affected, by the time the evaluation was ended by Adoptionplus in March 2019, seven Time 1 (T1) packs had been sent to families, and UEA had received four Time 1 packs back from parent participants. We received one Time 1 (T1) and Time 2 (T2) pack back from one young person.

Qualitative approaches:

Focus groups and semi-structured interviews were the two approaches initially proposed to gather in-depth data about different stakeholders experiences of the project. However, telephone interviews using a semi-structured interview frame was the only approach used (see appendix 1).

Parents were asked whether they would be prepared to be interviewed over the telephone, in order to gather more information about their experiences of using the consultation service or the clinical service. The initial sample size identified was 10 parents, however at the evaluation end, telephone interviews had been conducted with two parents who had indicated willingness to talk to a researcher.

Focus groups were planned with staff involved in delivering the consultation sessions, therapeutic life story work and clinical sessions, to enable staff views about the development of these services to be collected at two time points, and be taken into account in the evaluation. In April 2018 a decision was taken by the funder and UEA to replace the focus groups with individual telephone interviews with staff undertaking direct work with children and families. The reason for this was to gather staff perspectives on the complexity of the work they were undertaking, and identify the social work specific knowledge and skills being used in this direct work. Interviews were conducted with three members of staff by the end of the evaluation.

Information about the Actual Sample:

The sample size of families and children/young people taking part in the evaluation was n=4. All four families comprised a mother and father and all families were white English/Irish. All parents were qualified to at least degree level. All male partners were working full time, whilst half the female partners worked part time, with the other half at home full time. No parents had disabilities. All families had additional children, some of these were birth children and others were adopted children.

All adopted children in these families who were the subjects of the referral to Adoptionplus were female and all were white English. The age range of this group was 7-17 years, with three teenagers in this number. The length of adoption placement varied from 3 years to 13 years, with the age range at the beginning of the adoption placement from 1 year to 6 years. Prior to their adoption, children had experienced between 2 to 8 previous moves.

Of the four questionnaire packs returned by parents, two of these parents were subsequently interviewed by telephone by a UEA researcher.

4. Results

Quantitative data: Parents

Due to the limited number of packs returned to the research team at UEA (n=4), it is not possible to provide any in-depth analysis of the quantitative data gathered. We have provided a descriptive overview of the questionnaires completed by parents that shows their views about problems in their family at the time they were first seen at the post-adoption service. We have compared these scores with the metrics provided by each of the questionnaires used, so that it is possible to see the extent (or not) of difficulty reported by the parent at the time of referral. Since no T2 data-packs were returned to us, we cannot examine the effect that the service may have had on the family and we cannot perform any one-way statistical tests on the data.

Because of the low number of respondents, caution must be advised regarding the interpretation of these data. When considering how to even present these data, the research team did not want the families to be identifiable. Neither did we want the data presented to be meaningless in terms of its inclusion in this report. Consideration was given to ***NOT*** reporting on these data for this reason, but a decision was made to provide a brief overview of the data in order that some headline feedback could be given about the starting point for the four parents whose data were collected.

1. Strengths and Difficulties Questionnaire (Goodman 1997) *

The SDQ is designed for use with children aged between four and sixteen years. It comprises 25 items, each scored 0-1-2, which can be broken down into five scales covering: emotional symptoms; conduct problems; hyperactivity or inattention; friendships and peer relationship problems; and prosocial or positive behaviour. A 'general difficulties' score is identified by adding together the scores from the 20 items comprising the first four categories (www.sdqinfo.org). The potential range of this overall ‘general difficulties’ score is between 0-40. The scoring of the SDQ enables classification of the general difficulties score into one of three categories: normal (score is between 0-13); borderline (score is between 14-16); or abnormal/high (score is between 17-40).

Table 4.1: SDQ scores before therapy began

	Normal	Borderline	High
Total scores	1		3

Three out of the four children had very high SDQ scores (table 4.1). Across the four bandings of behaviour (emotional problems, conduct problems, hyperactivity and peer problems), three out of four young people had highest scores for problems with hyperactivity, followed by conduct and peer problems.

All parents reported that they thought their child had severe difficulties and that this affected home, friends, classroom and leisure activities. In terms of the impact in family life, three out of four parents reported that their child's behaviour had a significant effect on family life.

2. Assessment Checklist for Children (short version) (Tarren Sweeney 2007) *

This tool is designed to
- Screen for and monitor clinically-meaningful mental health difficulties experienced by children and adolescents in in foster, kinship, residential and adoptive care; and
- Be safely used by children's agencies and health services without oversight by a child and adolescent mental health clinician.

There are no subscales for this measure.

Table 4.2 ACC short version scores before therapy began

	Normal	Should be referred for further assessment
Total scores		4

The range of scores possible on this questionnaire is 0-40. The child or young person should be referred for further assessment when their score is 7 or higher. All four children's scores were significantly higher than 7 (Table 4.2). The range in children's scores was between 14-34.

Summary

Both the SDQ and ACC short version, refer to information about the child/young person, specifically the parent's views on problems that their child/young person had. In both these measures, three of the four children scored highly. One child scored within the 'normal' range for the SDQ, but their score was in the 'should be referred for further assessment' with the ACC measure.

The next group of scales and measures are concerned with parental functioning.

3. Parental reflective functioning questionnaire (Fonagy) *

The PRFQ was developed as a brief screening tool that can be used in studies with large sample sizes. It is designed to assess parental reflective functioning and asks parents whether they agree or not with a set of statements. The PRFQ produces a total score and three dimensions of reflective functioning:

1) Pre-mentalizing modes in parents. An example statement is, 'When my child is fussy he or she does that just to annoy me.'
2) Certainty of mental states. An example statement is, 'I can always predict what my child will do.'
3) Parental interest and curiosity in mental states. An example statement is 'I wonder a lot about what my child is thinking and feeling'.

