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Independent evidence review of post-adoption support interventions

Research report

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Executive summary

Overview

This report presents the main findings from a review of available evidence relating to 15 adoption support therapeutic interventions between August and November 2015. The interventions were selected as those that are most frequently funded through the Adoption Support Fund (ASF) or judged to be most high profile in the field of adoption support. This review was an initial step in a longer-term process led by DfE to improve the evidence base in post-adoption therapeutic support. Its overall aims were to better understand key post-adoption therapeutic interventions for children and families; to examine the extent of the existing evidence on their effectiveness in achieving successful outcomes for adopted children and their families; and to identify gaps and make recommendations on what future research is needed.

Background

Many adopted children have experienced painful, fragmented, unstable and chaotic beginnings to their lives, and evidence suggests that a high proportion – as many as 72% – have experienced abuse or neglect (Selwyn et al., 2014). These children have often suffered from psychological, sexual or physical abuse, neglect and malnutrition, exposure in the family to drugs and alcohol, parental mental health problems and domestic violence (Lewis and Ghate, 2015). This often results in a range of emotional and behavioural challenges, leading to adopted children being more likely to experience physical, emotional, cognitive, educational and social development needs (Richardson and Lelliott, 2003), and being at greater risk of poor mental health throughout their life span (McCann et al., 1996; Saunders and Broad, 1997). Due to the disturbances of their attachment patterns and experiences of early life trauma, the most severe consequences for adopted children and young people are those affecting the quality of their relationships (Stateva and Stock, 2013).

There is a growing drive to improve the therapeutic mental health support for adopted children as highlighted by Pennington (2012), with the aim to address and reverse the emotional, psychological and developmental traumas they may have suffered in their early lives. This concern was embodied in the launch of the national Adoption Support Fund (ASF) in May 2015, which initially provided funds £19.3 million over two years to improve adopted families access to therapeutic support, including growing local markets of therapeutic providers – the ASF was extended in January 2016 to provide support to families over the next 4 years. The fund recognises that adoption can improve outcomes and stability for looked after children (Holloway, 1997), but that many families post-adoption have short- and long-term therapeutic support needs that are currently not

being met, in particular help in managing the consequences of early childhood trauma, difficult behaviours and attachment problems (Randall, 2009; Atkinson and Gonet, 2007).

However, despite such an increased focus on improving post-adoption therapeutic support, there is a lack of knowledge of both the content of different interventions being delivered to adopted families through the Adoption Support Fund and their evidence base (Lewis and Ghate, 2015; NICE, 2015).

Methodology

The Department for Education (DfE) commissioned the Tavistock Institute of Human Relations (TIHR) to undertake an evidence review of the efficacy of 15 of the most well used, and high profile, therapeutic post-adoption support interventions. These included: Theraplay, Creative therapies, Filial Therapy (FT), Psychotherapy, Non-Violent Resistance (NVR), AdOpt, Break4Change, Multisystemic Therapy (MST), Dialectical Behaviour Therapy (DBT), Nurturing Attachments, SafeBase, Therapeutic Parenting Training, Eye Movement Desensitisation and Reprocessing Therapy (EMDR) and Equine Therapy.

The review aimed to better understand what these therapeutic interventions involve, and examine the extent of the existing evidence on their effectiveness.

The aims of the review can be divided into three overarching research questions:

1. What are the interventions: how are they delivered and what do they aim to achieve?
2. What evidence exists about whether each intervention does or not does not work?
3. What further research is needed to improve the evidence base for each intervention?

The review itself consisted of a rigorous review of the evidence, using a combination of realist synthesis (Pawson et al., 2004) and an understanding of evidence quality developed by Nutley et al. (2012). This was used to categorise each of the 15 interventions on a scale of evidence, including:

- Good-practice: 'we've done it, we like it and we feel it makes an impact' – this is likely to involve no robust empirical evidence, although some qualitative or anecdotal evidence from participants indicates that the approach is liked and is seen as having a positive impact

- Promising approach: some positive research findings, but the evaluations are not consistent or robust enough to be sure – this is likely to include small-scale empirical studies with no control groups
- Research-based approach: the programme or practice is based on sound theory informed by a growing body of robust empirical research – likely to include several cohort studies using pre- and post-treatment scales, as well as some small scale or explorative randomised controlled trials (RCTs)
- Evidence-based approach: the programme or practice has been rigorously evaluated and has consistently been shown to work – this is likely to involve several large scale cohort studies and RCTs.

For the purposes of this review, the 15 interventions were grouped into five broad categories based on their theoretical orientation; the main features of their clinical practice; and their target groups (in terms of either specific groups of people, such as adopted children, or for people with particular mental health problems). These are:

- **Play therapies:** including Theraplay, Filial therapy and SafeBase. These three interventions have many features in common, in particular they all draw on a developmental view of psychopathology and are underpinned by a focus on attachment and the disruptive effects of early trauma. Furthermore, both Theraplay and Filial Therapy were developed for use with pre-adolescent children and are delivered with both children and parents, while SafeBase is delivered predominantly just to parents.
- **Therapeutic parenting training:** includes DDP, Nurturing attachment and AdOpt. These interventions share key features with the play therapies, in the sense that they take a developmental view of the child, drawing on attachment and trauma theory. With the exception of DDP, which also includes the child, the key difference is that these interventions tend to work predominantly with parents only and focus on developing the parents' skills so as to improve parent-child interactions.
- **Conduct problem therapies:** this category, which includes NVR, MST and Break4Change, brings together three interventions designed to address serious conduct problems, such as child to parent violence and serious offending. A broad range of theories underpin the different approaches; however, they all share a systemic view that encompasses the family and wider social ecology of the individual child in trying to address difficulties.
- **Cognitive and Behavioural Interventions:** includes EMDR and DBT; both of these employ cognitive approaches to the treatment of particular mental health conditions, particularly DBT which represents an adaptation of CBT for people with Borderline Personality Disorder. EMDR, in contrast, emphasises the role of memory and information processing in addressing trauma. Both are highly structured interventions based on set treatments protocols.

- **Overarching categories:** this umbrella category was used to group together those therapies under study that represent whole classes of approaches rather than tightly defined interventions, including psychotherapy, creative therapies and equine therapy.

Key findings

Extent of evidence: general overview

- The review identified very few robust published studies providing evidence of the effectiveness of the 15 interventions for adopted children and/or adoptive parents.
- For some of the 15 interventions the review found no robust published evidence to date (AdOpt, Break4Change), while for others there is an extensive/fairly extensive evidence base – but only for particular conditions or issues rather than adopted children per se (MST, EMDR, DBT, NVR).
- There are very few robust published studies from the UK focussing on the effectiveness of the 15 interventions.
- There is a need for a further follow-up review to explore the evidence more fully, to explore the literature on other interventions in use in the UK not included in this review, and for additional studies to improve the evidence base.

Play Therapies

- Overall, the review identified very little robust published research on the effectiveness of play therapies for adopted children and no robust published studies from the UK.
- Theraplay is an attachment-focussed play intervention, typically for children aged 0-12 years and their parents and usually lasting 18-24 weeks. The review classified it as research-based.
- Filial Therapy is similarly a research-based integrative family play therapy, usually involving weekly sessions of small groups of parents and their children aged 3-12 years, also normally lasting for 18-24 weeks.
- SafeBase is a play-based, therapeutic parenting intervention, derived from Theraplay, and designed for parents of adopted children from birth up to their teenage years, with weekly parenting groups typically lasting 6-months. It was classified as a promising approach.

Therapeutic Parenting Training

- Dyadic Developmental Psychotherapy (DDP) is a framework to support looked after and adopted children that has multiple applications, including as an approach to psychotherapy for 0 - teenage years, lasting up to 15 months.
- There is only one quasi-experimental study from the USA for DDP – it is therefore classified as a promising approach.
- Nurturing Attachments is derived from DDP and is a group training programme for parents/carers of adopted or fostered children, typically delivered in 6 three hour sessions.
- Studies for Nurturing Attachments are mainly small scale and with no control groups (with the exception of one study of the related Fostering Attachments intervention) – it is categorised as a research based intervention.
- AdOpt: is a group-based parenting programme developed for adopted parents, involving weekly sessions for a duration of 16 weeks, alongside video feedback.
- There are no published research studies yet for AdOpt although there is one ongoing study – it was therefore classified as good practice only.

Conduct problem therapies

- Multisystemic Therapy (MST) is a holistic family and community intervention to help young people with antisocial or disruptive behaviours that lasts on average 4-6 months. The treatment has been rigorously evaluated and was therefore classified as evidence-based.
- Non-Violent Resistance is a research-based, systemic family therapy to address child-parent violence, involving weekly therapy with parents and crisis telephone coaching, for 3-4 months.
- Most of the evidence for NVR and MST comes from abroad (USA, Israel and Germany).
- Break4Change is a group-based programme for teenagers and parents to address child-parent violence, typically involving weekly sessions for 12 weeks.
- There is no robust published research yet for Break4Change – it is therefore classified as good practice.
- Overall, there is little research on the effectiveness of interventions aimed at addressing child violence/offending behaviour specifically for adopted children or adoptive parents.

Cognitive and behavioural therapies

- Eye Movement Desensitisation and Reprocessing Therapy (EMDR) is an evidence-based intervention for Post-Traumatic Stress Disorder (PTSD), involving weekly sessions lasting normally between 5-15 weeks.
- Dialectical Behaviour Therapy was classified as an evidence-based form of cognitive behavioural therapy designed for people with borderline personality disorder; it typically lasts one year, including weekly therapy sessions, group work and crisis telephone coaching.
- There is no robust published research on the effectiveness of DBT and EMDR for adopted children.

Overarching categories

- Psychotherapy is an umbrella term for ‘talking therapies’ encompassing a wide range of different theories, approaches and practices, including Psychoanalytic and Psychodynamic, Cognitive–Behavioural, Humanistic, Systemic Family therapies, and Integrative Therapy. It is categorised as evidence-based, but research is stronger for some types of approaches – the evidence is most extensive for CBT, including for children in foster care.
- Equine Therapy is an overarching term for a range of different interventions and promising approaches, that use horses or other equines, with varied target groups, including people with physical disabilities or issues such as ADHD, PTSD and attachment problems.
- Creative Therapies is an umbrella term for therapies that involve the arts or non-verbal forms of communication in a therapeutic setting. This includes art, music, drama, dance and play therapies among others, and can be seen as research-based.
- There are no robust published research studies for any of these interventions on their effectiveness for adopted children.

Recommended steps to build the evidence base

- The evidence base could be strengthened via a follow-up review using a ‘needs-based’ rather than an ‘intervention-based’ model, to explore which approaches (single or combined interventions) are effective in addressing particular needs or issues. This could go further than the current study by looking beyond the extent of the evidence base to examining the findings of which approaches work and why.
- A wider range of interventions could be included in a follow up review, including holistic models such as that of Family Futures, PAC-UK or AdCAMHS in Sussex.

- Qualitative and process evidence could be explored to understand adoptive family experiences and why interventions may or may not work.
- There is also a need for more robust quantitative research on the impact of particular interventions or combinations of interventions.

1. Background, Aims and Approach

1.1 Needs of Adoptive Children

Many adopted children have experienced painful, fragmented, unstable and chaotic beginnings to their lives, and evidence suggests that a high proportion – as many as 72% – have experienced abuse or neglect (Selwyn et al., 2014). These children have often suffered from psychological, sexual or physical abuse, neglect and malnutrition, exposure in the family to drugs and alcohol, parental mental health problems and domestic violence (Lewis and Ghate, 2015). Adverse childhood experiences often result in a range of emotional and behavioural challenges, leading to adopted children being more likely to experience physical, emotional, cognitive, educational and social development needs (Richardson and Lelliott, 2003), and being at greater risk of poor mental health throughout their life span (McCann et al., 1996; Saunders and Broad, 1997) than their peers. The disturbances of their attachment patterns and experiences of early life trauma in many cases also negatively affect the quality of their relationships during adolescence and in later life (Stateva and Stock, 2013).

Recent government reform as outlined in the Action Plan for Adoption (2012) aims to improve the efficiency of the adoption process and support to adoptive families. This builds on the Adoption and Children Act (2002) and the Adoption Support Services Regulation (2005), which introduced regulations and guidance to minimise delays in adoptions, and to improve the support provided. Families have the right to an assessment of their support needs, but provision of support is not statutory and differs across local authorities. This can include (means tested) financial support, access to support groups, help with contact with birth families, therapeutic support, respite care and assistance in cases of disruption (Farmer et al., to be published). Large numbers of adoptive families are not getting sufficient support post-adoption due to lack of service capacity, disjunctions between family needs and provision offered, or lack of awareness by adopters of support available (Rushton, 2003; Sturgess and Selwyn, 2007). If these needs are not addressed it can risk placement disruption (Sturgess and Selwyn, 2007).

There is a growing drive to improve the therapeutic mental health support for adopted children as highlighted by Pennington (2012), with the aim to address and reverse the emotional, psychological and developmental traumas they may have suffered in their early lives. This concern was embodied in the launch of the national Adoption Support Fund (ASF) in May 2015, which initially provided funds £19.3 million over two years to improve adopted families access to therapeutic support, including growing local markets of therapeutic providers – the ASF was extended in January 2016 to provide support to families over the next 4 years. The fund recognises that adoption can improve outcomes and stability for looked after children (Holloway, 1997), but that many families post-adoption have short- and long-term therapeutic support needs that are currently not being met, in particular help in managing the consequences of early childhood trauma, difficult behaviours and attachment problems (Farmer et al., to be published; Randall,

2009; Atkinson and Gonet, 2007). A growing body of evidence indicates that unaddressed mental health needs in adopted children can have a serious impact on placement success and increase the risk of disruption, further risking the long-term outcomes of adopted children (Selwyn, 2014). The failure of statutory services to address the mental health needs of vulnerable children was acknowledged in the Children and Adolescent's Mental Health Services (CAMHS) taskforce report *Future in Mind*, and for adopted children in particular, the urgent need to better tackle the impact of early-life trauma (NHS England, 2015). It was within this context that the Department for Education (DfE) held a Roundtable on Mental Health and Adoption Support to look at what more can be done to improve provision and access to mental health services for adopted children, discuss how best to transform services as set out in *Future in mind* and explore good practice examples.

However, despite increasing focus on improving post-adoption therapeutic support, there is a lack of knowledge of both the content of different interventions being delivered to adopted families and their evidence base; whether or not they achieve the outcomes for adopted children they intend. A rapid review as part of the evaluation of the Adoption Support Fund's prototypes drew attention to the potential lack of robust evidence underpinning a number of the therapeutic interventions being financed through the fund (Lewis and Ghate, 2015; NICE, 2015).

1.2 Aims of the Evidence Review

This review addresses the overall aim to better understand a selection of therapeutic interventions for children and families post-adoption, and examine the extent of the existing evidence on their effectiveness in achieving successful outcomes for adopted children and their families. This is an initial step in a longer-term process led by DfE to improve the evidence base in post-adoption therapeutic support. Hence, a key purpose of this review is to identify gaps and make recommendations on what future research is needed.

The review can be seen as having a descriptive and explanatory purpose, to improve understanding of what the main therapeutic interventions involve, including their origins, theory and content, to map what impact evidence currently exists, and make suggestions on next steps to improve this evidence base. It is not the purpose of this review to explore the findings of the impact evidence and make judgments on whether particular interventions work or do not work. Given this, the aims of the review can be divided into three overarching research questions (Table 1).