Currently this tool is available for research purposes only and is geared toward parents with children aged under 5 years. A version for older children and adolescents is currently being piloted. We will not report on the data collected with this measure.

4. Brief Parental Self-Efficacy Scale - BPSES (Woolgar)*

This scale measures the confidence that parents consider that they have in their ability to parent their child. The minimum score is five, maximum is 25, with the highest score showing the maximum self-efficacy.

Table 4.4 Parents sense of self-efficacy pre therapy

Mean	19
Range	17-23

The mean (n=4) for the families is above the middle of the range. Bearing in mind this was completed at the beginning of the intervention, this indicates that all parents thought that they had some self-efficacy skills.

5. Parenting Sense of Competence Scale - PSCS (Gibaud-Wallston & Wandersman, 1978)

A higher score (out of 101) indicates a higher parenting sense of competency. There are no other ‘cut-off’s’ for this tool.

Table 4.5 Parenting sense of competence pre therapy

Mean	60.7
Range	58-62

The range of scores for participants was not high, indicating that across the sample there was limited feelings of competence in parenting skills.

6. Thinking about your child questionnaire – TAYCQ (Adoptionplus, modified from Golding and CPLAAC)

The Thinking About Your Child Questionnaire targets the understanding, confidence, stability and level of reported reward the parent experiences with their child. There are 12 questions in the generic part of the questionnaire that are then broken down into four areas: parental skills and understanding (PSU); Parent-Child Relationship (PCR); Child Responsiveness to Care (CRC); and Placement Stability (St.). Total scores for this section is out of 110. The questionnaire then asks people to identify three concerns and answer questions about those concerns individually.

Table 4.6: Thinking about your child questionnaire pre therapy

Generic questions	**Mean scores**	**Range in scores**	**Possible Total**
PSU	28.5	22-35	40
PCR	19.5	17-21	30
CRC	18.5	16-23	30
St	8.25	4-10	10
Target problems	**Mean scores**		**Description of problems**
Friendships with peers, relationships with family members	45 (out of 60)	39-49	Present across all the sample
Feelings of anger, sadness, and effect on self esteem	43.75 (out of 60)	41-47	Present across all the sample
Safety	48 (out of 60)	47-49	Present in half the sample

Three out of the four families marked the stability/security of the adoptive placement highly, even though there was significant stress within the family. This might reflect the sense of attachment that the parents felt toward their adopted child, as all four children were still living in the family home. One family had a much lower score. The mean scores for the three other sections showed that the families had good insight into their children and their problems and some skills to manage this. The mean scores were just below the top third of the bandings.

There was considerable overlap in the target problems that adopters identified. All adopters identified problems with peer friendships or family relationships. All adopters also identified feelings of anger, sadness or others that affected the self-esteem of the young person. Two adopters also identified safety issues.

7. Parents well being - the Warwick-Edinburgh well-being scale.*

The Warwick-Edinburgh Mental Well-being Scale (WEMWBS) comprises 14 items that relate to an individual's state of mental wellbeing in the previous two weeks. Responses are made on a 5-point scale ranging from 'none of the time' to 'all of the time'. Scores vary between 14 and 70 with lower scores (scores below 41) indicating low well-being, scores of 42-58 indicating moderate well-being and 58 or more high well-being. In the general population, the vast majority (75%) fall into the average well-being category, about 12% have high well-being and 13% low well-being.

The general population mean score is about 51 (SD 8.70) for people aged 35-54 years of age (Health Survey of England 2011). In this sample of adoptive parents the mean score was 48. Two of the adoptive parents had a score below 40 indicating low well-being and two had scores indicating moderate well-being. The range of scores was 39-57. None of the adoptive parents had scores indicating that they had high well-being at the time the therapy began.

Summary

The findings from these quantitative data should be treated with caution because of the very small sample size. No statistical tests have been performed. A descriptive examination of the data indicates that parents had a range of needs across the different measures that were completed. The WEMWBS showed that the four parents reported low to medium wellbeing, and the PSCS showed that parents views of their own competence as parents to their child prior to therapy beginning were not strong. The BPSES showed a reasonable sense of self-efficacy amongst the parents, which might not be surprising given that they were actively seeking support for their difficulties within their families. The TAYCQ showed that parents had some level of insight into their children's difficulties.

Quantitative data: Young person:

One young person returned a data pack at T1 (pre intervention) and T2 (end of intervention). The research team made a decision not to report on these data in this evaluation report. This is because of the risk to the young person of being identified. Additionally, the analysis of this one person's data is not generalisable or transferable to the broader group of young people who are adopted.

Qualitative data: Themes emerging from interviews with parents

Support Prior to Adoptionplus Service

In both families interviewed, their children were under 5 when they were adopted. During the early years of placement, the families used their local authority for adoption-related support services, however, both families reported that after a while local authority services and support were not helpful. One parent stated that their child didn't respond well to therapies provided, such as play therapy and psychotherapy. During adolescence both families were struggling with their adopted child and this stress affected family relationships to the point where there was a very real likelihood of families splitting up. Both families also explained feelings of powerlessness, which had a big effect on family dynamics and relationships.

One family explained their journey to Adoptionplus as

> "Yes, well yes it was about trying Adoption plus. [A] was putting (themself) in danger, (they were) having inappropriate relationships with much older males, there was a huge amount happening and we felt completely powerless really as parents to try and keep (them) safe"

The second family also described the same issues

> "lots of concerns about [B] and how (they were) managing (their) feelings and behaviour and how we were going to, I don't know, sort of get better as a family, it was causing a lot of problems within the family. I think we were all just struggling really"

There were a number of other issues that also influenced families' decisions to seek support via Adoptionplus. 'A' was experiencing a number of mental health issues, including periods of self-harm. At the time of referral they were also experiencing problems at school, difficulties making friends and having relationships with older adults. 'B' was struggling with issues relating to trust, they were lying all the time, skipping school, associating with people who were not great influences and struggling with making friends.

One family found Adoptionplus through word of mouth, then approached their local authority social worker for funding to access Adoptionplus services. They explained that this took a long time. The other family approached their local authority post-adoption service about needing support as parents. The parent inquired about a referral to Adoptionplus services.

Experience with Adoptionplus

Both families were very positive about their experience with Adoptionplus describing the service as, “amazing”, “incredible” and “empathetic”. One family explained that after a few sessions, there were benefits to their family. Neither family identified any negatives about the service they had received from Adoptionplus. Both families reported that at their first appointment with Adoptionplus, they had completed many forms, so the staff could cater to their exact needs. Family B also explained that they were given a report of the findings of the assessment.

> “When we first went there, [therapist] did a very detailed assessment with us and went right through our family history, asked lots of questions and actually produced a report that was really, really helpful”

Both families also thought the therapeutic approaches used to work with them were flexible and suited their needs at the time.

> “When we started they had two therapists, so one therapist would take ‘B’ off and then they would come back and we would all get together and then do a group sort of thing. But then after a few sessions we all felt that it was working better when we were all together for the whole session”

Family A needed slightly different variations of the therapy but like family B, the therapy was suited to their needs.

> “They were very skilled at working out when one of us might need a little bit of time by ourselves to talk to one of them. They very quickly recognised whether ‘A’ needed to be by themselves or whether I need to be by myself or whether it was better than ‘A’ and I remained together and that (other parent) had someone to one time. They were just very skilled at seeing where the need was and meeting it”

The families were positive about the staff being skilled and recognising their respective family’s needs. They expressed positive satisfaction with Adoptionplus. The families also described the staff as incredibly supportive between sessions.

> “Yes absolutely, absolutely there were always emails or calls in-between”

> “Yes we were fully involved and even in-between sessions (the therapist) was available if I needed to speak to her about anything”

Having a trusting and supportive relationship with their therapist was imperative for families to gain the benefits of the programme. Families also commented about the staff as highly skilled in everything relevant to Adoption and Therapy Processes. Being non-judgemental and accommodating to each family’s beliefs, including acknowledging cultural and religious identities was also explained as a huge benefit. Having sessions together meant that the families could deal and process things, which allowed them to become more trusting of each other. It also helped parents have a greater understanding of their child and what their child had been through.

> “…[therapist] understands adoption, [therapist] understands young people that have had trauma and [therapist] is the right balance of encouraging our child to talk about their feelings but [therapist] is also directive when [therapist] needs to be…”

> “…the way that they have understood us and the empathy that we have had from them. They have remained professional but they have really shown that they care..”

Comparing Adoptionplus services to mainstream CAMHS

Families identified some differences between the service Adoptionplus offered and their experiences of mainstream CAMHS and local authority post-adoption services.

> “…it is just being flexible as well, not just sticking to ‘this is the way, this is the way I do therapy and I am not going to change my way,’ you know that is what worries me about CAMHS. Whatever type of therapy our child gets, they are depending on the person being flexible in their approach and not every approach suits every person or family.”

> “…it just felt like we were given a child and left to it, which is probably a bit unfair because the Local Authority did come and help with the Life Story Book, but considering they work in adoption, it never felt like they really understood what we were going through in the way that Adoptionplus just really really seems to get it, they really seem to understand it and they are very empathetic.”

When asking whether they would recommend this type of support service, both parents said ‘yes’, however one of the parents explained that

> “… parents have got to be willing to actually engage in the therapy and accept that some of it will challenge the way that they think and behave, and they might not want to be as open perhaps as we were.”

The Turning Point

Both parents stated that they were now in a better place than before they attended Adoptionplus

> “…we are in such a better place with our child I cannot tell you. It is almost miraculous where we are today. I suppose the concerns are still around, but it is completely different, the fact that our child is able to now talk to me about all kind of things and talk a bit about how they are feeling is massive, absolutely massive. They just look very different to when we first started.”

> “Umm yes well we don’t really have the problems now to be honest, it has brought us much, much closer together. My relationship with ‘B’ is a hundred times better than it was. They have stopped all of the, they used to lie all the time and just be really secretive. They don’t do that at all anymore; they are really open with me, trusting umm so yeah…, I think it has been the sessions but I think it has been the investment of time with them and you know encouraging them to open up and talk and for them to feel that that’s safe to do and that we are okay with that.”

Both parents spoke of the individual benefits for their children. They explained that they are now both able to make and maintain friendships which is something they were struggling with. Both young people are also doing well in school and have a vision for their futures, something that may not have been important to them prior to Adoptionplus. They also think their young person is happier and content with their lives. They both explained that their children have more of an interest in family life. For example, their young person will go and spend time with them, whether that be through watching TV or just sitting and talking with them.

Parental benefits were also identified. Both parents explained that they are actually able to be a parent now:

> “the fact is we understand so much more about them that we are able to parent in a different way and because of the support it now means that ‘A’ will accept us parenting them”

> “I mean you always have concerns when you have children, but I feel much more confident that whatever happens now we can sort of manage it.”

Furthermore, the parent of ‘B’ also explained in a way that she and her partner could have a life of their own as well without worrying or having concerns for the welfare of their child:

> “yeah it is just completely different. My husband and I are going away overnight this weekend. That could never have happened before, we could never have left the house or done anything just for us.”

Benefits for the siblings of the adopted children and relationships with extended family members have also improved. For example, in Family A the Mother explained that:

> “You know it has made a huge difference to my (birth child), everything with him, he is so much better as well because he went through a period of depression just from witnessing what was happening to us. And so he is fine, you know he is working doing his degree and that is all going well, so yeah, it is a completely different household.”