Table 1 Research questions

	Sub-questions
<p>1a. What are the interventions: How are the therapeutic interventions delivered?</p>	<p>Roots of each intervention: Where was it developed and by who? When was it introduced into the UK? Have any other approaches/interventions developed from it? Was it originally designed for adopted children or other groups?</p>
	<p>Delivery: Is there an official body or service that oversees delivery of the intervention/practitioners? What qualifications/accreditation do practitioners need to deliver the intervention? Is the intervention manualised? How do practitioners know how to deliver the intervention? Is there a specific assessment process prior to embarking on the intervention? Is there a typical length/dosage of treatment and how much is this likely to cost?</p>
	<p>Other interventions: Are there any other therapeutic interventions with a significant role in adoption support? Are they generic or specifically aimed at adopted children and families? Is a further evidence review needed on these interventions?</p>
<p>1b. What are the interventions: What do they aim to achieve?</p>	<p>Target Group Needs: What are the needs of adopted children and families that the intervention claims to treat/support? Is the intervention designed for a specific target group? Why is the intervention suitable for adopted children and families?</p>
	<p>Theory: What theories of change are there? What approach does the intervention stem from e.g. behavioural or relationship based and does it rely on any particular theories e.g. social learning theory.</p>
<p>2. What evidence exists on whether each intervention does or does not work?</p>	<p>Impact: What is the UK and international evidence base on the impact of the intervention for adopted children and families? How robust is this evidence? Are there any gaps in the evidence on the intervention's impact?</p>
	<p>Why it works: Why does it work, with whom and where? Are service users satisfied?</p>
<p>3. What further research is needed to improve the evidence base for each intervention?</p>	<p>Plans and Evidence Standards: Are there any existing plans to improve the evidence base? What standards of evidence are needed?</p>
	<p>Recommendations: What is recommended to make the evidence base for the interventions more robust? What practical steps need to take place?</p>

The DfE, in collaboration with stakeholders, identified 15 therapeutic interventions that are the most frequently funded through the Adoption Support Fund (ASF) or judged to be

high profile in the adoption support field, to be reviewed within this study. These interventions are:

- Dyadic Developmental Psychotherapy (DDP)
- Theraplay
- Creative therapies
- Filial Therapy (FT)
- Psychotherapy
- Non-Violent Resistance (NVR)
- AdOpt
- Break4Change
- Multisystemic Therapy (MST)
- Dialectical Behaviour Therapy (DBT)
- Nurturing Attachments
- SafeBase
- Therapeutic parenting training
- Eye Movement Desensitisation and Reprocessing Therapy (EMDR)
- Equine Therapy

The review consisted of a rigorous review of the evidence, using a combination of realist synthesis (Pawson et al., 2004) and an understanding of evidence quality developed by Nutley et al. (2012). This matched the descriptive purpose of the review, and the pragmatic concern around a paucity of research, that required an examination of broader sources of evidence and a more flexible review method than a traditional systematic review.

The review encompassed 15 interventions. Therefore, due to the constraints of time and available information, it predominantly focussed on how these interventions related to adopted children and their families. However, where no such evidence was available, it also explored other key studies related to the content and effectiveness of the interventions aimed at looked after children or in relation to relevant mental health problems. While a broad understanding of evidence was applied to answer the first research question, time limitations in identifying the extent of the impact evidence (research question 2), meant the review had to mainly focus on robust quantitative studies including meta-analyses, RCTs and before and after studies with or without comparison groups. However, the review team strongly recognises the value of qualitative studies in answering questions about 'what works', in particular the

experiences of adopted families, and recommends that this evidence is considered in a follow-up review (see Chapter 4). For full details of the methodology, please see Appendix B.

2. Theories of Therapeutic Support for Adoptive Families

Key Findings

- There are many different types of treatments of relevance to adopted children and their families based on a range of theories, linked to different therapeutic practices, training and regulation, mode of delivery, target group, setting and length of treatment.
- The major categories of psychological therapies include Psychoanalysis and Psychodynamic Therapies, Cognitive and Behavioural Therapies, Humanistic Therapies, Systemic and Family Therapies and Integrative Therapies.
- For the purposes of this review, the 15 interventions have been categorised into the following five clusters based on their theoretical orientation, the main features of their clinical practice and their target groups:
 - Play therapies
 - Therapeutic parenting training
 - Conduct problem therapies
 - Cognitive and Behavioural Therapies
 - Overarching categories.

2.1 Theories and Types of Therapy

There is a vast range of treatments and therapies available for those with mental health, behavioural or emotional difficulties (Lebow, 2012). In addition to psychiatric or medical treatments there are various psychosocial or psychological therapies with different underlying theories about the causes of mental distress. These in turn are linked with a broad range of therapeutic practices. There is no definitive categorisation of types of therapies, with different commentators identifying different broad categories. Key ways of distinguishing therapeutic approaches are by: underlying theory (discussed below); therapeutic practice (use of particular therapeutic techniques); the role of the therapist (interpretive, directive, non-directive); training and regulation; mode of delivery or target group (one-to-one, group, family, couple, child); setting (inpatient, clinical, out-patient consulting room, community or home-based); and length of treatment (brief, long-term or open ended).

The major traditions and underlying theories of psychological therapies are:

- **Psychoanalysis and Psychodynamic Therapies:** Drawing on the writings of its founder Sigmund Freud, this is the oldest class of “talking therapies”. Concerned with the relationship between past and present, this approach views psychopathology in terms of unconscious conflicts within the client. This approach tends to involve regular 50-minute, 1 to 1 sessions, where the role of therapist is to interpret and reflect on what the client brings. It has numerous schools and has derivations developed to work with groups, couples, and children.
- **Cognitive–Behavioural Therapies (CBT):** A combination of Behavioural therapy and Cognitive therapy, these therapies focus on addressing problems through changes in behaviour and thinking. For example, CBT focuses on both how the client thinks about themselves, others and their wider context and on how their own behaviour may perpetuate problems experienced. It tends to be problem-orientated and, as with psychoanalytic approaches, CBT involves regular sessions with a therapist or coach. CBT interventions tend to be future orientated and relatively brief (for example 6 sessions) but in some cases therapy can be more lengthy (30 sessions).
- **Humanistic Therapies:** These therapies draw on humanistic and existential philosophy, and emphasise people's capacity to make rational choices and make meaning in their lives. The three main types are: client-centred, Gestalt and Existential therapy. Sometimes described as ‘non-directive therapies’, these approaches emphasise the therapist as a partner in the therapy as opposed to the expert or doctor.
- **Systemic and Family Therapies:** Based on systems theory and family therapy, these approaches tend to focus beyond the individual on their wider social network, including their family and other close relationships. Rather than seeking to identify pathologies within the individual, such therapies aim to identify and change patterns of behaviours or ways of relating. Normally, systemic therapies involve more than just the person experiencing problems such as their family or other close family members.
- **Integrative (also known as eclectic or holistic) Therapies:** This group of therapies describe the way in which many practitioners combine multiple approaches. Many of such interventions draw on a range of theoretical foundations and adopt practices from a range of therapies. In practice, many mental health professionals tailor their approach to the needs of their clients and draw on various theoretical and practical traditions to provide treatment and support. Many of the interventions included in this review could be described as integrative.

2.2 Grouping the Interventions

For the purposes of this review, we have sought to group the interventions under study into five broad categories to help draw out some of their similarities and differences. To this end, we have adopted a pragmatic approach that categorises interventions based on their theoretical orientation; the main features of their clinical practice; and their target groups (in terms of either specific groups of people, such as adopted children, or for people with particular mental health problems). Consideration has also been given to the mode of delivery and the history of the interventions. We recognise that, there is, of course, some degree of overlap between categories and some approaches could fit within more than one category. However, this approach was felt to provide a good way of structuring and discussing available evidence in a helpful way. The five categories used are:

- **Play therapies:** This category includes **Theraplay, Filial therapy and SafeBase**. These three interventions have many features in common, in particular they all draw on a developmental view of psychopathology and are underpinned by a focus on attachment and the disruptive effects of early trauma. Furthermore, both Theraplay and Filial Therapy were developed for use with pre-adolescent children and are delivered with both children and parents, while SafeBase is delivered predominantly just to parents.
- **Therapeutic parenting training:** Contains **DDP, Nurturing attachment, and AdOpt**. These interventions share key features with the play therapies, in the sense that they take a developmental view of the child, drawing on attachment and trauma theory. With the exception of DDP, which also includes the child, the key difference is that these interventions tend to work predominantly with parents only and focus on developing the parents' skills so as to improve parent-child interactions.
- **Conduct problem therapies:** This category, which includes **NVR, MST and Break4Change**, brings together three interventions designed to address serious conduct problems, such as child to parent violence and serious offending. A broad range of theories underpin the different approaches; however, they all share a systemic view that encompasses the family and wider social ecology of the individual child in trying to address difficulties.
- **Cognitive and Behavioural Interventions:** Contains **EMDR and DBT**; both of these employ cognitive approaches to the treatment of particular mental health conditions, particularly DBT which represents an adaptation of CBT for people with Borderline Personality Disorder. EMDR, in contrast, emphasises the role of memory and information processing in addressing trauma. Both are highly structured interventions based on set treatments protocols.
- **Overarching categories:** This umbrella category was used to group together those therapies under study that represent whole classes of approaches rather

than tightly defined interventions, including psychotherapy, creative therapies, and equine therapy.

3. Findings on the Interventions

Key Findings

- The review identified very few robust published studies providing evidence of the effectiveness of the 15 interventions for adopted children and/or adoptive parents.
- For some of the 15 interventions we found no robust published evidence to date (AdOpt, Break4Change), while for others there is an extensive/fairly extensive evidence base – but only for particular conditions or issues rather than adopted children per se (MST, EMDR, DBT, NVR).
- There are very few robust published studies from the UK focussing on the effectiveness of the 15 interventions.
- There is a need for a further follow-up review to explore the evidence more fully, to explore the literature on other interventions in use in the UK not included in this review, and for additional research to improve the evidence base.

This section outlines the main findings from the review of evidence for the 15 interventions – as noted in Chapter 1, the main aims of this review were to explore the origins, aims, theory and content of the interventions, and the **extent** of evidence on whether they work. This chapter uses the concept of an ‘evidence journey’ (Nutley et al., 2012) to map the current position of each of the 15 interventions towards being fully ‘evidence-based’ and also builds on the distinction between ‘robust impact evidence’ and ‘supporting impact evidence’ introduced in Chapter 1.

Such an evidence journey consists of the following four stages (Nutley et al., 2012):

- **Good-practice:** ‘we’ve done it, we like it and we feel it makes an impact’ – this is likely to involve no robust empirical evidence, although some qualitative or anecdotal evidence from participants indicates that the approach is liked and is seen as having a positive impact
- **Promising approach:** some positive findings but the evaluations are not consistent or robust enough to be sure – this is likely to include small-scale empirical studies with no control groups
- **Research-based:** the programme or practice is based on sound theory informed by a growing body of robust empirical research – likely to include several cohort studies using pre- and post-treatment scales, as well as some small scale or explorative randomised controlled trials (RCTs)
- **Evidence-based:** the programme or practice has been rigorously evaluated and has consistently been shown to work – this is likely to involve several large scale cohort studies and RCTs.

The following sections focus on each of the 15 interventions in turn – they start by providing an overview of the origins, aims and content of the intervention, and then map the current position of each intervention on the evidence journey. This is done by providing an initial summary of the available evidence, followed by details of the robust impact studies, where available, identified for each intervention.

3.1 Play Therapies

Key Findings

- Theraplay is a **research-based** attachment-focussed play intervention typically for children aged 0-12 years and their parents, which typically lasts 18-24 weeks.
- Filial Therapy is also a **research-based** integrative family play therapy, usually involving weekly sessions of small groups of parents and their children aged 3-12 years, lasting for 18-24 weeks.
- SafeBase is a play-based, therapeutic parenting intervention, derived from Theraplay, and designed for parents of adopted children from birth up to their teenage years, with weekly parenting groups typically lasting 6-months. It is classified as a **promising approach** on the evidence journey.
- There is very little/no robust published research on the effectiveness of play therapies for adopted children and no robust published studies from the UK.

3.1.1 Theraplay

Theraplay: is an attachment-focussed play intervention to help children feel safe and secure, better regulate their emotions and build parent-child relationships through fun and physical activities. It was designed for parents and their children aged 0 - 12 years old, involving weekly sessions for 18-24 weeks; however, the intervention has expanded to other target groups and settings.

What is the Intervention?

Theraplay was developed by Ann Jernberg and her assistant Phyllis Booth in the late 1960s while she worked at the Head Start programme in Chicago, a US child development programme for pre-school children and families in poverty (Jernberg, 1979; Jernberg and Booth, 1999; Booth and Jernberg, 2010). Jernberg identified high numbers of children needing psychological help but the resources for children's mental health support at the time were unable to meet the level of presenting need (TI, 2015). Based on the work of Austin Des Lauriers (1962) and Viola Brody (1997), she developed

Theraplay, a therapeutic attachment-based play intervention that could be delivered by non-clinical staff and supervised by mental health professionals. It draws on attachment theory, self-psychology and object relations theory from the work of Winnicott (1957; 1958), as well as child development and neuroscience (Siegal, 1999). Theraplay is an interactive short-term play therapy designed to replicate a healthy parent-child relationship, with the aim of improving child social interactions with their carers (TI, 2015; Wettig et al., 2011; Booth and Jernberg, 2010; Snipp, 2004). Initially the intervention was not specifically designed for adopted or fostered children, but latterly models have developed to work with this group. Theraplay is used to treat a range of issues, including attachment disorders, social anxiety and shyness, as well as developmental and communication disorders such as speech delay (Wettig et al., 2011; Munns, 2000). Its rationale is that children with disrupted attachments, have experienced inadequate structure, nurturing, play, touch and a lack of positive challenge and boundary setting by their parent/carer. Theraplay therefore aims to build parent-child attachments, and seeks to improve a child's self-confidence and trust in others, alongside facilitating happy interactions and engagements with others. Theraplay is designed to be playful, physical and fun, to create a positive emotional connection between the child and therapist, which leads to the child feeling loved, worthy, and to experience relationships with their parent/carer as positive and rewarding (Booth and Jernberg, 2010; Jernberg and Booth, 1999; Munns, 2000; Wettig et al., 2001; TI, 2015).