> “…to some extent people didn’t really understand why we were still hanging on in there with our child. There were some family members who felt that they didn’t necessarily want them to remain as part of the family, so that put us under strain. Whereas now we have been able to explain to them with the help from Adoptionplus, so that they have got a greater understanding of where our child was and why they were behaving in that way, and so that has helped us reintegrate them back into the wider family without there being any awkwardness. They understand our child more now as well.”

Both families explain that their household dynamics are more cohesive. The families can now have meals together and do activities together.

> “We might go out together, go out for a walk or go out for dinner that kind of thing. Friday nights we always go and get pizza, so we will be doing that tonight.”

These activities may not have been able to happen prior to the therapy. The Mother of Child A explained their new family lifestyle as being “normal”:

> “Yeah it is just, yeah it just feels like we are just a normal, yeah, in fact, it is normal family dynamics really, I mean she is a teenager so don’t get me wrong, you know there is stuff that you think ‘oh gosh!’ umm but that is just normal yeah, that is fine.”

Both families value communication as important to their family’s dynamics and their bond as a family improved as a result of the therapeutic work completed with Adoptionplus.

Barriers to Access:

Both parents who were interviewed, expressed positive experiences with Adoptionplus. There were no negative experiences raised about the service. Both families alluded to problems with obtaining financial support to enable them to be seen quickly by Adoptionplus and for them to have the length and frequency of support that they would have wanted. Both families stated they had to wait a long time for funding and one family had to take a break in the programme while they waited for their funding.

> “I heard that there might be some money funding available so then I spoke to our Social Worker and she applied for the funding for us, which took a very long time, months and months and months”

> “I suppose the only thing was the fight for the finances for it to continue. There has been a little bit of a delay while I have been waiting on that and there were some times when we possibly could have really done with it but unfortunately the money wasn’t there.”

Both the families had to travel to the centre as it was not local to them.

> “you know we have had to travel … for the service, but in some ways even that has been a good thing because we have had to go on the train but just sometimes the act of doing that and journeying somewhere together, we have been able to chat with ‘A’ on the train and kind of use that time positively.”

To summarise, there were four main themes that came from this study, the family’s situation prior to Adoptionplus, the experience with Adoptionplus, the turning point during and after the service and the issues applying for funding to access the service for as long and as often as the families would have liked. Both interviewees experiences were positive, not only for the adopted child but for the wider family. The interviewees state they would recommend this service to other people.

> “Oh I would tell them it’s amazing, I have already recommended it to lots of people! I would tell them to do it, that it has been incredible for us.”

> “…they have been, it is not, to put too fine a word on it, that they really have been ‘life savers,’ because it was looking so black. We were, well we had kind of gone beyond family breakdown and it was not good. It has been life changing, it really has.”

Qualitative data: Themes emerging from interviews with staff at Adoptionplus

All three members of staff interviewed were qualified and experienced social workers who had previously worked as social workers in local authorities and some in voluntary sector organisations. Their views of the service were overwhelmingly positive.

> “You know it is a very amazing and exciting service to be part of.”

Aim of service

Workers all had clear ideas about the aim of the service and their contributions all went beyond responding to behaviours to working and building on relationships and attachments between adopters and their children. The workers articulated a clear rationale for their involvement with families.

> "The overriding aim really is to increase parent acceptance and understanding and empathy for the child and thereby strengthen the attachment between the child and the parents. Because it is very much not a kind of behaviour based sort of model, but it is much more about increasing understanding and empathy using playfulness, acceptance and curiosity.
>
> "…supporting and working with the relationship between adoptive parents and their children … often I think adoptive parents are coming umm at this from the hope of thinking about strategies of managing the children's behaviour and whilst there is absolutely a place for that… alongside that we're working with Adoptive Parents to really think about the child's inner world and about what is underlying the behaviour … working to improve their attunement and their understanding of you know what might be the emotional drivers for these children.
>
> "… to provide therapeutic support to adopted families and their children, to help them with attachment and trauma, to support their relationships, umm and to yeah to help try and understand life and their life experience from their perspective … "

There was also agreement about what a typical day's work entailed, and workers spoke about their role being 'innovative', 'flexible' and that they were an 'advocate' for adopters and young people on occasion with other agencies. Workers spoke about being able to work in partnership with young people and with adopters, separately and together, in a meaningful way, and be responsive to the needs of family members at each session. They were able to let young people have a say about the kind of service they felt they needed too. One worker described this as a move away from the 'three strikes and you're out' model that many CAMH services offer:

> "..we find eventually if we just keep going that they do engage…"

Support for workers

Workers were positive about the training opportunities they had received since beginning work at Adoptionplus. All had undertaken or were part-way through their DDP training at level 1 and 2, and said that there were opportunities to undertake additional specialist therapeutic courses where required. Each worker also had regular supervision including: clinical team supervision, line management supervision and DDP consultation and certification. There was an additional option of external personal therapy provision, funded by the organisation if required.

DDP

Workers spoke positively about using DDP and thought that this approach "improve(d) the dance between the Adoptive Parents and the children." There was recognition that "…DDP is about that specific attachment relationship really; it needs to kind of focus on that attachment relationship…"

The DDP training for level 1 and 2 were completed quickly, close together, in order that they could be assessed to complete the qualification. Workers welcomed this and the clinical support they received to embed the skills they had learned on the training,

> "I present videos of sessions that I've run where I've doing DDP work... And then I'll get supervision on those and then whoever the supervisor is will go through and score that and give feedback, and so at different points during the practicum they are looking for specific things "

Workers were able to articulate the difference they felt this approach gave to their work with families

> "…a big part of the DDP model is about rupture and repair that we do. We do have the ability to repair things and that's one of the big things that we help parents with as well is thinking about repair… you are not going to be an angel all the time and you are going to lose your rag sometimes and you are going to do things which aren't what you would like to do when you are feeling totally calm but that doesn't mean that you are a bad parent, it just means that you need to do a little repair afterwards, and that's very much how we work as well. So in terms of those ruptures, we would then look at repairing them and saying 'oh I am really sorry we had to do that' or 'these are the reasons' or 'I got it wrong there and let's think about that again, I am really sorry and you tell me if I have got it, if I have got it right this time' and that kind of sort of tentative sort of approach I think really, really works with people."

However, workers said they were not always able to use DDP. It very much depended on understanding where the family was at and working with that, to get to a point where DDP could be used in sessions. Most families were referred to the service because they were in some sort of crisis and so the early assessment processes were important to gather information about the family members and talk with members of the team and with the family, including the young person about the kind of help and support that the service could provide

> "… a big part of it is really just accepting where the family is at and working with them at that point rather than trying to push them into a position where they are going to feel uncomfortable, because if we are going to bring the child and the parents together, we need the child to feel that their parents are safe people and that's kind of got to be, that's got to be present before we can do any kind of DDP work with them. We might do something, we do some DDP with them altogether if that's helpful but it wouldn't be a kind of a DDP kind of session unless we were confident that the parents were able to be emotionally safe for their child in that position."

Strengths and weaknesses of a post-adoption service provided by social workers

Collectively all three workers had undertaken a range of roles, including child protection, children in need and adoption work. They thought that these experiences helped their ability to understand and work with different perspectives.

> "I think that we have a really good understanding of what the journey that adoptive parents will have been on and I think we have a really good understanding how families are formed through links and matching and those very very early days and we have a good idea of the sort of tensions and pressures. So often Adoptive Parents, when they are feeling under stress, will look back at the process and say "we weren't prepared for this, nobody told us" or umm "the Social Workers were useless!" … but I think if you have got a lot of experience of having worked in that system, I think you are able to both recognise some of the criticisms that the adoptive parents

> have… there are Local Authorities under huge pressure and yeah there is some, you know, not great practice going on at times, but I think you are also able to hold a balanced view… "

One staff member identified the difficulties of parents not being able to see past the 'social worker' professional label because they may have been let down by social services:

> " A lot of adoptive families have awful experiences with Social Workers; some of our families that we are working with have tried for years and years and years and years and years to get support and have always been let down, umm and so we do struggle with that tension sometimes as well, that we are Social Workers…"

How the service differs from other therapeutic services

Because workers had worked in local authorities, one of the key points that staff made was their ability to understand the complexities of adoption families.

> "… I have been at the other end, I have been a Social Worker referring into a therapeutic service and I have met with therapists who have no experience of front line of adoption work. They might be saying something about you know 'well how were this couple ever approved' or 'why was this match made?' … they don't have any sense really of the sort of assessment process that people go through, and an understanding that actually umm it is not an exact science."

Workers thought the adoption service was unique: "I think our offer is probably the only one out there exactly like what we do," and workers were able to identify specific ways in which the service differed from other post-adoption provision:

1. "There is no difference in cost between us and other services"
2. "all of us have a broad range of experience working with families for a long time in social care settings"
3. "there is a familiarity with the kind of experiences and families that these children and young people come from"
4. "Social work's 'bread and butter' should be attachment, and that is what DDP is"
5. "there is inherent flexibility in the service"
6. "able to be a bit more of a 'magpie' service and use tools from here and there"
7. "we are small"
8. "we are particularly giving the focus to DDP"
9. "we will go out to see adolescents"
10. "We are all social workers so we've all had experiences of working in the 'real adoption world'"
11. "We are able to go out and engage children and families in a different way than a traditional CAMHS or clinical service"
12. We can be flexible
13. "…our [professional] background provides us with a knowledge of the system that a clinician wouldn't necessarily have
14. "We know and understand the way local authorities work because we have worked in them – we understand the process that a lot of our parents and children have experienced."
15. "Families feel their experiences are validated."

There are many similarities in this list of points drawn from the interviews of the three different workers. They articulated a pride in their work and believed that they were offering something that was genuinely making a difference to the families they were working with, and that was because of the way workers engaged with families. Two workers were involved with every case and on a 'typical day', a considerable amount of time was spent analysing material from the sessions by the team working with a family, including in the various supervision sessions that workers had regular access to.

> “”[the service] has kind of been a lifeline…it has been the thing that has kept them going.”
>
> “I just think [the service] is essential…there is an utter lack of investment in all child and adolescent mental health across the country…and there is a shocking lack of attention to it by the Government.”

Endings

Workers said that the team carefully considered endings for families.

> “We plan for endings. We signpost to other services and make ongoing requests for funding so that families can remain with us.”

At the time of interview very few families had finished.

> “we are reaching the point where there are going to be families who feel they need continuous work, but the funding won't be there and so our manager will be using up a lot of her time having discussions with local authorities…”

The workers said they thought about the way in which families could continue to be supported but one of the major factors that determined whether services could continue was money.

Funding of service

The referral route for families was either from local authorities or self-referral. Workers knew that the project initially had Government money that enabled Adoptionplus to offer therapy at a subsidised rate for a little while. They also all understood that the changes to the Adoption Support Fund had had a big impact on referrals and the type of work that the service could offer families.

> “What we perhaps had in mind to offer at the beginning has kind of altered slightly ummm, partly because of the Adoption Support Fund cap coming in and so we have kind of had to shift a little bit what it is that we do and how we offer the work.”

This has meant that local authorities have had to be approached to 'match fund' provision.

> “It is particularly hard in the financial climate the way things are that local authorities do not have a lot of money to spend and they want to try and get as much money as they possibly can for the funding that is available, which is completely understandable.'

Workers reported that the number of sessions a family were offered having to be cut short whilst further funds were applied for across financial years, and sessions not occurring with the frequency that would be ideal, because of these funding pressures. Workers were also aware that many families had been referred to them because they were in crisis, and some young people had moved out of the family home and were back in local authority accommodation because of the stress and pressure families had experienced. It was only in exceptional circumstances that local authorities would match fund post-adoption support. Families found this lack of access to funding frustrating, as did the workers.