Typically each Theraplay session is designed for children from 0-12 years, lasts at least thirty minutes on a weekly basis, for a duration of 18-24 sessions. However the exact length of treatment varies depending on the needs of the child (Booth and Jernberg, 2010; Wettig et al., 2011). Theraplay is relationship-based, focusing on replicating an experience of secure attachments between the child and therapist, that in turn helps the child better relate to their parent/carer (Booth and Jernberg, 2010; Bowlby, 1969). It uses fun, lively and interactional play activities that are carefully structured to enable the child to experience pleasure and enjoyment in their relationships (Booth and Jernberg, 2010; Panksepp, 2007), alongside positive and safe use of touch (Williamson and Anzalone, 1997). Since the early 1970s, Theraplay has been used in conjunction with the Marschak Interaction Method (MIM), a clinical assessment tool using structured observation to understand parent-child interactions in order to plan therapeutic treatments. MIM takes up to an hour to administer, using set tasks that are videotaped (Marschak, 1960; Martin, 2006). The core concepts behind Theraplay are a focus on creating positive 'here and now' experiences (TI, 2015; Trevarthen and Aiken, 2001); a safe, structured 'holding environment' with an adult that provides appropriate boundaries, to help the child better regulate their emotions (Winnicott, 1987; Sroufe, 2005); empathy and attunement to the child's and parent's needs (Bowlby, 1988; Stern, 1985); which in turn aims to reorganise a child's brain and patterns of behaviour to change how they interact with others (TI, 2015; Schore, 1994). Theraplay involves four dimensions: the use of structure by setting boundaries and clear rules to help the child feel safe and

secure; fun activities to help the child engage with their caregiver, such as peek-a-boo and games; nurturing and soothing to help the child feel unconditionally cared for, such as rocking and humming; and finally, playfully challenging the child, to express and release pent-up emotion in a safe way, such as tug-of-war or pillow fighting (Wettig et al., 2011; Jernberg, 1979; Jernberg and Booth, 1999; Booth and Jernberg, 2010; Snipp, 2004).

Theraplay was traditionally used in individual sessions with a child and their parents, but has been adapted to work with particular groups including sexually abused, fostered and adopted children, children that have experienced domestic violence, those with autism, down syndrome, ADHD, selective mutism, foetal alcohol syndrome and deaf children, among others (Munns, 2000; TI, 2015). Other variations include using Theraplay with older age groups such as adolescents and the elderly, in settings such as schools, mental health hospitals, or homeless shelters, and in group formats such as with siblings, whole families and parent groups (Ibid). Theraplay has close connections with Dyadic Developmental Psychotherapy (DDP) and has given rise to similar interventions such as SafeBase (Meredith, 2010; After Adoption, 2015a; Neil, 2015).

The manual for delivering Theraplay is now in its third edition (Booth and Jernberg, 2010; Jernberg and Booth, 1999; Jernberg, 1979) and this is complimented by a manual and activity book for the Marschak Interaction Method assessment tool (TI, 2011). Theraplay is aimed at social care and mental health professionals, such as social workers and school counsellors that do not necessarily have to have clinical training as psychotherapists, although many clinicians also deliver the intervention (Booth and Jernberg, 2010). In 1971, the Theraplay Institute (TI) was founded to oversee implementation and provide training and supervision. The Institute is currently the only organisation that can certify Theraplay therapists. All Theraplay training is approved by the Association for Play Therapists (A4PT), National Board for Certified Counsellors, American Psychological Association in the US (TI, 2015a). However, there are not yet equivalent relationships with UK professional bodies to accredit Theraplay such as the British Association for Counselling and Psychotherapy (BACP), The British Association of Play Therapists (BAPT) or the Professional Standards Association. Alongside introductory seminars for professionals interested in undertaking Theraplay training, there are two levels of training available, both of which need to be completed to become a certified Theraplay practitioner. Level One is a four-day introductory practitioner certificate including eight two-hour group supervision meetings, and Level Two, is a modular three-day training course (TI, 2015a). Further training includes a course in Group Theraplay for use in schools and other group settings, and Masterclasses for certified practitioners on specialist areas, such as using theraplay with children that have experienced sexual abuse, or combining Theraplay with DDP (Ibid; Booth and Jernberg, 2010; Wettig et al., 2011).

Extent of Impact Evidence

Research-based: Overall, the review found no published research of the impact of Theraplay on adopted children. It did find robust evidence of its impact for other groups of children, but none of the published studies were based on research conducted in the UK and most of the studies were either small-scale and/or did not include a control group.

The available evidence includes a meta-analysis (Wardrop and Meyer, 2009) of previous research, which found some evidence of effectiveness for the following groups of children:

- Language disabled children
- Children with behaviour disorders
- Children with mild-moderate autism/PDD
- Foster children.

However, sample sizes for most of the studies included were small and many did not use control groups.

The current review identified evidence of the impact of Theraplay from Germany (Wettig et al., 2011), Iran (Mousavi, P.S. et al., 2014), the USA (Weir et al., 2013), Canada (Bojanowski and Ammen, 2011) and Hong Kong/China (Siu, 2009; 2014). Most of the studies used quasi-experimental research designs only or did not include a comparison or control group. The exceptions are two studies by Siu (2009; 2014), which used an RCT design.

Siu (2014) explored the impact of a program 'using Theraplay principles' lasting for a whole year in a special school in Hong Kong for children with developmental disabilities to enhance their social development. The sample included 38 children of which 23 were randomly assigned to receive the treatment and 15 randomly assigned to a control group. The results showed significant improvements for Social Awareness, Social Cognition, Social Communication; and Social Motivation compared with the control group.

Additionally, Siu (2009) reports on a waiting list RCT as part of which 46 children with internalising problems were randomly allocated to receive 8 weekly Theraplay sessions or to a waitlist group. The study showed that Theraplay reduced the number of internalising symptoms compared with children in the control group.

3.1.2 Filial Therapy

Filial Therapy: is an integrative family play therapy, designed to treat a range of family problems, and most recently applied to issues of attachment and trauma. It involves small groups of parents and their children aged 3-12 years, in weekly group sessions that typically last for 18-24 weeks, alongside skills practice, group reflection and individual supervision with a therapist. A wide range of adaptations has emerged.

What is the Intervention?

Filial therapy is a type of family play therapy developed in the 1960s by Bernard and Louise Guerney (Guerney, 1964, 1976, 1997; Andronica et al., 1967) in the US at Rutgers University, who then established the National Institute of Relationship Enhancement. It was first introduced in the UK by Risë VanFleet from 2002 (NIRE, 2015; Rye, 2015; Vanfleet, 2011). Filial Therapy was not originally designed for adopted or looked after children, and has been used to treat a range of family problems such as anxiety, depression, family substance misuse, chronic illness, divorce, single parenting, but more recently has been applied to treat trauma and attachment issues (VanFleet and Guerney, 2003; VanFleet and Sniscak, 2012; FEPHT, 2015). This is an integrative therapy based on the client-centred theory of Carl Rogers, the play therapy of Virginia Axline (1947), and using a psycho-educational model. It draws from a wide range of theories including psychodynamic, humanistic, behavioural and social learning theory, interpersonal, cognitive, developmental/attachment, and family systems theory (Cavado and Guerney, 1999; Ginsberg, 2003; Vanfleet, 2009, 2011). Unlike traditional play therapy, Filial Therapy is dyadic, where the client is the parent-child relationship, and where parents are trained to conduct therapeutic non-directive play sessions with their own child. They are supervised by a therapist, who helps parents build their competence and better understand their child's feelings and behaviours (Vanfleet, 2011; Vanfleet and Topham, 2011, Andronico et al., 1967). The aim is to strengthen relationships, reduce the child's anxiety, improve their self-esteem and unlearn difficult behaviours through improved parent-child interactions and understanding of their emotional needs (Ginsberg, 2003; Guerney, 1997). Establishing empathy between parent and child is central, as well as using a psycho-educational model to develop the knowledge, skills and tools of family members to resolve their problems (Vanfleet, 2011a; Vanfleet, 2011b).

Filial therapy is aimed at children aged 3 to 12 years and was originally designed as a group-based programme (Group Filial Therapy), where 6-8 families (both parents and children) can share their difficulties about their parent-child relationship and get feedback in a supportive environment. The typical duration was 18-24 two hour sessions, alongside individual supervision of 4-6 play sessions, skill practice and reflection with therapist feedback (Guerney and Ryan, 2013; Guerney, 1964, 1976, 1997). Vanfleet (2005, 2006, 2011) then adapted Filial Therapy for individual families, involving 15-20 one hour sessions designed for a range of settings such as the family home, schools or

hospitals. Subsequently a wide range of adaptations to Filial Therapy has emerged (VanFleet, 2011b): including the VanFleet-Sniscak Group Format for adoptive and foster families to address trauma and attachment issues (VanFleet and Sniscak, 2012; VanFleet and Guerny, 2003); another individual family model by Ginsberg (1997); a shorter, more focused, manualised 10-week version called Child-Parent Relationship Therapy by Landreth and Bratton (2006); the Wright Walker Group Filial Therapy for Head Start Families (VanFleet and Guerny, 2003); and a 12-week version (Pernet-Caplin FT Format for Disadvantaged families) to treat those affected by natural disasters (VanFleet, 2011b).

There are a number of manuals and training tools on Filial Therapy – often linked to the different adaptations - including *Group Filial Therapy* (Guerny and Ryan, 2013), the *Casebook of Filial Therapy* (VanFleet and Guerny, 2003) amongst others (VanFleet, 2006, Landreth and Bratton, 2006). But there does not appear to be a specific assessment required before delivering the interventions. Several professional bodies and organisations oversee delivery and training of Filial Therapy: in the US the National Institute of Relationship Enhancement (NIRE, 2015) run 2-day courses, and the UK Society for Play and Creative Arts Therapies (PTUK) (a local affiliate of Play Therapy International (PTI) runs the only clinically accredited course in collaboration with APAC (Accredited Play Therapy and Therapeutic Play Training Courses). This is a 4 day course designed for Certified Play Therapists with at least 100 hours supervised clinical experience in non-directive play therapy. In 2013 the PTUK also developed a register of accredited play therapists in Filial Therapy, by the Professional Standards Authority (PTUK, 2015). However, there are many other courses available in Filial Therapy given its diverse variations (IATE, 2015; Thomas, 2015), and in general, Filial Therapy does not require specific qualifications except for recommendations that practitioners are clinicians, educators and family therapists with an awareness of integrative psychotherapeutic approaches (VanFleet, 2011a).

Extent of Impact Evidence

Research based: The review found only one published study using an RCT design exploring the effectiveness of a particular form of Filial Therapy on adopted children. Otherwise, it identified several other relevant robust studies involving other groups of children, but none from the UK and they were either small-scale and/or did not include a control group.

Bratton et al. (2005) carried out a meta-analysis of studies between 1953 and 2000 of Play Therapies (including, but not restricted to Filial Therapy) including various types of target groups, including adopted children. Overall, the meta-analysis calculated a mean effect size of 0.80 for play therapies with children – the effect size was even larger for parent-provided play therapies, such as Filial Therapy.

Carnes-Holt and Bratton (2014) reported on the only published study focussing on the impact of Filial Therapy on adoptive families identified as part of this review. It involved a waiting list RCT design involving 61 adoptive families of which 32 were randomly assigned to receive a modified form of Filial Therapy (child parent relationship therapy, CPRT) consisting of a more structured and condensed 10-session filial therapy training course and 29 were assigned to a wait list. The study reported that after 10 weeks of receiving Filial Therapy: 'Statistically significant findings and large treatment effects on all measures indicated the effectiveness of CPRT over the wait-list control condition on reducing child behaviour problems and increasing parental empathy' (p.328).

None of the other studies identified (Cornett and Bratton, 2014; Topham et al., 2011) focussed on adoptive families or involved a control group.

3.1.3 SafeBase

SafeBase: is a play-based therapeutic parenting programme for adoptive families derived from the principals of Theraplay. It is typically for adopted parents with children from birth to their teenage years, involving a video-feedback family play session, a four-day parenting programme and ongoing parent support groups, and lasts 6 months. A number of variations to SafeBase have been developed.

What is the Intervention?

SafeBase is a therapeutic parenting programme using structured play techniques, developed in the UK in 2003 by After Adoption for adoptive families. It was originally known as SAFE (Strengthening Adoptive Families in England) and piloted in 2005-2008 with funding by DfES in a number of local authorities. Since 2009 it has expanded, most recently with funding from the Timpson Foundation, and is currently being used in 53 local authority areas (Meredith, 2010; After Adoption, 2015a; Neil, 2015). The programme is based on theories of attachment, child development and object relations theory (Schofield and Beek, 2006; Bowlby, 2008; Winnicott, 1957), targeted at adoptive children with attachment disorders and their parents. The rationale is that these children have not developed normal neural pathways due to early life experiences, but that through the right parental stimulation this can be readdressed in later life (Meredith, 2015). It aims to improve parent-child relationships, family stability and reduce adoption breakdown by improving parenting skills to help adopted children feel safe and secure with their parents (SafeBase, 2015; Neil, 2015).

SafeBase comprises of three parts and is derived from the principals of Theraplay (Jernberg and Booth, 2001): a video-feedback family play session using the Marschak Interaction Method, to observe the interactions and dynamics between parents and their children, with a tailored follow-up session giving insights in how to improve parenting approaches (Marschak, 1960); a four-day parenting programme for 4-10 families

outlining attachment theory, with practical suggestions to help their child's behaviours and improve the parent-child relationship using the techniques of Theraplay and narrative storytelling (Jernberg and Booth, 2001; Lacher et al., 2012); and parent support groups to give ongoing opportunities for learning (SafeBase, 2015; After Adoption, 2015; C4EO, 2015; Neil, 2015). The usual duration of the intervention is 6-months, with a follow-up session 3 months later (Ibid). SafeBase has given rise to several new adaptations: SafeBase for Schools was developed in 2014 as an attachment-based half-day training for school staff, that is being piloted in the North West and rolled out nationally; and a version of SafeBase for adolescents aged 10 or over (SafeBase for Teenage Years) that is currently being piloted (After Adoption, 2015a).

There is a trainer's manual and a SafeBase handbook containing information and tools for parents/carers, but these are internal documents and not yet published (After Adoption, 2015b). There does not appear to be a specific assessment required of parents before undertaking SafeBase. After Adoption, a voluntary adoption agency oversees the delivery of SafeBase, and has recently set up an After Adoption Support Support Service to manage referrals centrally and its national expansion (Ibid;, 2015a). SafeBase is delivered directly by After Adoption staff and licensed partners, to parents/carers or school staff, so there is not yet a national training programme or oversight by independent professional bodies for accreditation such as Play Therapy UK (PTUK) or the British Association of Play Therapists (BAPT). However internal quality assurance procedures require SafeBase trainers to be qualified social workers that have attended the 4-day Level 1 training in Theraplay. They also have to observe and shadow experienced trainers, and attend annual 3-day training courses to ensure consistency in ongoing delivery (After Adoption, 2015b).

Extent of Impact Evidence

Promising approach: The review found no published research of the impact of SafeBase – although there are some examples of positive evaluation evidence available, including an unpublished report (Carol Meredith Consultancy Limited, unpublished), based on surveys, semi-structured telephone interviews and case studies which provide indicative evidence of its effectiveness.

3.2 Therapeutic Parenting Training

Key Findings

- Dyadic Developmental Psychotherapy (DDP) is a framework to support looked after and adopted children that has multiple applications, including as an approach to psychotherapy for 0 - teenage years, lasting up to 15 months.
- Nurturing Attachments is derived from DDP and is a group training programme for parents/carers of adopted or fostered children, typically delivered in 6 three hour sessions.
- AdOpt: is a group-based parenting programme developed for adopted parents, involving weekly sessions for a duration of 16 weeks, alongside video feedback.
- There are no published research studies yet for AdOpt – it is classified as **good practice**.
- There is only one quasi-experimental study from the USA for DDP – it is therefore classified as a **promising approach**.
- Studies for Nurturing Attachments are mainly small scale and with no control groups (with the exception of one study of the related Fostering Attachments intervention) – it is a **research based** intervention.