One gap in service provision noted by one worker was work with the birth children of the adopters. This worker knew that some of the families they were involved with included birth children and that there were poor relationships between the adopted child and the birth child which could have benefitted from exploration. However it was acknowledged that this support to birth children did not come under the ASF criteria at this time.

To summarise, there was much agreement between the three workers interviewed about their experience of working in this service. They were all positive about the service offered to families and thought that it made a difference to their lives. They clearly articulated the added value of being social workers and involved in a post-adoption therapeutic service. All were positive about DDP as an approach and highly regarded the training and supervisory input they were offered as part of the work. All were aware of the impact of the Adoption Support Grant funding changes on the service and on the families.

5. Discussion

Research questions

1. **Are there differences in children's wellbeing and functioning before and after the interventions and are these sustained six months after the interventions?**

This is not a question that can be addressed conclusively as the project evaluation ended before further quantitative data could be collected from participants at the end of their service that would enable a comparison of pre and post intervention scores. However, the interviews undertaken with two of the parents, who were still part way through the service at the time of their interview, were overwhelmingly positive about their experiences of the postadoption service and the positive changes that both parents reported about family life, including the wellbeing of their adopted child. This would indicate that the post-adoption service shows promise as an intervention that supports young people, according to the parent data. The evaluation team was not able to collect sufficient data from young people themselves to indicate their perspective on the service.

2. **Are there differences in parents' wellbeing and functioning before and after the intervention and are these sustained six months after the intervention?**

As with the previous question, the limited quantitative data available did not enable a comparison of pre and post intervention scores. The qualitative data reported differences in parent's wellbeing part way through receiving the therapeutic post-adoption service, with one parent saying it had kept their family together. Parents valued the individually tailored service and spoke positively about the flexibility that staff provided, including keeping in touch with families during times where there were gaps in services because of funding issues. Parents felt listened to and consulted about every aspect of the service, which they highly valued.

3. **Did the parents feel helped and supported to undertake their parenting tasks?**

Parents reported in the qualitative interviews that their relationships with their young person had improved and they were able to be a more effective parent to their young person. Parents reported that some concerns expressed at the beginning of the therapy had changed to what they described as ‘manageable levels’, that is, the same as with any other adolescent.

4. **How satisfied were children and parents with the services they received?**

Parents views, collected through qualitative interviews, were overwhelmingly positive about the service they had received from Adoptionplus.

Young people’s views about the service were not able to be analysed because of the low number collected.

5. **What were the key issues for the social workers involved in being trained and then delivering DDP?**

Social workers valued the opportunity they had to complete their DDP training as part of their employment at Adoptionplus and all spoke positively about this, including the supervisory support and feedback that they regularly received. They thought that DDP complemented and added to their social work skills. All commented on the highly complex nature of this work. They believed that their previous social work experiences in local authorities and voluntary sector organisations enabled them to demonstrate their understanding and support for the families they were working with. They were able to offer a flexible, tailored service that acknowledged the crisis situation that most families felt they were in at the point of referral, and work in partnership with parents and young people. They were able to use other skills and approaches when working with families where DDP was not appropriate at a given point.

6. Conclusion

The Adoptionplus post-adoption service works with adopted families, including children and young people, with high levels of need who require intensive support and intervention. Researchers at UEA collected pre-intervention data from four parents, which indicated that the children of all four families had a high level of need at the point they began the service. In-depth interviews were carried out with two parents who had partially completed the programme, both of whom were positive about the value of the intervention. In-depth interviews were also undertaken with three members of staff (social workers) who also reported positive experiences of delivering the intervention, both in terms of their own staff development, and impact on families they were working with.

However, because of these small numbers, the study is unable to reach any conclusion about whether the intervention makes a significant difference to families. The small amount of data collected looks promising, as the experience of the adopters who were interviewed was positive.

Further research to explore the interventions more thoroughly would be beneficial. Collection of additional data would help gain a more robust picture of the effects of the intervention.

The service has been affected by changes to the Adoption Support Fund, in particular the cap that was applied to the amount of money that could be given to an adopted child and their family in any given year. This has impacted on the business model originally developed for this service, as the numbers of referrals the project envisaged receiving did not materialise. Importantly the introduction of the cap also impacted families being able to receive the services that they said they were finding helpful. The experience of Adoptionplus has also been that it is rare for local authorities to match fund post-adoption support, and this has also affected the funding of their services.

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Appendix 1: Questions for qualitative interviews

Questions for parents

Family information

- Can you tell me who is in your family?
    - Age of child/ren at time of adoption
    - Age of child/ren now
- Before we start talking about your involvement with Adoptionplus, are you able to recall any services you accessed *prior* to Adoptionplus?
    - What was the service?
    - Why was it accessed?
    - Did it meet your needs?

Initial involvement with Adoption Plus

- Can you tell me a little about your family and how you first came into contact with Adoptionplus?
- What kind of help did you think you needed most?
- What did you expect when contact with AP first started?
    - Hopes
    - Concerns
- Which service/s are you accessing at AP?
- Who do the staff spend time with?
- How often?
- What does the practitioner do?
    - With the whole family
    - With individuals
- What are your main problems/worries/issues right now?
- Do you feel better able to manage or work through those problems/worries/issues since you have been involved with Adoptionplus?
- Has anything in particular made a difference to the way that you manage your problems now?
- What/Who has been the most helpful?
    - How has she/he/it been helpful?
- Do you feel that the service pays attention to your family's cultural/religious identity and values?
    - How?
    - Why not?
- Do you always feel fully involved in the process?
    - How?
- Can you think of something that has stopped you making the most of the Adoptionplus service?
- Can you list the three best things about being involved with the service? Discuss/expand
- What are the three worst things about being involved with the service? Discuss/expand

The family situation now

- Who are you involved with now?