3.2.1 Dyadic Developmental Psychotherapy

Dyadic Developmental Psychotherapy (DDP): is a framework for parenting support designed for fostered, looked after and adopted children, that can be used as an approach to psychotherapy, as therapeutic parenting training and to develop packages of multi-agency support. Applied to psychotherapy, DDP involves weekly sessions with children aged 0 - teenage years and their parents, for up to 15 months.

What is the Intervention?

Developed by Dan Hughes, and latterly by Arthur Becker-Weidman in the US in the late 1980s, and first published in 1997, DDP was originally designed for adopted and fostered children who have experienced developmental trauma, neglect and abuse by their birth families (Hughes, 2007; 2009; 2011). It is based on attachment theory, alongside understandings of child development and trauma, in particular the work of John Bowlby and Daniel Stern (Bowlby, 1969; 1973, 1980, 1988; Stern, 1985; 1995). It is a framework or model for supporting parenting, rather than a therapy per se – but can be applied to

therapy usually involving parents and children (Casswell et al., 2014). The focus is on helping to develop secure attachments, healthy relationships and communications between a child and their parents, build connections and trust and feelings of safety, in order to help their child recover from early trauma and attachment problems (Ibid; Becker-Weidman, 2011; Hughes 2009; 2011). The DDP model can be used in a variety of settings, including as an approach to therapy, as therapeutic parenting, in developing a multi-agency package of support for adoptive families, and in residential settings. The approach is about attuning parents to intersubjective experiences in the moment (or here and now) in the therapy room or at home, to understand why the child needs to use difficult behaviours (Casswell et al., 2014; Hughes, 2009). As the child begins to feel understood, the child feels more connected, safer and in an accepting and unconditional relationship with their parents, and better supported to regulate their emotions. The approach of PACE is central to DDP parenting, creating a playful, accepting, curious, and empathic environment for the child (Ibid; Casswell et al., 2014; Golding and Hughes, 2012).

DDP has multiple applications but the approach to psychotherapy typically involves weekly two-hour sessions with parents and children, lasting ten to fifteen months for adolescents, and for younger children one month for every year of the child's age. The first sessions only involve the parents/caregivers, but then the child joins for the rest of the intervention (but with individual meetings with parents pre and post each session). There are five main phases to treatment: creating a parent-child alliance, maintaining this alliance, exploration, integration and healing (Becker-Weidman, 2010; 2011; 2012; Hughes, 2011). A number of therapeutic parenting and play-based interventions are connected to, or derived from, DDP: this includes Nurturing Attachments a group-based therapeutic parenting intervention (Golding, 2006; 2007; 2012), PACE (Golding and Hughes, 2012; Hughes, 2009) and Theraplay (Booth and Jernberg, 2010). As above, DDP can also be applied as a framework for multi-agency wrap-around services and in residential settings (Casswell et al., 2014; Hudson, 2006). In addition the Attachment-Focused Treatment Institute (AFTI) was set up by Becker-Weidman to certify attachment-focused psychotherapists, but while this includes the theory and principals of DDP, it is not recognised as having fidelity to the DDP model (DDP Network, 2015; ATTACH, 2015).

Controversy arose from 2007 onwards after a series of articles by Jean Mercer argued that DDP was over-claiming its evidence base, had unclear underlying assumptions, and most seriously, used a form of holding therapy that has been shown to be physically and emotionally harmful to children (Pignotti and Mercer, 2007; Mercer et al., 2010; Mercer, 2014; 2012). These allegations have been firmly denied by the DDP founders, in particular stating that holding therapy has never been a part of the intervention (DDPI, 2014; Becker-Weidman and Hughes, 2010).

A manual for DDP was developed in 2010, including a practical workbook and training protocols, alongside a case-book. There is also an assessment to understand the impact of complex trauma on the child and to develop a tailored treatment plan that is required before starting the intervention (Becker-Weidman, 2010; 2011; 2012; Hughes, 2011). The Dyadic Developmental Psychotherapy Institute (DDPI) was set up in the US in 2009, as the official overseeing organisation for DDP. It was founded to develop the training package and manuals as well as a certification process for practitioners (DDP Network, 2015). While a list of certified practitioners is held by this organisation, there is not yet an overseeing or accreditation body based in the UK, nor a connection with one of the UK established professional bodies such as the British Association for Counselling and Psychotherapy (BACP) or the UK Professional Standards Association. DDP is targeted at social care professionals, therapists or parents/carers, but there are no particular clinical qualifications required to deliver the intervention. There are a range of training courses available including introductory half-day, two-day or conference events, but the core DDP training is split into two levels: Level 1 (introductory) and Level 2 (advanced), each lasting 28 hours or four days (DDPI, 2015). The additional non-obligatory certification process involves supervision and submitting a minimum of ten recorded reviews of family cases. Certification is also available to become trainers and organisational consultants in DDP (Ibid).

Extent of Impact Evidence

Promising approach: The review identified only one robust published study, using a quasi-experimental design from the USA. However, there has been a recent study conducted in the UK to explore the feasibility of conducting an RCT of DDP (Turner-Halliday, 2014), which indicated a strong desire and willingness to produce more robust evidence of this intervention.

A study by Becker-Weidman (2006) used a quasi-experimental design involving 64 foster or adopted children (not randomly), with 'significant past histories of abuse, neglect, or orphanage care' (p.147), allocated to a treatment or another treatment/no treatment group. It found significant improvements for children in the treatment group in comparison to the control group with regard to symptoms of attachment disorder, withdrawn behaviours, anxiety and depression, social problems, thought problems, attention problems, rule breaking behaviours, and aggressive behaviours.

3.2.2 Nurturing Attachments

Nurturing Attachments: is derived from Dyadic Developmental Psychotherapy, as a form of group training in therapeutic parenting for parents of adopted or fostered children. It is typically delivered in six three hour sessions, and teaches day-to-day parenting strategies to help children with attachment and trauma issues.

What is the Intervention?

Nurturing Attachments is a form of group training in therapeutic parenting developed in the UK over the past ten years by Kim Golding. Golding was trained and mentored by Dan Hughes, the co-founder of Dyadic Developmental Psychotherapy (DDP) in the US, and Nurturing Attachments can be seen to derive from the approaches of DDP. The first attachment based group training of parents was called *Fostering Attachments* and published in 2006, shortly followed by the *Nurturing Attachments* training programme in 2007 (Golding, 2004; 2006; 2007; 2012). This is a group-based programme designed to give practical support and step-by-step guidance to adoptive parents, foster and kinship carers, using attachment theory and an understanding of child development and trauma (Bowlby, 1988; Stern, 1995). It also offers tools and training exercises that health and social care professionals can use in their individual support of carers (Golding, 2007; 2013). Many adopted or looked after children have developed worrying or challenging behaviours to cope with earlier traumatic events. Usual everyday parenting assumes that the child trusts their parents, feels safe at home, and can function well independently but this is often not the case for adopted or looked after children, so *Nurturing Attachments* aims to train parents in alternative strategies more tailored to the specific needs of these children including attention to self-care, blocked care and mentalisation (Ibid; Golding and Hughes, 2012).

The group training comprises of eighteen sessions split into three modules, typically delivered in six three hour sessions. The first module is an introduction to therapeutic parenting and theories of attachment, the second is an introduction to parenting techniques to help the child feel safe and secure in the family (building a secure base), and the last module gives guidance on how parents can improve their relationship with their child and better manage difficult behaviour (Golding, 2007; 2008; 2013a). The sessions introduce the 'House Model of Parenting' – an approach which aims to help build parenting strategies that match with the specific emotional and behavioural needs of their children (Golding, 2013a). Nurturing Attachments is a relatively new programme so it does not appear to have given rise to any alternative versions, but it draws upon the approaches of DDP and PACE (Golding, 2012). However a similar intervention 'Nurturing Adoptions' has developed in parallel by Deborah Gray (2012; 2012a; 2014; 2015) and provides day-to-day parenting strategies to help adopted children overcome attachment problems and trauma.

There are several manuals and workbooks to guide practitioners, in particular *Nurturing Attachments Training Resource* (Golding, 2013) and *Nurturing Attachments: Supporting Children who are Fostered or Adopted* (2008). These include training exercises, tools and worksheets for those delivering the intervention, but there is no specific assessment for parents before using the intervention. As a new intervention, there is not yet an overseeing or accreditation body, requirements for trainers to have specific qualifications, nor a programme of training available to guide practitioners in delivery.

Extent of Impact Evidence

Research based: The review identified several cohort studies, using pre- and post-intervention measures, for this treatment and a similar related programme (Fostering Attachments). The latter included a study using a waiting list design, which found only limited evidence of effectiveness. There is an ongoing evaluation of this intervention involving 55 families with adopted children across four sites receiving the intervention¹.

Wassall (2011) explored the effectiveness of the Fostering Attachments programme involving 25 foster carers and adoptive parents allocated alternately to receive the treatment (n=11) or to remain on a waiting list for six months (n=14). The study identified positive effects of the programme in improving carers' sense of competence and confidence, although there was no positive measurable effect on their perception of their foster / adoptive child, their stress levels or their children's emotional, behavioural or relational functioning.

Other cohort studies (Laybourne et al., 2008; Gurney-Smith et al., 2010) similarly identified improvements for only some of the measures used in these studies – although this could be the result of the rather small sample sizes used in these studies. Laybourne et al. (2008), for example, in a study involving 10 carers of which 8 completed an 18-week programme found a statistically positive impact on parental distress and total stress, but no statistically significant change for other measures including relationship problems and child mental health difficulties.

The review also identified evaluations (The Hadley Centre for Adoption and Foster Care Studies and The Evaluation Trust, 2007; Selwyn et al., 2009) providing some evidence of a positive impact on adopters' confidence and skills in managing difficult behaviour of a similar programme, called 'It's a Piece of Cake?' – this therapeutic parenting programme has recently been rebranded as 'Parenting Our Children'.

¹ See: <http://www.bristol.ac.uk/media-library/sites/sps/documents/hadleydocs/summary%20An%20Evaluation%20of%20Nurturing%20Attachments%20Training%20Programme%20for%20Adoptive%20Parents.pdf>

3.2.3 AdOpt

AdOpt: is a group-based parenting programme developed for adopted parents, involving weekly sessions for a duration of 16 weeks. Sessions are videotaped and individual feedback is given by the facilitators in weekly telephone calls. AdOpt developed from the US intervention MTFC-Prevention and KEEP.

What is the Intervention?

AdOpt is a parenting programme developed in the UK in 2011 by the National Implementation Service (NIS) based at South London and Maudsley NHS Foundation Trust, in collaboration with Phil Fisher University of Oregon (Fisher et al., 1999; 2005; Pears and Fisher, 2005), and funded by the Department for Education. The NIS evolved from the Multidimensional Treatment Foster Care Programme (MTFC-Prevention) implementation team supported by the Department of Health since 2003, which developed a model for delivering a series of US interventions for looked after children and foster families within the UK. These US interventions, in particular MTFC-Prevention and KEEP, were founded by Patricia Chamberlain at the University of Oregon Social Learning Centre (OSLC, 2015; Lewis and Chamberlain, 2012; Rhoades and Chamberlain, 2013), and aimed to help prevent placement disruptions and improve behavioural and emotional difficulties experienced by fostered children (NIS, 2015; Chamberlain et al., 2008; Price et al., 2008; 2009; Fisher et al., 2005). When the NIS and several local authorities were delivering these interventions in the UK, they identified that more specific support was needed for the unique challenges experienced by adoptive families. AdOpt is a preventative parenting programme, aimed at UK adoptive parents of children aged 3 – 8 years both pre and post adoption. It aims to help parents better understand and manage the complex needs of their children, drawing on social learning theory, attachment theory, child development and neuroscience, trauma and neglect (Cornwell et al., 2015; AdOpt, 2015; Gunnar and Fisher, 2006).

AdOpt is a group-based programme for adoptive parents that involves weekly sessions of 1.5 hours, facilitated by two trainers for a duration of sixteen weeks. Sessions are videotaped and these recordings are then used by the trainers in weekly individual telephone calls with parents, to discuss their child's current behaviour in a Parent Weekly Review (PWR). Group-work involves interactive learning methods such as video clips, psycho-education and reflective group discussions, to help parents develop and practice parenting skills (Cornwell et al., 2015; AdOpt, 2015). They learn techniques, including the use of play, to enable their child to learn new behaviours, as well as issues around school attainment and contact with birth families. Parents are required to complete a range of outcome measures to assess their family's needs and progress at four time-points: during an initial home visit before the intervention, at its completion, as well as six and twelve months after the last session (Ibid). The tools used include the Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997), Assessment Child Checklist Short

Form, Parenting Sense of Competence Scale (PSOC) (Jones and Prinz, 2005), and Plus (ACC-SF, ACC+) (Tarren-Sweeney, 2013) and the Parent Weekly Report (PWR) designed by the NIS.

The intervention is manualised with clear session-by-session guidance, with training and delivery overseen by the National Implementation Service (NIS). The NIS has managed the process of piloting AdOpt and testing its implementation in the UK, as well as supervising quality assurance and developing its future roll-out. This includes developing a training package and infrastructure, to provide ongoing organisational support and consultation during delivery (Cornwell et al., 2015; AdOpt, 2015), alongside monitoring programme fidelity building on learning from the KEEP and MTFC-Prevention programmes (Buchanan et al., 2013; Chamberlain, 2008a; Fisher et al., 2005). Providers of AdOpt are required to have been trained and accredited by the NIS and regular fidelity checks are made to ensure the programme is being delivered as anticipated. Training lasts for a week, involving family scenarios, role-play and group feedback. For each AdOpt intervention, at least one of the two trainers is required to either be an adoptive parent or to be a social worker specialising in adoption. There is also a licensing scheme for organisations, with an 'in house' supervisor trained to provide organisational support to delivery (Cornwell et al., 2015; AdOpt, 2015).

Extent of Impact Evidence

Good practice: The review found no published research on the impact of AdOpt – although an unpublished report (Cornwell et al., unpublished) includes self-evaluation evidence of impact using several pre- and post-measures. An independent evaluation of AdOpt by the Rudd Centre for Adoption Research and Practice at the University of Sussex started in September 2015 and was expected to end in March 2016. The primary design was a pre- and post-programme assessment of parenting and child-based outcomes, involving around 90 families. The study also hoped to recruit a comparison group consisting of parents who had not received the AdOpt programme support, but who may have received other adoption support services.

3.3 Conduct Problem therapies

Key Findings

- Multisystemic Therapy (MST) is an **evidence-based**, holistic family and community intervention to help young people with antisocial or disruptive behaviours that lasts on average 4-6 months.
- Non-Violent Resistance is a **research-based**, systemic family therapy to address child-parent violence, involving weekly therapy with parents and crisis telephone coaching, for 3-4 months.
- Most of the evidence for NVR and MST comes from abroad (USA, Israel and Germany).
- Break4Change is a group-based programme for teenagers and parents to address child-parent violence, typically involving weekly sessions for 12 weeks.
- There is no robust published research yet for Break4Change – it is therefore classified as **good practice**.
- Overall, there is little research on the effectiveness of interventions aimed at addressing child violence/offending behaviour specifically for adopted children or adoptive parents.

3.3.1 Non Violent Resistance (NVR)

Non-Violent Resistance: is a systemic family therapy designed for parents that experience child-to-parent violence and abuse. It involves weekly therapy, and regular crisis telephone coaching, for a typical duration of 3 to 4 months. The intervention has expanded to a wide range of different target groups.

What is the Intervention?

Developed by Haim Omar at the University of Tel Aviv, Non-Violent Resistance (NVR) is a form of systemic family therapy designed to address violent, abusive and self-destructive behaviour in young people (Omer, 2001; 2004). The intervention was originally developed for children with ADHD, conduct and oppositional defiant disorder, and latterly expanded to address anxiety and externalising disorders (Ibid; Lebowitz and Omer, 2013). However, after its introduction to the UK by Peter Jakob at the organisation *Partnership Projects*, the model was specifically adapted for looked after children or those involved with Social Services (Jakob, 2006; 2011; 2013). NVR draws

on the political theories of non-violent resistance such as Ghandi and Luther King (Omer, 2004; Millham, 2014), alongside understandings of child-to-parent violence (Holt, 2015; 2013), and directive forms of family therapy (Minuchin, 1974; Minuchin and Fishman, 2004; Fisch et al., 1982). The rationale is that a number of young people in the care system present as violent, aggressive and undertaking risky behaviours that can lead to alienation by their parents/carers, and potentially family breakdown. Families get locked in cycles of negative behaviour where parents and children try to achieve control over the other (Omer, 2004; 2001; Jacob, 2011; Patterson, 1982; Patterson et al., 1984). However traditional talking psychotherapies were felt to be ineffective for young people who are violent and exhibit coercive behaviour, as they are not likely to engage. NVR focuses on re-establishing boundaries and parental authority with a child through non-violent strategies. This includes avoiding the escalation of conflicts by not fighting, and re-establishing parental presence and continuity, where parents make it clear they will stay by a child no matter how difficult their behaviour (Omer, 1999; 2011; Omer et al., 2013). The intervention is systemic with the premise that children cannot be treated separately from their parents (Jacob, 2011; Millham, 2014).

Non-Violent Resistance is aimed at the parents of violent children, and consists of a one-hour therapy session, plus home-exercises and 1-2 telephone calls for coaching and support each week (Partnership Projects, 2015; Omer, 2004). On average the intervention lasts for three to four months, but this can be longer for complex cases such as with looked-after children, trauma or child abuse (Ibid). NVR seeks to apply theories of political non-violent resistance to the family and includes techniques such as 'sit-ins', which involves the parent entering and sitting in the child's room for about 45 minutes and remaining relatively quiet (Millham, 2014; Jacob, 2011). The idea is to de-escalate and break the negative cycles of blame and criticism present in previous conflicts (Kool, 2008; Patterson, 1982), as well as demonstrating parental presence, determination and caring, by communicating their closeness and commitment to the child (Omer, 2001; 2004; Weinblatt and Omer, 2008). There are four main principals to non-violent resistance (Partnership Projects, 2015; Omer, 2004): (1) de-escalation, to help parents better regulate their own emotions and unhelpful beliefs that can accentuate conflict and power-struggles (Alon and Omer, 2006); (2) breaking taboos, rather than appeasing their child to maintain peace in the family; (3) taking non-violent action, as traditional punishments no longer work in the family, parents use carefully planned and delayed action (Milliam, 2014; Jacob, 2011); and finally, (4) reconciliation gestures, to move beyond angry reactions and instead show the child they care for them and understand their needs (Partnership Projects, 2015; Omer, 2004; Jacob, 2011). NVR has expanded into new target groups, including a parenting programme to address gang violence (RB Greenwich, 2015), work with teachers in schools (Omer, 2010), and organisational consultancy training to encourage healthy workplace relationships (Partnership Projects, 2015a).

There is a manual for NVR, that includes step by step guidance for parents on using the intervention (Omer, 2004), but no specific assessment tool that needs to be undertaken before parents can receive the programme. No particular qualifications are required to deliver NVR, however it is designed for CAMHS clinicians, social workers, teachers or school counsellors (Ibid; 2001; Jacob, 2006). The School of Non-Violent Resistance based in Israel, was set up by Omer to develop and deliver international training, but to date there is not yet a link to established international or national professional bodies in psychotherapy and related disciplines, to accredit or create a list of registered practitioners (SNVR, 2015). In the UK, the organisation Partnership Projects runs a series of training courses at foundation and advanced levels (of four days each respectively), and a certification scheme which involves 2 additional practice days and the submission of case-studies, evaluations and a reflective log. Half day introductory workshops are available as well as specialist training, such as on trauma (Partnership Projects, 2015b). Other UK organisations are increasingly delivering NVR training, including PAC-UK and Adoption UK.

Extent of Impact Evidence

Research-based: The review did not find any published evidence of the impact of NVR on adoptive parents, although it did identify one pilot study with foster parents in Belgium. Otherwise, there are several robust studies exploring the effectiveness of NVR as a treatment for parents of children with behaviour problems from the USA, Israel and Germany – and one study from the UK.

One longitudinal cohort study (van Holen, 2015) in Belgium – described as a pilot study – focussed on the impact of NVR on a convenience sample of 25 foster parents. It identified 'significant reductions in externalizing, internalizing, and total problem behaviour in the foster children and in parenting stress' (p.1).

In the UK, Newman et al. (2014) explored the impact of NVR groups on parents of children with violent and aggressive behavioural problems in Kent. The study involving 29 parents and a pre- and post-intervention test design identified a significant 'difference in a positive direction ... on all but one of the measurements used' (p.138).

Otherwise, there are several studies exploring the effectiveness of NVR for other groups of non-adoptive parents, including a wait list RCT study of 73 parents (41 families) of children with acute behaviour problems in Israel (Weinblatt and Omer, 2008); a wait list RCT of 46 parents in Israel (Lavi-Levavi et al., 2013) and a German study (Ollefs, von Schlippe, Omer, and Kriz, 2009) involving a sample of 89 families, involved either in an NVR treatment (59 families), a Group Teen Triple P treatment (21 families) or a waiting list control group (9 families).

3.3.2 Break4Change

Break4Change: is a group programme, for teenagers and their parents, to address child-to-parent violence, typically involving weekly sessions for 12 weeks. This is a new intervention delivered locally in Brighton and Hove that has not yet expanded nationally.

What is the Intervention?

Break4Change was developed in 2008 in the UK, as a group work programme to address child-to-parent violence. It originated in Brighton and Hove, in a partnership between the Local Authority's Integrated Team for Families (ITF), Youth Offending Service (YOS) and the voluntary sector organisations Rise and AudioActive, and is funded by the Ministry of Justice. It is a group skills-based and community education programme, for both teenagers and their parents, including dialogue, the use of film, and education about child to parent violence (Munday, 2009; Break4Change, 2015). Break4Change typically involves 2 hour weekly group sessions for 12 weeks. It draws on Solution Focused Brief Therapy and Systemic Family Therapy (De Shazer and Berg, 1997, 1995). The aim is to help break and stop patterns of abuse and violent behaviour of children towards their parents, carers or siblings, where usual power and authority relationships between parents and children are reversed. This includes physical, financial, psychological and emotional abuse, such as threats, intimidation, property destruction, degrading language and violence (Cottrell, 2003). It seeks to create safety in the family home and develop more respectful and positive relationships between family members (Munday, 2009; Break4Change, 2015).

Break4Change is a new intervention so does not yet have a published manual, but a tool-kit appears to be in development. It is delivered by a local authority-led partnership in Brighton and Hove directly to children and parents, and does not yet have a training programme for external professionals, an overseeing independent professional body or infrastructure to standardise and roll-out the intervention nationally (Munday, 2009; Break4Change, 2015).

Extent of Impact Evidence

Good practice: The review found no published research of the impact of Break4Change – although an unpublished report (Munday, unpublished) provides some positive findings from a project evaluation based on the completion of pre- and post-intervention questionnaires.

3.3.3 Multisystemic Therapy (MST)

Multisystemic Therapy: is a family and community intervention to support young people with antisocial or disruptive behaviours. It involves an assessment of the young person, their family and wider situation, and lasts for between 4-6 months.

What is the Intervention?

Developed in the United States during the 1980s and 1990s by Dr Scott Henggeler, MST is a multi-faceted home and community-based intervention designed primarily for young people with antisocial or disruptive behaviour problems (Tolman et al., 2008; van der Stouwe et al., 2014; Henggeler, 2012). MST is based on the premise that behavioural problems are caused by an accumulation of risk factors at individual, family, peer, school and wider community levels (van der Stouwe et al., 2014). The origins of MST are in Urie Bronfenbrenner's (1979) bio-ecological-system approach as well as systemic family therapy (Stratton, 2011). The main focus of MST tends to be on family functioning, as it is argued that improvements here mediate improvements in other contexts (van der Stouwe et al., 2014; Henggeler, 2011). The approach includes assessments of the young person, their family, and the wider context, establishment of clear treatment goals, and use of a range of treatment strategies derived from family therapy, parent training and CBT (Borduin, 1999) that fit with the assessment and goals set (Henggeler et al., 1998; Tolman et al., 2008). Typical treatment length is between four and six months (Tolman et al., 2008).

MST Services was founded in 1996 and is the licensing body for MST worldwide, providing training and supervision, support and tools to help ensure treatment integrity (MST Services, 2015; van der Stouwe et al., 2014). MST has been practiced in the UK since the 1990s, where it is overseen by MST-UK which is a networked partner of MST Services in the USA. Attempts to apply MST to different target groups have seen numerous adaptations including MST-CAN (child abuse and neglect) and MST-PSB (problem sexual behaviour).

Extent of Impact Evidence

Evidence Based: MST has been extensively evidenced, using robust quantitative methodologies, in terms of its effectiveness with young people with conduct disorders, serious offenders and young people with other serious social, emotional, and behavioural problems.

From the mid-1990s MST programmes have undergone a large number of evaluations and RCTs (Littell et al., 2006). MST Services, in a recent review of evidence, reported: 48 published outcome, implementation and benchmarking studies; around 100 published peer-reviewed journal articles; 25 randomised trials; and a further 28 independent evaluations (MST Services, 2015). The majority of this research comes from the USA

and is not specific to adopted children, however, more recently research has also been conducted in other countries, including the UK (Wells et al., 2010; Butler et al., 2011; Fonagy et al., 2013; Cary et al., 2013). MST has been included in meta-analyses of interventions with young offenders (Lipsey and Wilson, 1998; Latimer, 2001), and in studies of parenting interventions for conduct disorders more recently (Woolfenden et al., 2001; 2002; Littell et al., 2006). One of the largest and most recent reviews, a meta-analysis of 22 studies (van der Stouwe et al., 2014) concluded that MST had small but significant treatment effects on delinquency, psychopathology, substance use, family factors, out-of-home placement and peer factors.

There has however been some controversy about the evidence for MST. Tolman (2008) notes that “treatment effect sizes are greater in studies of efficacy than in studies of effectiveness”, suggesting that further evidence is needed for the replicability and scaling of the intervention (Curtis et al., 2004; Henggeler, 2004; Littell et al., 2005). Moreover Littell’s (2005) systematic review of MST challenged some of the claims of the founders of MST, noting that, based on the 8 RCTs that met its inclusion criteria, it “is not consistently more or less effective than other services in preventing restrictive out-of-home living arrangements (e.g. incarceration, psychiatric hospitalization), reducing arrests or convictions, or improving youth and family functioning”

3.4 Cognitive and Behavioural therapies

Key Findings

- Eye Movement Desensitisation and Reprocessing Therapy (EMDR) is an **evidence-based** intervention for Post-Traumatic Stress Disorder (PTSD), involving weekly sessions lasting normally between 5-15 weeks.
- Dialectical Behaviour Therapy is an **evidence-based** form of cognitive behavioural therapy designed for people with borderline personality disorder that typically lasts one year including weekly therapy sessions, group work and crisis telephone coaching.
- There is no robust published research on the effectiveness of DBT and EMDR for adopted children

3.4.1 Eye Movement Desensitisation and Reprocessing Therapy (EMDR)

Eye Movement Desensitisation and Reprocessing Therapy (EMDR): is an intervention to treat Post-Traumatic Stress Disorder (PTSD), to help clients reflect and develop coping strategies for past events. It typically involves between 5 and 15 weekly sessions, each lasting 60 to 90 minutes.

What is the Intervention?

Developed in the USA by Francine Shapiro in 1989 as a treatment for PTSD (Shapiro, 1989), EMDR was first adapted for use with children and adolescents in the mid 1990's (Adler-Tapia and Settle, 2009; Rodenburg et al., 2009). It has since been used to treat a wide range of symptoms and problems including conduct disorders (Soberman et al., 2002), child sexual abuse (Jaberghaderi et al., 2004) and attachment disorders (Taylor, 2002). EMDR has been used in the UK since the 1990s, and is governed by the EMDR Association UK and Ireland, and EMDR Europe, to monitor standards of practice and provide training and accreditation.

EMDR is a highly structured intervention applied through a standardised protocol consisting of a sequence of eight treatment components (Rodenburg et al., 2009). The client is helped to reflect on past traumatic events, the present triggers of symptoms, and develop future strategies for coping with these experiences (Shapiro, 2001). It draws on aspects of a range of other therapeutic approaches such as cognitive, experiential, psychodynamic, and hypnotic therapies (Greyber et al., 2012); however, its distinguishing feature is the use of 'bilateral stimulation', most commonly in the form of eye movements (Field and Cottrell, 2011). The approach is seen as a type of exposure therapy marked by the combination of visualization, desensitization, and reprocessing (Shapiro, 2001; Greyber et al., 2012). The typical length of treatment will range from between 5 and 15 weekly sessions, with each session running for between 60 to 90 minutes.

EMDR is underpinned by the adaptive information processing (AIP) model (Shapiro, 2007) which emphasises memory networks and the brain's information processing functions (Schnyder and Cloitre, 2015). However, critics have argued that there is a lack of empirical validation for this model (Gunter and Bodner, 2008; Perkins and Rouanzoin, 2002; Rodenburg et al., 2009) and Shapiro herself has stated that the AIP model should be seen as a working hypothesis (Rodenburg et al., 2009).

Extent of Impact Evidence

Evidence Based: EMDR is extensively evidenced in terms of its effectiveness treating PTSD, particularly in adults, however there is less evidence of its effectiveness for use with children and adolescents or specifically with adopted children.

EMDR is used with adults suffering from PTSD and other trauma related issues, and has been extensively researched with its efficacy being demonstrated in approximately 20 controlled studies (Rodenburg et al., 2009). There have however, been comparatively few rigorous studies of the efficacy or effectiveness of EMDR for children or for other conditions (Adler-Tapia and Settle, 2009). In three recent robust reviews of evidence focusing on the use of EMDR with children and young people, none identified more than 8 studies that met their inclusion criteria (Adler-Tapia and Settle, 2009; Field and Cottrell, 2011; Greyber et al., 2012). Furthermore, this current review did not identify any robust studies looking at the treatment of looked after or adopted children. Moreover, even within the limited number of studies on children, many of these focus on EMDR's use with type I trauma (or single incident trauma such as from a serious accident), which means that there is no evidence that EMDR will be equally effective in treating children and young people with type II trauma (or complex trauma, more likely to be present among many adopted children).