    - Which other agencies/professionals/services
        - Why?
        - When did contact start (before AP)?
        - What do they do for your family?
        - Have any of those contacts ended?
        - Why? Did you drop out?
- What is it like to live in your family now?
    - Can you talk me through a typical day?
    - Is it different to before the intervention?
    - Have any of the stressors lessened?
    - How have other relationships in the family (extended family) been affected by your involvement with Adoption Plus?
- How is your child doing
    - School
    - Friendships
- Has anything got worse as a result of being involved with Adoptionplus?
    - How/why did this happen?
- Looking back, what has made the biggest change to your family so far?

Looking to the future

- What do you value most about your family?
- What would be different if you hadn't got involved with Adoptionplus?
- What new strengths have you found as a family?
- How likely is it that the/any positive impacts will last?
- Looking forward, how do you see your family in one year?

Reflections on service

- Do you think the service is different to services you have been involved with before?
    - How?
- How important is it to have a service like Adoptionplus?
    - Who should it be aimed at?
- Did the service meet your family's needs?
- After your experiences, is there any advice you would give to other families who get involved with Adoptionplus?
    - How would you describe Adoptionplus to another family?
- Any advice you would like to give Adoptionplus or the people who supported you there? (reiterate confidentiality)
- Is there anything that you feel it would be useful for us to know about/need to understand better?
- Anything you would like to ask me about the research?

Finishing

- Reiterate confidentiality
- Consent to re-contact
- Thank you

Questions for staff

- First of all, can you tell me what your role is within the team?
- How did you become involved in the work?
- What was your previous job/role?
- What is your understanding of the purpose of the service?
- How prepared did you feel for the work that you are currently undertaking?
- What kind of training have you had?
- Would you like further/different training?
- What do you do during a typical day?
  - Examples of the kind of work undertaken incl. paperwork
- Do you work with one family or all families?
- Do you work with the whole family?
  - Together?
  - Separately?
- How do you engage families who find it difficult?
  - Parents
  - Children
- How do you adapt the intervention to individual families (cultural/religious identity/values)?
- What happens to families when the service ends?
- How do you monitor any improvement made during/after the intervention?
- Do you have any suggestions for changes/improvements to the service?
- How does your service at Adoption + differs to other adoption support services?
- Do you think that it is a good idea for social workers to deliver the interventions?
  - Benefits?
  - Difficulties?
- How important do you think this kind of service is for adoptive parents and their children?
- Does the work have an emotional impact on you?
- Who supports you?
  - How?
  - How often?
- Would you like more/different support?
- Do you have any other comments about your work and the service?
- How have you found this interview?
- Is there anything you would like to ask me about the research?

Thank you for taking the time to talk to me. If you have any questions at a later date then please contact me. I will also email you details of the Head of School of Social Work should you have any complaints about the way the research has been carried out.

Appendix 2: Description of scales and questionnaires used in the study

Measures for parents to complete:

1. *Strengths and Difficulties Questionnaire (SDQ) (Goodman 1997) **

The SDQ is designed for use with children aged between four and sixteen years. It comprises 25 items, each scored 0-1-2, which can be broken down into five scales covering: emotional symptoms; conduct problems; hyperactivity or inattention; friendships and peer relationship problems; and prosocial or positive behaviour. A 'general difficulties' score is identified by adding together the scores from the 20 items comprising the first four categories (www.sdqinfo.org). The potential range of this overall 'general difficulties' score is between 0-40. The scoring of the SDQ enables classification of the general difficulties score into one of three categories: normal (score is between 0-13); borderline (score is between 14-16); or abnormal (score is between 17-40). There are three versions of the SDQ: the parent/carer, teacher and the self-report scale (completed by 11-16 year olds), which provide the potential for triangulation of information about a child across the different versions. An 'impact supplement' is available on an 'extended' version of the SDQ, which asks whether the respondent thinks that the child or young person has a problem and then asks further questions about 'chronicity', 'distress', 'social impairment' and 'burden to others'. This enables clinicians and researchers to gather additional information about the impact of any difficulties on the child (Goodman, 1999).

The main benefit of the SDQ is that it is quick and relatively straightforward to use. It is also free to use, unlike many of the American equivalents, such as the Child Behaviour Checklist (CBCL). Additionally, it is much shorter than the CBCL, the Development and Well-Being Assessment (DAWBA) and the long form Assessment Checklist for Children (ACC) and, unlike short form ACC, it has sub-scales. The SDQ is used routinely in CAMHS in the UK (CAMHS Outcome Research Consortium, 2010) and is also used in many other countries, having been translated into more than 80 languages (Goodman, 1997, Goodman et al., 2004b). It has become one of the most widely used and well recognised child and adolescent screening tools (Tarren-Sweeney, 2013).

2. *Assessment Checklist for Children (short version) (Tarren Sweeney 2007) **

Tarren-Sweeney has developed a number of screening tools specifically for looked after children. The Assessment Checklist for Children (ACC) (ages 4 to 11 years - 125 items) and the Assessment Checklist for Adolescents (ACA) (ages 12 to 17 years -105 items), developed by Tarren-Sweeney (2007; 2013), is a screening tool that has recently been used in more than 20 studies with looked after and adopted children in the UK, Europe and Australia. A short version (ACC-SF is 44 items, and the ACA-SF is 37 items), and a brief version (BAC-C and BAC-A are both 20 items long) are also available. According to Tarren Sweeney (2013), the ACA and ACC measures have similar screening accuracy (sensitivity and specificity) as the SDQ for identifying mental health problems for children in care. The full and short versions of the ACA/ACC have subareas that can be independently analysed, whereas the brief version, which has a similar number of questions as the SDQ, does not. The SDQ has five sub-categories which can be independently examined. There are reports about foster carers favouring the BAC over the SDQ as it better captured the specific difficulties experienced by looked after children (Lewis, 2014)

3. *Parental reflective functioning questionnaire* (PRFQ)** (Information about the PRFQ is from the 'Nurturing Attachments' report)*

The PRFQ (Luyten et al. under review) is designed to assess parental reflective functioning and asks parents whether they agree or not with a set of statements. The PRFQ produces a total score and three dimensions of reflective functioning:

1) Pre-mentalizing modes in parents. An example statement is, 'When my child is fussy he or she does that just to annoy me.'