Though limited, reviews of the available literature do provide the general conclusion that EMDR is an effective treatment for children for PTSD, showing significant medium effect sizes (Rodenburg et al., 2009). However, questions remain as to whether it offers 'incremental benefits' above other established treatments such as trauma focussed cognitive behavioural therapy (TFCBT), with a recent systematic review suggesting that EMDR should be seen as one effective trauma treatment among others (Rodenburg et al., 2009). A more recent study supported this conclusion, but added that while EMDR does not provide incremental benefits it does achieve its therapeutic effects in a reduced number of sessions (Field and Cottrell, 2011).

3.4.2 Dialectical Behaviour Therapy (DBT)

Dialectical Behaviour Therapy: is a form of cognitive-behavioural therapy designed to treat patients with borderline personality disorder. There are a number of variations to DBT, but the standard treatment typically lasts one year and involves weekly therapy, group skills training and telephone crisis coaching.

What is the Intervention?

Dialectical Behaviour Therapy (DBT) is a type of cognitive-behavioural psychotherapy, developed in the USA in the late 1980s by Marsha Linehan, to treat patients with borderline personality disorder and who are suicidal/self-harm (Linehan et al., 1991; 1993; Linehan, 1993; 2014). The scope of the treatment has now widened to other co-morbid problems such as eating disorders, substance misuse, learning disabilities, or to specific target groups such as offenders (Linehan, 2014; Behavioural Tech, 2015; Rathus and Miller, 2014; Miller et al., 2011; Safer et al., 2011). The primary principle of DBT is the integration of the opposite strategies (or dialectics) of self-acceptance and changing unhelpful thoughts and behaviours. This focus on clients accepting themselves, is where

the intervention differs from CBT: Linehan found that clients with Borderline Personality Disorder and recurrent suicidality found the emphasis on change within CBT invalidating, resulting in high drop-out rates. DBT derives from behavioural science, mindfulness and dialectics (Ibid; Swales, 2008; Koerner, 2001; British Isles DBT Training, 2015).

Standard treatment (called Standard Comprehensive DBT) typically lasts one year, and involves a combination of individual weekly therapy in hour-long sessions; group individual skills training (two hours per week); a team meeting for therapists (one and a half hours per week); and unscheduled phone calls at times of crisis, such as before self-harming (Limbrunner et al., 2011; Linehan, 1993; 2014). DBT is skill-based, teaching techniques to regulate emotions, control self-harm, suicidal thoughts and destructive behaviours, as well as improve the client's relationships. Dialectics is a central principal of the intervention, where in each session the therapist balances an emphasis on acceptance and change. This helps prevent the client and therapist becoming 'stuck' in rigid patterns of thought or behaviour, by recognising that emotions can become highly charged when treating clients with Borderline Personality Behaviour (Ibid; Swales, 2008; Koerner, 2001). DBT takes a structured approach with the group skills training involving four modules:(1) distress tolerance, learning safer strategies to deal with crises; (2) interpersonal effectiveness skills in asserting needs effectively; (3) emotional regulation, to help people become more aware and in control of their emotions; and (4) Mindfulness, techniques to live life in the present rather than worrying about the past or the future (Lineham, 2014; 1993; 1993a; Linehan et al., 1991; 1993;1999). Individual therapy is also structured into functions (aims of the intervention), modes (individual, group or telephone sessions), stages and targets (to organise the intervention through a logical progression of pre-defined problems). The latter is to avoid the sessions becoming dominated by day-by-day crises. As above, a range of variants to the original DBT model have been developed, such as for adolescents and people with eating disorders (Linehan, 1993; 2014; Behavioral Tech, 2015; British Isles DBT Training, 2015).

DBT has a well-established manual for the original treatment model, as well as toolkits and DVD materials (Linehan et al., 1993). There are also a range of subsequent manuals, including for the use of DBT in specific target groups (Swales, 2008; Koerner, 2001; Rathus and Miller, 2014; Miller et al., 2011; Safer et al., 2011). Implementation needs to be by qualified therapists and clinicians, and there is now an accreditation process in the UK and Ireland through the Society for Dialectical Behaviour Therapy (Linehan et al., 2014; SDBT, 2015). The British Isles DBT Training is the sole licensed provider of training in DBT in Britain and Ireland, running intensive group training for teams wishing to set-up a DBT programme since 1997. This is devised of two parts (5 days training each), with Part 1 focusing on in-depth theory and DBT strategies and Part 2 supervision of live cases (British Isles DBT Training, 2015). Other training options for DBT practitioners that wish to extend their skills include a DBT Masterclass for consultation and supervision of clinical work, specialist workshops such as adapting DBT for substance misuse, or undertaking a post-graduate certificate in DBT. A 5 day-foundational training course is available for therapists who are members of a DBT

programme (or intensively trained team) but are not DBT trained themselves (Ibid). There are also short one-off introductory workshops, such as a one-day DBT taster workshop, a 2-day essential skills course or courses for non-clinical frontline staff in suicide prevention (Ibid). Behavioural Tech, The Linehan Institute is the international overseeing body for DBT, founded by Marsha Linehan and responsible for licensing national training organisations (Behavioural Tech, 2015).

Extent of Impact Evidence

Evidence-based: The review found no published impact studies exploring the effectiveness of DBT for adopted children; but otherwise a very strong evidence base of DBT in treating BPD (borderline personality disorder).

There are many examples of robust impact studies of the effectiveness of DBT (Stoffers et al., 2012) including, for example, a RCT conducted in the UK (Feigenbaum et al., 2012) involving 42 patients randomised to a DBT treatment or treatment as usual group. This study consisted of a range of individualised service provisions according to patient need - of which only 31 completed the follow-up assessment after 12 months. Both treatments were found to be effective in reducing risk and distress, while DBT was significantly more effective in reducing self-reported risk and in suicidality and PTSD symptoms.

The evidence base also includes a longitudinal study in Germany (Stiglmayr et al., 2014) looking at the effectiveness of DBT in routine outpatient care. A follow-up of 47 patients who completed 12 months of DBT found significant reductions in self-injurious behaviours, number of inpatient hospital stays, severity of borderline symptoms and psychopathology.

3.5 Overarching Categories

Key Findings

- Psychotherapy is an umbrella term for ‘talking therapies’ encompassing a wide range of different theories, approaches and practices, including Psychoanalytic and Psychodynamic, Cognitive – Behavioural, Humanistic, Systemic or Family therapies, and Integrative approaches. It is categorised as **evidence-based**, but research is stronger for some types of approaches – the evidence is most extensive for CBT, including for children in foster care
- Equine Therapy is an overarching term for a range of different interventions and **promising approaches**, that use horses or other equines, with varied target groups, including people with physical disabilities or issues such as ADHD, PTSD and attachment problems.
- Creative Therapies is an umbrella term for therapies that involve the arts or non-verbal forms of communication in a therapeutic setting. This includes art, music, drama, dance and play therapies among others, and can be seen as **research-based**.
- There are no robust published research studies for any of these interventions on their effectiveness for adopted children.

3.5.1 Psychotherapy

Psychotherapy: is a broad umbrella term for ‘talking therapies’. This is an overarching category that covers a wide range of different theories, methods and practices, including Psychoanalytic and Psychodynamic, Cognitive – Behavioural, Humanistic, Systemic or Family therapies, and Integrative approaches that combine multiple orientations.

What is the Intervention?

Psychotherapy is an overarching term applied to a wide range of different therapeutic approaches best captured by the phrase “talking therapies”. The most common forms of psychotherapy are Psychoanalytic or Psychodynamic therapy; Cognitive–Behavioural Therapy; Humanistic Therapy; Systemic or Family Therapy; or Integrative therapy, though even these contain a large degree of internal variation. The common feature of all traditions is the application of various psychological techniques through the personal interaction or relationship between the therapist and client. The most common forms of

psychotherapy are practiced one-to-one with the client and therapist, however there are also forms of psychotherapy for groups, families and couples, and more recently, attempts to provide therapy remotely by telephone or over the internet are being explored.

Psychotherapy has a long and complex history, emerging from the treatment of the insane with non-invasive approaches in Europe in the 19th Century. Early antecedents of modern approaches to mental illness started in the 1870s, with clinical studies into hysteria leading onto Sigmund Freud's development of psychoanalysis in early 20th century Austria (Leahey, 1987). The 20th and 21st Centuries have seen a huge proliferation of different treatments (Lebow, 2012). Key developments include the emergence of various humanistic approaches (Rogers, 1951; Perls, 1951), cognitive and behavioural approaches in the second half of the 20th Century (Ellis, 1962, Beck, 1967), and systemic and family therapy (Jackson, 1956; Bateson et al., 1956).

Reflecting the range of different schools of psychotherapy and their presence internationally there are numerous professional bodies and governing institutions that oversee training and accreditation. The regulation of psychotherapy in the UK is currently voluntary (DoH, 2011) however registers of accredited practitioners are held by a number of professional organisations, the largest of which are the United Kingdom Council for Psychotherapy (UKCP); The British Psychoanalytic Council (BPC); and The British Association for Counselling and Psychotherapy (BACP).

The types of qualifications that psychotherapists hold range significantly between different approaches and awarding bodies as does the level of training required in terms of duration and intensity. Length of treatment can range from relatively brief (between 5 and 20 session) to extensive or open ended. (For example, psychoanalysis may be undertaken for many years at a frequency of up to 5 times a week). Psychotherapy is most commonly undertaken in sessions of around an hour (though this may vary depending on approach), on a regular basis ranging from several times a week to weekly, fortnightly or less frequently still. Some approaches are more circumscribed by protocols (such as CBT or DBT) whereas other are more client led and develop around what the client chooses to speak about (such as psychodynamic psychotherapy or humanistic approaches). Psychotherapies are used to treat people with a wide range of difficulties, ranging from mental illnesses such as schizophrenia, to issues such as anxiety and depression, to coping with specific problems such as bereavement or redundancy. Specific approaches have also been developed for work with children and families.

Different approaches are underpinned by significantly different theoretical perspectives. There are a wide range of views on the causes of mental distress and therefore on the purposes of psychotherapy. Psychoanalytic and Psychodynamic therapies focus on the influence of early life experiences on current relationships and wellbeing, often viewing

psychological distress in terms of unconscious conflicts within the client (Prochaska and Norcross, 2013). Cognitive-Behavioural Therapy represents a combination of the prior Behavioural therapy and Cognitive therapy, and focuses on both how the client thinks about themselves, others and the world and on how behaviour may perpetuate problems. These approaches tend to be problem orientated and relatively brief (Hofmann, 2011). Humanistic Therapies draw on humanist and existential philosophy and emphasise people's capacity to make rational choices and to develop meaning in their lives (Kramer et al., 2008). Systemic and Family Therapy draws on systems theory and focus beyond the individual to their wider social network, family and other close relationships. Rather than seeking to identify pathologies within the individual, systemic therapy aims to identify and change “stagnant” patterns of behaviours or ways of relating (Dallos and Draper, 2010). Integrative therapies (also known as eclectic or holistic) do not represent a distinct approach so much as a combination of approaches described above (Norcross and Goldfried, 2005). In practice, many interventions will draw on a range of theoretical foundations and adopt practices from a range of therapies. Moreover many mental health professionals tailor their approach to the needs of the client and draw from various theoretical and practical traditions to provide treatment and support.

Extent of Impact Evidence

Evidence-based: The evidence of effectiveness is most extensive for Cognitive Behavioural Therapy (CBT), including for children in foster care. However, the review was not able to identify any robust published evidence of the effectiveness of psychotherapy for adopted children.

A recent systematic scoping review by the British Association for Counselling and Psychotherapy (McLaughlin et al., 2013) exploring 114 research papers found evidence of effectiveness for the following types of psychotherapy and counselling: Cognitive behavioural therapy (CBT), Psychodynamic therapy, Play therapy (see Section 3.1) and Humanistic therapies and interpersonal psychotherapy. Of these, CBT has the strongest evidence base and also includes several studies involving children or adolescents in foster care.

These include, for example, a US-based RCT (Dorsey et al., 2014) comparing the impact of trauma-focussed CBT (TF-CBT) with TF-CBT provision supported by engagement strategies for 47 children and adolescents in foster care and one of their foster parents. The study found significant improvements for all patients (in the treatment and control groups) in the form of reduced post-traumatic stress and other emotional and behavioural symptoms.

Of interest is another US-based study (Weiner et al., 2009) comparing the outcomes of three evidence-based interventions for treating traumatic stress symptoms among 216 ethnic minority children and adolescents: Child Parent Psychotherapy (CPP), Trauma-

Focused Cognitive Behavioural Treatment (TF-CBT) and Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS). The results of the study showed that all three treatments were equally effective across racial groups in reducing traumatic stress symptoms.

3.5.2 Equine Therapy

Equine therapy: is an overarching term for a range of different interventions that use horses or other equines with a range of target groups, including people with physical disabilities or issues such as ADHD, PTSD and attachment problems.

What is the Intervention?

Equine therapy can be understood as an umbrella term for a group of approaches rather than a single tightly defined intervention. The common factor among these is the use of horses or other equines for therapeutic or learning purposes. Examples of interventions include Equine Assisted Psychotherapy (EAP), Equine-Assisted Learning (EAL), Equine-Facilitated Psychotherapy (EFP), Hippotherapy and other Equine-Related Treatment (ERT) (Anestis et al., 2014). These approaches often have differing aims and methods and vary in terms of setting and type of practitioner (Kendall et al., 2015). In keeping with this diversity, Equine therapies have been used with a wide range of target groups including people with physical disabilities as well as those with mental health problems such as ADHD, PTSD and attachment disorders (Kendal et al., 2014; Lentini and Knox, 2015).

The origins of these approaches lie in the USA, Germany and Switzerland during the mid-twentieth century, where riding was used to help people with physical disabilities. It is in the last 20 years that horses have been used in therapies aimed at resolving psychological issues. Equine therapies started to be used in the UK around 15 years ago. In the case of EAP, there has been a move towards greater standardisation of its approach through the professional body The Equine Assisted Growth and Learning Association (EAGALA). Based in the USA with national bodies in 50 other countries (including the UK), EAGALA oversees training and accreditation of this particular form of Equine Therapy. There are estimated to be around 100 EAGALA practitioners in the UK (Stakeholder Interview). The EAGALA approach usually involves 6 - 8 sessions, after a detailed assessment process.

The therapeutic mechanism involved in equine therapy remains contested. A recent study, for example, identified three competing accounts of the 'active ingredient' of such therapies (Kendal et al., 2014). Under the EAGALA approach equines are seen as an aid to personal exploration and provide a context whereby the therapist and client can work together to investigate the nature and significance of the clients' difficulties (Klontz et al., 2007; Anestis et al., 2014). Horses are seen to be suitable for this task as they are

social animals, which means they are happy to interact with, and are sensitive to the mood of, humans.

Extent of Impact Evidence

Promising approach: There is a growing body of research on equine therapy that provides some evidence that it is effective in treating children for a range of emotional and behavioral problems. However, there are very few robust quantitative studies.

The evidence base for equine therapies is quite limited with few robust quantitative studies or controlled trials. The evidence picture is further diluted by the diversity of approaches falling under the umbrella term ‘equine therapy’ meaning that conclusions drawn about one approach are not necessarily applicable to another. While the search generated a large amount of literature on equine therapies, most of the studies identified were descriptive or evaluations only (Anestis et al., 2014). However where an equine therapy has been researched it is most often in the treatment of children and young people (Smith-Osborne and Selby, 2010) and used in the treatment of a wide range of with conditions and problems including: Intra-family violence (Schultz et al., 2007); Serious emotional disturbance (Ewing et al., 2007); Sexual abuse (Kemp et al., 2014) ; Autism (Bass et al., 2009; Chen, et al., 2015).

Six literature and evidence reviews of equine therapies were identified in this review. These focus on a variety of outcome categories and target groups and adopt a variety of methods and inclusion criteria (Ratliffe and Sanekane, 2009; Lentini and Knox, 2009; Graves, 2010; Selby and Smith-Osborne, 2013; Anestis et al., 2014; Kendall et al., 2015). These reviews demonstrate the comparatively low number of robust studies available for this type of therapy. Thus, the two most recent systematic reviews of evidence of the psychological benefits of equine-assisted interventions identified 15 and 14 qualitative or quantitative studies providing any evidence of outcomes (Anestis et al., 2014; Kendal et al., 2015).

3.5.3 Creative Therapies

Creative Therapies: is an umbrella term for therapies that involve the arts or non-verbal forms of communication in a therapeutic setting. This includes art, music, drama, dance and play therapies among others. They are used for a wide range of target groups but seen as particularly useful for those who have difficulty expressing themselves through speech alone.

What is the Intervention?

“Creative” or “expressive” therapies do not represent a single tightly defined intervention but a whole domain of psychotherapy. Beneath this overarching banner fall a wide variety of approaches, most often distinguished by the modality used in each. Common

forms of creative therapy are: Art therapy, music therapy, drama therapy and psychodrama, dance/movement therapy, poetry therapy, play therapy (considered separately section 3.1), sand play therapy, and integrated arts approach. (Malchiodi, 2013). Notwithstanding this variety, creative therapies share the common feature of holding non-verbal forms of expression and communication as useful in a therapeutic context (Malchiodi, 2013). McNiff (1981) argues that creative or expressive therapies are those that add action to psychotherapy: through activities such as painting, creative movement, or play, clients are able to express themselves in a different way than simply through speech. This is often misunderstood as meaning that creative therapies are solely non-verbal, as the literature makes clear that with most forms of creative therapy, speech plays an important role (Malchiodi, 2012; Malchiodi and Crenshaw, 2014).

Art and music started to be used in conjunction to medical and psychiatric treatment from the late 19th century onwards (McNiff, 1981; Fleshman and Fryrear, 1981). However it is in the 1920s that recognisably contemporary forms of creative therapy emerged, with the development of the use of “psychodrama” (Moreno, 1923), drawing (Goodenough, 1926) painting (Prinzhorn, 1922) and play (Lowenfeld, 1935) to therapeutic ends. This developed through the 1930s and 40s as major psychiatric institutions started to use creative therapies with people with severe mental illness, that were not amenable to more conventional talking therapies (Malchiodi, 2013).

Practitioners using creative therapies will most often have studied their particular modality through graduate-level training at either master’s or doctoral level, or will hold registration or certification from a creative therapy professional association (Malchiodi, 2005). There remains a debate within the field about the degree to which practitioners should have expertise in their chosen modality (Knill, 1995). Due to the breadth of the field there are numerous professional bodies that offer training and accreditation, that vary by country and by approach. In the USA, where the creative therapies have been most professionalised, the National Coalition of Creative Arts Therapies Associations (NCCATA) acts as an umbrella organisation for the various modalities’ national associations. In the UK key institutions include the Institute for Arts in Therapy and Education, and The British Association of Art Therapists.

Creative therapies are used with a wide range of target groups and are in principle available to the general population. However they are seen as particularly useful with groups that have difficulty expressing themselves through speech, especially young children, people with autism, adults who have limited speech due to stroke or dementia, people suffering from trauma where indirect expressions may be more manageable (Brooke, 2006).

Creative therapies have much in common with other forms of counselling and psychotherapy and use their particular modality of creativity to address family issues, fears and concerns, current problems or painful past experiences. However the client will

be asked to express themselves on a given issue through, from example, drawing an image of an idea or feeling or, acting out a scenario using a set of figures. Underlying creative therapies is the idea that different people may have different 'expressive styles' and that by employing creative forms of expression within the therapy this may allow people to more fully communicate, thereby enhancing the therapy (Malchiodi, 2013). Often creative activities are integrated with established therapeutic approaches such as psychodynamic, systemic, or humanistic psychotherapy therefore the way the creative output of the client is used in the session will vary depending on the theoretical orientation of the therapist. Malchiodi (2013) argues that creative therapies add four unique aspects to the traditional psychotherapeutic approaches: self-expression, active participation, imagination, and mind–body connections.

Extent of Impact Evidence

Research-Based: The review has found no evidence of the effectiveness of creative therapies for adopted children, but some reviews and studies of its impact on other target groups, most often adults with mental health issues.

A review (Slayton et al., 2010) of studies from 1999 – 2007 explored the effectiveness of a wide variety of different types of arts-based therapy for all ages of clinical and nonclinical populations. It identified 11 studies that had fully experimental designs with random assignment of groups 'to support the claim that art therapy is effective in treating a variety of symptoms, age groups, and disorders' (p.108), including depression, anxiety, low self-esteem and trauma symptoms, although none of these included young people in care or adopted.

Similarly, a more recent review (Van Lith et al., 2013) of both qualitative and quantitative research studies identified several quantitative and mixed methods studies with various creative therapy approaches and outcomes measured. One noticeable finding was that several quantitative studies reviewed had very high levels of participant drop out, leading to underpowered results. Overall, the evidence was strongest in relation to psychological outcomes, including self-discovery, self-expression, rebuilding of identity, motivation and self-esteem.

4. Building the Evidence Base

Key Findings

- While evidence is scarce on the effectiveness of these interventions specifically with adopted children, in a number of cases evidence does exist on their impact in addressing particular issues or problems that were beyond the scope of this review and could be explored further in more detail (e.g. DBT for BPD treatment and EMDR for PTSD)
- It might be helpful to conduct a follow-up review using a 'needs-based' rather than an 'intervention-based' model, to explore which approaches (single or combined interventions) are effective in addressing particular needs or issues. This would go further than the current study by looking beyond the extent of the evidence base to examining the findings of which approaches work and why.
- A wider range of interventions could be included in a follow up review, including holistic models such as that of Family Futures, PAC-UK or AdCAMHS in Sussex.
- Qualitative and process evidence could be explored to understand adoptive family experiences and why interventions may or may not work.
- There is also a need for more robust quantitative research on the impact of particular interventions.

In conclusion, this review of post-adoption support interventions has identified very few robust studies from 2005 onwards providing evidence of the effectiveness of the 15 interventions for adopted children and/or adoptive parents. This would suggest that we are still very much at the start of the 'evidence journey' (Nutley et al., 2012) in demonstrating the possible impact of these interventions on the target groups. This final chapter, therefore, provides some suggestions on how to build the evidence base, based on gaps identified in this review and feedback from the Adoption Support Mental Health Roundtable meeting on 21st October 2015.

4.1 Further Evidence Review

Focus on needs-led evaluation

A finding of this review is that the next stage in building the evidence base could approach the appraisal of the evidence base from a different angle. In particular, it could focus less on particular interventions, and instead focus on the evidence of effectiveness

in addressing the particular needs experienced by adopted children and families. There is considerable cross-over between different therapeutic interventions, and in practice, therapists/social workers tend to tailor the delivery of (often multiple) interventions to address the needs of different families. While the impact evidence for interventions in relation to adopted children is often scarce, in some cases there is strong evidence of effectiveness of these interventions on particular conditions that were beyond the scope of this review (for example, DBT for BPD treatment and EMDR for PTSD). Similarly, while this study focused on better understanding specific interventions and identifying the extent of the impact evidence, there is a need to review the findings of existing quantitative and qualitative studies (see below) in more detail in order to ascertain whether the interventions worked as anticipated and why.

It would be worth considering moving away from an 'intervention-led model' towards more of a 'needs-led model' of evaluation. This would mean rather than trying to establish the effectiveness of a pre-defined list of interventions in addressing the needs of the target group, the next stage could be to start with a clear definition of the needs or issues of adopted children and adoptive parents. This would be followed by an exploration of the evidence for the different types of support available on how to address these needs or issues.

The project steering group suggested that with regard to adoptive parents this would involve exploring the most effective and appropriate methods of parental therapeutic support to address the needs of children with attachment issues, pervasive developmental disorders or other neurodevelopment difficulties, externalising behaviour problems and problems of identity and personality development. The next step would be to explore the available evidence on what works in supporting parents facing these issues. A large quantity of research evidence already exists in relation to some of these problems as demonstrated in the National Institute for Health and Care Excellence 2015 guidance on Children's Attachment (NICE, 2015), although only few of these studies provide robust evidence. Much of the available research is likely to include some of the interventions included in this study (such as AdOpt, DDP, Nurturing Attachments, Filial Therapy, NVR, Break4Change, MST, etc.) as well as others (for example, Family Future's Neuro-Physiological Model NPP, Parenting Our Children, or ABC). The main focus, though, would be on exploring the evidence on effectiveness of addressing the particular needs faced by adoptive families.

Similarly, the next stage of the review could focus on the specific needs of adopted children and what interventions are known to work in addressing these. This would start with an exploration of the specific needs and issues faced by adopted children. These include, among others, emotional and behavioural challenges, mental health issues, autism spectrum disorder (ASD), oppositional defiant disorder (ODD), post-traumatic stress disorder (PTSD) and several other issues. The review would seek to explore the

evidence of effective treatments for these disorders – but also the extent to which treatments were effective in treating such conditions among children with multiple issues or with difficulties that do not meet clinical diagnosis thresholds. This is important as a treatment shown to be effective in treating ASD, may not work for children with multiple issues including, but not restricted to, ASD.

This would mean that rather than trying to identify particular interventions that are effective in supporting adopted children and/or adoptive parents – as has been done for this review – the next stage could be to explore the evidence base of what approaches (which may consist of single or combined interventions) are effective in addressing the particular needs or issues faced by them.

Pragmatically this is likely to involve the following steps:

- Reviewing the specific needs of adopted children and families, and how these differ from other populations, including mapping the prevalent disorders or problems they face, frequent issues that do not meet clinical diagnosis thresholds, and where multiple issues are experienced.
- Clustering into groups of related issues or problems. For example, this could include specific issues such as conduct problems, attachment disorders, anxiety, alongside co-morbid problems or multiple issues.
- Building on this review to map the therapeutic interventions commonly used in the adoption field, and matching these interventions to the agreed clusters of needs. Interventions that seek to address similar outcomes would be grouped together. This would be an iterative process as the review progresses, and involve an exploration of the underpinning theories of different interventions in addressing particular outcomes.
- Explore the evidence base of which interventions (single or combined) are effective in addressing the particular needs or issues faced by them. This would also build on this review, but go further by examining the quantitative and qualitative findings on the impact of interventions in addressing particular issues or conditions. It would also involve exploring a broader range of interventions currently in use with adoptive families, as detailed below.

Such a study could predominately focus on reviewing existing evidence and literature but also, where gaps are identified, seek to enhance this information via primary research involving individual or group interviews with experts (from practice and academia), and/or a survey of local authorities using the Adoption Support Fund. Such primary research could help validate literature findings and further understand the common problems and disorders faced by adopted families, or the full range of therapeutic interventions currently being used on the ground.

Additional Interventions

The 15 interventions selected for this review were chosen by DfE as the most well used and high profile being commissioned under the Adoption Support Fund. However, it has become apparent that there are a number of additional interventions currently in use with adopted families that were not within this review's original scope. This includes more holistic approaches designed to address multiple issues, such as the approach of Family Future's Neuro-Physiological Model NPP, PAC-UK, and AdCAMHS Sussex Partnership NHS Foundation Trust that would be valuable to explore. There are also a number of single interventions in use such as Parenting our Children, ABC, Trauma-focused CBT, and Secure Base among others (see Annex 5.3). It would be worth considering including these interventions in a follow-up review, using the above needs-based model, in order to present a fuller picture of the range of delivery approaches being practiced.

4.2 Other research

Process and qualitative research

As explained in Section 1.2, the main focus of this review has been on quantitative studies to provide robust evidence of the impact of the 15 interventions. This has meant that other research using more qualitative methodologies was not included in the current review. However, such studies can provide important insights into the way such interventions are implemented, and how and why they are effective in bringing about the desired changes. It would be worth reviewing this evidence in any future work to explore the ways in which it can help to bring a greater understanding of the processes in which adopted children and adoptive parents access and receive help and the ways in which, in their own words, such services are able to help them.

More quantitative research of interventions

The study identified a few ongoing studies expanding the current evidence base relating to the 15 interventions, including AdOpt (see Section 3.2.3) and Nurturing Attachments (see Section 3.2.2). However, the overall lack of robust quantitative evidence of the effectiveness of many of the 15 interventions reviewed in this study highlights an opportunity for more primary research to strengthen the evidence base. This could involve commissioning further studies to explore how a particular intervention, or a combination of such interventions, are effective in addressing the particular needs of adopted children and adoptive parents. RCTs are regarded as the gold-standard (Akobeng, 2005), providing the most reliable evidence on the effectiveness of interventions. However, RCTs of complex interventions, particularly in social work contexts, are notoriously challenging given the multiple aspects of variation and difficulty in achieving standardisation (Turner-Halliday et al., 2014). It is important to ensure, therefore, that any commissioned evaluations of interventions – or combinations of

interventions as argued above – using a RCT design build on careful preparation work. This includes, among other things, ensuring that:

- It is known what particular needs or issues the intervention(s) are trying to address.
- The expected effect sizes of the intervention or combined interventions for each of these issues or problems are known, building on previous research using robust pre- and post-survey designs or meta-analytic studies.
- The most suitable and reliable outcome measures have been chosen which are able to measure change in the target group.
- The potential for recruiting sufficient numbers of participants willing to take part in such a study has been explored.
- Any potential research ethical issues or barriers for employing a particular type of RCT design (including, for example, waiting list or delayed treatment) have been examined and addressed.

The evidence base could also be strengthened by making links with The Child Outcomes Research Consortium (see: <http://www.corc.uk.net/>) which aggregates and reports on outcome data of relevance to young people with mental health and wellbeing issues and their families.

APPENDIX

Appendix A: Bibliography

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Appendix B: Methodology

The Department for Education (DfE) commissioned the Tavistock Institute of Human Relations (TIHR) to undertake an evidence review of the efficacy of fifteen of the most well used, and high profile, therapeutic post-adoption support interventions. The review aimed to better understand what these therapeutic interventions involve, and examine the **extent** of the existing evidence on their effectiveness. It was not the purpose of this review to explore the findings of the impact evidence in any detail and make judgments on whether particular interventions work or do not work. Instead, this review was an initial step in a longer-term process led by DfE to improve the evidence base in post-adoption therapeutic support. Hence, a key purpose of this review was to identify gaps and make recommendations on what future research is needed.

As detailed in chapter 1, the aims of the review can be divided into three overarching research questions. These questions were developed and agreed collaboratively with DfE in the project scoping stage.