2) Certainty of mental states. An example statement is, 'I can always predict what my child will do.'

3) Parental interest and curiosity in mental states. An example statement is 'I wonder a lot about what my child is thinking and feeling'.

The development and validation of the measure was completed on parents whose children were aged between 0 and 5 years old but has been used with foster parents in England (Fonagy 2012) and in the US (Adkins unpublished).

4. *Brief parent self-efficacy scale (Woolgar)* (Information about the BPSES is from the 'Nurturing Attachments' report)*

Brief parental self-efficacy scale (BPSES) The BPSES is a five item scale that assesses a parent's belief that he/she can effectively perform or manage tasks related to parenting. The scale is recommended by the Child Outcomes Research Consortium (www.corc.uk) for use in the evaluation of parent training and developed by Woolgar (National Academy of Parenting Research, King's College London). Reliability of the scale was good. Alpha .752

5. *Parenting sense of competence (Johnson and Marsh, 1989) . Information from: https://researchingparents.wordpress.com/2013/02/15/parenting-sense-of-competence-psoc/*
   (used by Alan Rushton in his adoption research)

The Parenting Sense of Competence scale measures parental competence on two dimensions: Satisfaction and Efficacy. It is a 16 item Likert-scale questionnaire (on a 6 point scale ranging from strongly agree [1] to strongly disagree [6]), with nine questions under Satisfaction and seven under Efficacy. Satisfaction section examines the parents' anxiety, motivation and frustration, while the Efficacy section looks at the parents' competence, capability levels, and problem-solving abilities in their parental role.

This is free to use and advice is given on analysing questionnaires.

6. *Thinking about your child Questionnaire (Golding and CPLAAC)*

'This measure targets the understanding, confidence, stability and level of reported reward that the parent experiences with the child. Psychometric properties are not available yet for this measure.'

(https://ddpnetwork.org/library/thinking-child-questionnaire-scoring/)

7. *Parent's wellbeing - the Warwick-Edinburgh well-being scale. *(Information about the scale is from the 'Nurturing Attachments' report)*

The Warwick-Edinburgh Mental Well-being Scale (WEMWBS) The Warwick-Edinburgh Mental Well-being Scale was funded by the Scottish Government National Programme for Improving Mental Health and Well-being, commissioned by NHS Health Scotland, developed by the University of Warwick and the University of Edinburgh, and is jointly owned by NHS Health Scotland, the University of Warwick and the University of Edinburgh. The WEMWBS is a validated measure of mental well-being (age 13-74). It is a 14 item scale with five response categories, summed to provide a single score ranging from 14-70. The items are all worded positively and cover both feeling and functioning aspects of well-being. The findings can be used to establish whether a specific population or group of people has low, average or high mental well-being and can be used to measure changes over time. WEMWBS has proved sensitive to change at both the group and individual level. At group level, in keeping with other studies, changes of half a standard deviation or more are likely to be important. The importance of a change of three or more points has been corroborated in a further study which examined score changes on WEMWBS compared to the gold standard of clinical assessment of change in the context of a counselling service (http://www2.warwick.ac.uk/fac/med/research/platform/wemwbs/)

8. Experience of Service Questionnaire (ESQ) (Brown et al., 2014). Information available from: http://www.corc.uk.net/outcome-experience-measures/experience-of-service-questionnaire/

The Experience of Service Questionnaire (ESQ, formerly CHI-ESQ) was developed by the then Commission for Health Improvement (now the Health Care Commission) as a means of measuring service satisfaction in Child and Adolescent Mental Health Services. The CHI-ESQ was originally used as an anonymous measure for one-off audits of service delivery but CORC recommends that it should be used routinely in conjunction with other core measures so that a family's experiences with the service can be understood alongside the child's symptom reduction.

The ESQ consists of 12 items and three free text sections looking at what the respondent liked about the service, what they felt needed improving, and any other comments.

There are three versions of the ESQ: ESQ Child Self-report for 9-11 year olds; ESQ Child Self-report for 12-18 year olds; ESQ Parent/carer report.

This is free to use and guidance is given on the website about analysis.

Measures for children to complete:

1. *SDQ self-report version (from age 11)*

(Information as above)

2. *The Inventory of Parent and Peer Attachment, Revised (Armsden & Greenberg, 1987; Gullone & Robinson, 2005): (Information about the IPPA is from the 'Contact after adoption' study, Neil et al 2013)*

This is a measure of adolescents' perceptions of their relationships with their parents and peers, in particular how well these figures serve as sources of psychological security. It examines three dimensions: degree of mutual trust; quality of communication; and extent of anger and alienation. Only the parent part of this measure was used. Young people used a 5 point Likert scale to rate on how true a set of statements were (never true to always true). Although the original version of the IPPA asks questions in relation to parents, in line with the latest revision by Armsden & Greenberg (2009) we had two separate scales-one for the adoptive mother and one for the adoptive father. The items were positively and negatively phrased and included statements such as 'My mother accepts me as I am' (trust item), 'My father supports me to talk about my worries' (communication item) and 'I get upset a lot more than my mother knows about' (alienation item). For the wording of the 28 items, we use the revised version of the IPPA developed by Gullone & Robinson. The items have the same meaning as the original version, but the wording is slightly easier for use with children and adolescents

3. *Experience of Service Questionnaire (ESQ) (Brown et al., 2014). Information available from: http://www.corc.uk.net/outcome-experience-measures/experience-of-service-questionnaire/*

(information as above)