Overall Approach and Design

Our approach to this review was based on three key principles:

- An **inclusive understanding** of what is ‘good evidence’. Public discourse on evidence quality appears to favour the apparent certainty of evidence generated from RCTs (the ‘gold standard’ in the ‘hierarchy of evidence’ models such as the Maryland Scale). Whilst this method, when applied appropriately, offers strong evidence **that** an intervention works, it often cannot tell us **why** it works (including the theories underpinning it) or whether it will work in different contexts, with different target groups and struggles with non-standardised and complex interventions (Nutley et al., 2012). A more suitable quality framework for this review is one employing a more inclusive understanding of evidence: a matrix approach which rates evidence quality generated by using a range of methods in relation to the research questions (*ibid*). This matches the descriptive purpose of the review to not only explore the extent of the impact evidence, but also the content of the interventions, their aims, origins and underlying theories. Similarly, given the paucity of RCTs and quasi-experimental research undertaken on these interventions, a traditional systematic review would exclude the full extent of the current impact evidence available.
- Using the **realist synthesis** method (Pawson et al., 2004) which explicitly requires reviewers to consider the theoretical underpinnings of an intervention such as, for example, attachment theory and the specific needs of adopted children and families, the importance of context and where interventions are developed, as well as effects of other factors such as how interventions are delivered in practice. Understanding the theories of change of the interventions and their complex interconnections is important to ascertain the nuances between different types of

therapeutic interventions to produce an explanatory analysis of the rationales of ‘how and why [interventions intend to] work’ (*ibid*, iv) in relation to the differing needs of adopted families. This, alongside the flexible/iterative method of realist synthesis, matches the task of unpicking the complicated, often messy, links between different types of therapies on the ground.

- **A collaborative approach** to the design of the review as well as its quality assurance: working in partnership with DfE throughout the study and establishing and using the skills of a selected group of scientific expert advisors from academia, health and social care, and the statutory and voluntary sectors that have specific knowledge of the area.

Review process

Realist synthesis prescribes a seven-stage process which we followed while carrying out the review. This is outlined below.

Realist synthesis sequences and associated activities (adapted from: Pawson et al., 2004)

Realist synthesis step	Activities	Work Package	Research Question
1. Clarify scope of review	Finalise review questions, the purposes and envisaged uses of the review. The evidence types and quality criteria Search terms and inclusion/exclusion criteria Scope in exploring additional interventions Set up expert interviews Set up tailored evidence matrix	WP1	
2. Searching relevant evidence	<u>i. Mapping Interventions</u> Conduct expert interviews Retrieve descriptive information on content of interventions Articulate key theories of the interventions in relation to specific needs of adopted children and families	WP2	1
	<u>ii. Evidence on Interventions' Impact</u> Using agreed search terms to retrieve a long list of references from relevant bibliographic databases and other sources Import references into matrix	WP3	2
3. Appraise quality of studies	Apply evidence matrix criteria and inclusion/exclusion criteria to quality rank and cluster literature	WP3	2
4. Extract data from the studies	Read / review studies, following an iterative inclusion / exclusion process, to produce narrative around review questions and ‘what works for whom, and where’	WP4	1&2
5. Synthesise	Analysis of key findings, testing evidence	WP5	1, 2 & 3

data to determine what works for whom, and where	against 'theories/aim' of each intervention Identify gaps in evidence base		
6. Make recommendations	Recommendations on improving evidence base Review and verification by DfE and expert advisors in Roundtable Event October 2015 Report writing	WP6	3
7. Disseminate findings	Publication of evidence review		

The review was undertaken by a multidisciplinary team specialising in conducting studies on family relationships and mental health, in particular with vulnerable children and families.

Clarify Scope of the Review (Synthesis Stage 1)

This involved identifying the breadth of the investigation, including the number and types of interventions to be covered, target groups, geographical coverage, time-frame, and review questions. Following a meeting with DfE, the review and sub-level questions were clarified (see above).

In order to establish parameters around this potentially very broad-ranging review, the team explored the theories around psychotherapeutic interventions to inform our thinking around clustering the 15 interventions. A first-stage classification was created to group the interventions, based on a pragmatic classification of underlying theory, mode of delivery, target group and content. This clustering can be seen below:

Clustering of Interventions covered in the Review:

	Overarching categories	Play therapies	Therapeutic Parenting Training	Conduct Problems	Cognitive Behavioural
Interventions	Psychotherapy; Creative therapies; Equine therapy.	Theraplay, SafeBase, Filial therapy	DDP, Nurturing Attachments, AdOpt	NVR, Break4Change, MST	EMDR DBT.

Theories		Attachment theory, trauma, child development,	Attachment, trauma, child-development, social learning (AdOpt)	Systemic Family Therapy, Solution Focused (Brief) Therapy	Trauma , Integrative and Cognitive Behavioural
Target Groups		Children and parents Adopted children and parents	Adoptive parents (DDP also children)	Conduct disorder, Child to parent violence, serious offending	PTSD, Personality Disorders, Self-Harm

There is considerable overlap between the interventions, and several could arguably be placed in different categories: for example SafeBase, Theraplay and Filial Therapy could be identified as therapeutic parenting training, while certain types of creative therapies have strong links with play therapies. Given these complex interconnections, the review tasks were distributed by research question into (1) searching the **descriptive evidence** on the content of the interventions (research question 1) and (2) searching the **impact evidence** (research question 2), so each reviewer could retain a holistic picture across multiple interventions.

Due to the volume of literature identified across the fifteen interventions and time/resource limitations, it was decided that the principle focus of the review was on adopted children and families, and other target groups, such as looked after children or evidence addressing particular mental health problems, was beyond the feasibility of the review's scope. However, where there was no or limited literature on the interventions in relation to adopted children, key studies in relation to the latter groups were explored.

Similarly, due to resource limitations it was decided that while the descriptive research questions would use a broader understanding of evidence (Nutley et al. 2012), literature searches of the impact evidence had to focus predominantly on robust quantitative evidence: namely meta and systematic reviews, RCTs, and robust before and after designs with or without a control group. We are aware of valuable qualitative studies exploring adopted families' experiences of the effectiveness of the interventions. However we recommend that this evidence is considered in a follow-up review (chapter 5).

Subsequently, a pre-defined review protocol was developed for the screening stage, including agreed inclusion and exclusion criteria, alongside an evidence matrix to assess the quality criteria of studies to be included. This was an iterative process, with initial criteria established in the scoping stage. However, due to the volume of material (work-package 2) the criteria were subsequently narrowed (see below). Similarly, being mindful of broader understandings of evidence quality used in this review (Nutley et al., 2012), exceptions were made to these criteria which are detailed below:

Final inclusion, exclusion and quality criteria used in the study

	Criteria
Date	Literature from 2005 onwards <i>Exceptions: seminal literature e.g. key meta-analysis or articles on the origins of interventions</i>
Location:	UK only or key UK comparison <i>Exceptions: theoretical literature or where UK evidence is unavailable, international evidence from US, Canada, Australia and Europe.</i>
Full-text	Full text available
Relevance	In terms of: <ul style="list-style-type: none"> • Interventions: focus on the 15 interventions under study <i>Exceptions: record names of other therapeutic post-adoption support interventions currently in use in the field</i> • Target Group: adopted children and families, including birth siblings <i>Exceptions: if no/weak evidence key studies on fostered/looked after children, or specific mental health problems</i> • Research Questions
Evidence Quality	Using a tailored matrix of evidence quality against the research questions under study (see below, Nutley et al. 2012). Evidence quality was determined by: <ul style="list-style-type: none"> • Study design • Sub-criteria on how studies were conducted <p>The latter involved a critical appraisal of aspects such as sample size, effect size, randomisation methods etc.</p> <p>The matrix used a traffic-light system (Excellent***, Good**, Average/Variable* and Poor) to indicate evidence quality as per the above criteria in relation to the research questions.</p>

Evidence Quality Matrix:											
Key Quality of Evidence: Excellent *** Good ** Average/Variable * Poor											
Research Question	Qualitative	Mixed Methods	Cross-sectional/ One Shot Survey	Cohort Studies/ Longitudinal Survey	Quasi Experimental/ Case-Control Studies	RCT/ Experimental	Economic Evaluation	Meta-review/analysis, Systematic or Realist Review	Literature and Policy Review	Other Grey Literature (Policy Papers, VCS Reports etc.)	Expert Interviews
1a. How are the therapeutic interventions delivered?											
Roots of Interventions	*	*						**	**	**	**
Delivery	**	**	*					***	**	*	**
Other Interventions	*	*						***	**	*	**
1b. What do they aim to achieve?											
Target Group Needs	**	**	**	*				***	**	**	***
Theory	*	*						***	**	**	***
2. What evidence exists on whether each intervention does or does not work?											
Impact	*	*	*	**	**	***	**	***	*		**
Why it works	**	**	*	*				**	**	*	*
3. What further research is needed to improve the evidence base for each intervention?											
Plans and Evidence Standard									*	*	**
Recommendations	*	*	*	*	*	*	*	***	**	**	**
Sub-criteria on Quality	- Sampling - No. interviews - Analysis methods	Quali: - Sampling - No.interviews - Analysis Methods Quant. - Significance/ Effect size - Follow-up - Sample size	- Significance/ Effect size - Follow-up - Sample size	- Significance/ Effect size - Follow-up period - Sample size - Sampling error	- Significance/ Effect size - Follow-up - Sample size - Sampling error - Control group selection	Significance/ Effect size - Follow-up - Sample size - Sampling error - Control group Selection - Randomisation process	- Design type e.g. Cost Effectiveness (comparative) Cost Benefit (single Intervention) SROI - Bias: monetising outcomes	- Design type e.g. Systematic Realist - Scope: Search terms Selection criteria No. articles - Bias: Selection criteria QA processes	- Bias: Authors/ Org. Independent or Political agenda? Funders	- Bias: Authors/ Org. Independent or Political agenda? Funders	

The search terms for the review were also agreed during the scoping stage, by drawing up a long list of potential terms and then selecting a narrower list to be used in the study. The main search terms focused on the intervention and the target group (left-hand columns), however, given the breadth of research questions, a list of additional terms (right-hand columns) were devised.

Search Terms Used in the Review:

Intervention	Target group	Additional terms	Research Question
Dyadic Developmental Psychotherapy (DDP)	Adopted children	Therapy/therapies	All
Theraplay	Adoptees	Therapeutic Intervention	
Filial Therapy	Adoption	Support	
SafeBase	Adoptive parents	Origin	1a. Roots of each intervention
Dialectical Behaviour Therapy	Adopters	Roots	
Eye Movement Desensitisation and Reprocessing Therapy	Adopted siblings	Delivery	1.a Delivery
Creative therapies	Adopted/adoptive Family	Assessment/ Assessing	
Non-Violent Resistance	Foster Children	Cost	
Break4Change	Looked after children	Handbook	
Nurturing Attachments	Children in care	Guide/Professional Guide	
Equine therapy	Foster care	Manual	
Psychotherapy	Fostering	Needs	
Therapeutic parenting training	Foster parents	Problems/ difficulties	1.b. Target Group Needs
Multisystemic Therapy (MST)	Relationships	Mental Health	
AdOpt	Family/ Family relationships	Attachment Problems	
		Theory	1.b Theory
		Attachment theory	
		Aims	
		Evidence/ evidence	2. Impact

		base	
		Impact/ Outcome	
		Evaluation	
		Effect/Effectiveness	
		What works	
		Evidence gaps	

Additionally, a reference group of 11 experts was selected and contacted individually for their knowledge of the interventions of the adoption support field and relevant literature. This group is in addition to the existing Expert Advisory Group on adoption support established by DfE. The 11 experts included three academics in UK universities, six representatives of independent voluntary/charitable organisations and two from statutory services.

Search Relevant Evidence and Appraise Quality of Studies (Synthesis Stages 2 and 3)

This activity involved searching and retrieving a long list of references from relevant bibliographic databases and other sources. The search terms and inclusion/exclusion criteria identified above were applied, although material that did not meet the inclusion criteria were still recorded in the database to ensure quality control across reviewers in later screening. The resulting list of references was then imported into the review team's tailored database. The academic databases and sources used in the review were:

Sources of literature used:

Academic Journal Databases	ERIC, PsycINFO, PsycARTICLES, Medline, Social Policy and Practice, Child Development and Adolescent Studies
Library Databases	OU Main Catalogue, British Library Main Catalogue, EBSCO host (e-books), Wiley Online Library, Social Care Online
Specific Journals	Adoption and Fostering, Adoption Quarterly, Child & Adolescent Social Work Review, Children and Youth Services Review, Family Relations
Grey Literature	Google; Google Scholar; Websites relevant to topic area (national and local government, research organisations, think tanks, voluntary and community sector)
Expert Panel	References from expert panel interviews

The references were screened and a priority score between 1 and 4 given according to their relevance to the review and an appraisal of the quality of studies through applying the evidence matrix criteria. In the ratings applied, a score of 1 meant 'very relevant' and 4 'very unlikely to merit further reading' on grounds which included (but were not confined to) their being not directly linked to the research questions and topic, outside the specified timeframe, not having a robust methodology, or related to a different target group (see work-package 1). Screening to quality rank the literature was a two-stage process that was fully documented: titles and abstracts were first screened, then full reports. For rigor and quality control, double-blind screening was undertaken on a selection of references to check consistency of the ranking process across reviewers.

Following screening, articles were identified for review as detailed below (this includes both descriptive studies and those providing evidence of impact):

Numbers of References Retrieved/ Imported into Database and Reviewed

Intervention	References Retrieved	References Reviewed (Fully or Partially)
Dyadic Developmental Psychotherapy (DDP)	37	16
Theraplay	55	19
Creative therapies	19	12
Filial Therapy (FT)	31	15
Psychotherapy	20	14
Non-Violent Resistance (NVR)	25	13
AdOpt	22	11
Break4Change	19	8
Multisystemic Therapy (MST)	51	25
Dialectical Behaviour Therapy (DBT)	33	14
Nurturing Attachments	24	11
SafeBase	23	12
Eye Movement Desensitisation and Reprocessing Therapy (EMDR)	39	21
Equine Therapy	45	18
Total	443	209

Extract Data from the Studies (Synthesis Stage 4)

The selected references were reviewed and data were extracted from the studies to produce a narrative around review questions and to determine the extent of the current evidence on 'what works for whom and where' (Pawson et al., 2004). To enable this task a thematic analytic extraction framework was created, based on the review questions and the interventions under study. To achieve consistency across researchers, regular analysis workshops were held by the review team to share the emerging themes and narratives, reconcile areas of overlap and share references between team members.

Synthesise Data to Determine What Works for Whom, Make Recommendations and Disseminate Findings (Synthesis Stages 5-7)

Each reviewer undertook thematic analysis and synthesis of the data extracted to identify key findings and determine what each intervention entailed and what evidence currently exists on its impact. Robust results were produced from summarised evidence by exhausting lines of enquiry through a matrix of cases in the extraction framework and

generated themes. A final analysis workshop was held to determine the key findings and recommendations from the evidence reviewed. The main findings from the review were shared with relevant stakeholders in a presentation at the Adoption Support Mental Health Roundtable (October 2015) organised by DfE. This gave the review team the opportunity to validate the initial findings and gather additional data to inform the conclusions (chapter 4).

Appendix C: List of Additional Interventions

Below is a list of some additional therapeutic interventions identified by some of the 11 experts spoken to as part of this review as currently being used within the post-adoption field:

- Family Future's Neuro-Physiological Model NPP
- Holistic Model of PAC-UK
- Parenting Our Children
- ABC
- KEEP
- Trauma-Focused CBT
- Attachment Focused Parenting
- Life Story Therapy
- Secure Base Model
- Nurturing Adoptions
- Attachment-Focused Psychotherapy (AFTI Institute)
- Sensory Integration



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