



Centre for excellence  
for looked after children in Scotland

# Supporting Kinship Families

Final report from the evaluation of the Notre  
Dame Centre's support programme for kinship  
families

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[www.celcis.org](http://www.celcis.org)

*Improving care experiences*

## Acknowledgments

We are very grateful to all participants who gave their time and attention to taking part in this study. They generously and eloquently shared their experiences and reflected on matters that were sometimes very sensitive. Without their input, this evaluation would not have been possible. We are also grateful to all those at Notre Dame who facilitated the study by providing information, support, and helpful explanations. Finally, I would like to acknowledge my research colleague Richard Withington who ably assisted with some of the data collection.



*Cat with a Polka Dot Bow, by young research participant.  
Shared with their permission.*

### **An introductory quote**

*I want to get this in, Notre Dame does, and HAS, filled a big gap that's missing out of psychological services for children [...]. I've got children from a very troubled background, and a lot of the kinship kids do, and they're not getting helped [...] If it was not for Notre Dame, and the few that manage to get to Notre Dame, and they do as much as they can, I believe that, you know the statistics, well my two would've become them, it has helped them move away from that type of life.*

*(Carer, interview – see also page 41)*

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# Introduction

## Purpose of this report

This is the final report for the evaluation of the Notre Dame support service for kinship families. The aim is present the findings and conclusions of the evaluation and, where it is helpful, to provide some background and explanation. Notre Dame have agreed that this report is made freely available in order to share learning; readers requiring further detail about evaluation methods may contact the author.

## Background information

### *About the Centre for Excellence for Looked After Children in Scotland (CELCIS)*

CELCIS is based at the University of Strathclyde, it is committed to improving outcomes and opportunities for looked after children through a collaborative and facilitative approach. CELCIS offers a range of services to organisations engaged in work with looked after children and their families; these include continuing professional development, consultancy, and research.

### *About the Notre Dame Centre*

The Notre Dame Centre is a voluntary agency established in 1931 in response to local need. Since its inception, it has provided a range of services to emotionally troubled children, young people and their families, as well as those who work with them. Statutory bodies including those responsible for health, social care and education commission the centre to provide specialist input or support not available through statutory bodies. In addition to work funded through statutory provision, the centre also offers work supported by charitable sources.

The approach adopted by the Centre since its early days is described as psychodynamic, holding the child at the centre of any intervention. Available therapies and approaches now include Play Therapy, Group Play Therapy, Relationship Based Parent/ Child Work, Adolescent Therapeutic Work, Eye Movement Desensitisation and Reprocessing (EMDR), Cognitive Behavioural Therapy (CBT), Video Interaction Guidance (VIG), Family Therapy and Seasons for Growth (a loss and bereavement programme for children and adults). In

addition, the centre offers professional clinical supervision and various training opportunities to practitioners from other agencies.

### ***About the Kinship Family Project***

There has been growing awareness in Scotland of the need for support for kinship carers and the children whom they look after. This is possibly reflective of the increasing number of children placed in formal kinship care from 1303 in 2002 to 4138 in 2017 (more than a three-fold rise)<sup>1</sup>. This source also shows that a high proportion of Scottish kinship families live in Glasgow and surrounding areas. For example, Glasgow has 1152 children living in formal kinship and its coterminous authorities have 890; suggesting that in total, nearly half of all formal kinship families in Scotland live in and around Glasgow. These numbers are substantially larger than Edinburgh (301), and its coterminous authorities (253). In addition, kin informally care for many children without a supervision order being in place.

The Notre Dame Centre noted increasing numbers of referrals for support on behalf of children who were being looked after by relatives, and in response, designed a service specifically to meet the needs of this group. The Centre was successful in securing funding from Big Lottery, this additionally allows families to self-refer and consequently receive support more quickly than they might by following other referral routes. Two objectives were set out for the kinship project; each is accompanied by four indicators that enable the project to assess its progress.

- Children and young people in kinship care will have improved emotional wellbeing, confidence, and behaviour, leading to better relationships in all aspects of their lives (home, school, and community).
  - Children engaging in community activity
  - Children with improved attendance and behaviour in school
  - Children with improved sleep patterns
  - Children with less anger and anxiety

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<sup>1</sup> (Scottish Government 2018) Children Looked After Statistics available at: <http://www.gov.scot/Topics/Statistics/Browse/Children/PubChildrenSocialWork>

- Kinship carers will be better able to cope with their caring role and have improved relationships with the children and young people they care for.
  - Carers with new coping strategies
  - Carers having improved communication with child
  - Carers engaging in positive activities with child
  - Carers who are less stressed and anxious

Intervention mainly comprises a parallel model whereby the child and the carer visit the Centre together but receive input from separate therapists, one working with the child and one with the adult in a different space. Therapeutic options from all those available at the centre are used according to the needs of the child and family. As well as schools, health services and other local agencies, links have been established with all seven kinship carers' groups in Glasgow; these are visited regularly to provide support and a secure connection to ease self-referrals.

The Centre monitors its work using a number of standardised instruments, and reports to funders on a regular basis. However, managers were keen to supplement this by introducing an element of objectivity through external evaluation and contacted CELCIS to discuss potential approaches and the possibility of collaborative work.

## Outlining the evaluation

### Evaluation tasks

In brief, the evaluation comprised a number of tasks:

- A review of existing outcome tools, advising on their strengths and highlighting any apparent duplication or gaps; identification of additional or alternate tools for consideration; discussion of relative merits in an Interim Report.
- Analysis of existing data (numeric and documentary) identifying and assessing evidence of impact, process, and context; incorporation of this into the Interim and Final Reports as required.
- Collection and analysis of additional data for qualitative work:
  - Interviews with kinship carers using the service
  - Group interview(s) / focus groups with kinship carers not using the service
  - Interviews with a small number of children using the service using creativity and pictures
- Identification of relevant literature (e.g. academic, grey and policy literature) – presented as a bibliography of abstracts annexed to this report
- Synthesis of Interim and Final evaluation reports

## Ethics

A number of ethical issues arise from the fact that the project delivers important services to potentially very vulnerable people. With this in mind, we gained advice and ethical approval from the Ethics Committee at Strathclyde University. Furthermore, we took great care to protect the wellbeing, rights, and privacy of participants, to promote voices less-often heard, to empower service users and staff, and to produce a reliable, accurate, and useful assessment of the work of the project.

## Technical approach: methodology, focal areas, and data used

### *Methodology*

We described the evaluation approach and methods in more detail in the first report, but it is useful to outline it again here. Given the relatively small size of the project, the fact that the study began after the service was established, and the impracticality of monitoring a comparison group, the study adopted a realistic mixed-methods approach. The approach was organised around three focal areas (context, process, and outcomes) and used data from two broad sources (new and existing). We outline these below.

### *Focal areas*

The three focal areas are described in more detail below. These are also used as a structure when presenting the findings and conclusions.

#### *Evaluation of context*

Context explores the nature and size of kinship care in Scotland and highlights the experiences and needs that prompted kinship families to seek help. Questions that underpinned the analysis included:

- How many kinship families are there in Scotland?
- What support needs do they have?
- Why do families self-refer and why are families referred by stakeholders?
- What other services or sources have these families used / attempted to use?
- What else in the lives of these children and families is important?
- Who might be best able to benefit from the service?

### *Evaluation of process*

Process explores the delivery of support and people's experiences of it. It also covers rationales, explanations, and meanings ascribed to the approach. Questions guiding the analysis include:

- How does the project operate?
- How do children and families experience the service?
- What are the views of staff and other stakeholders?
- What are the unique features of the service?
- What elements of the service are seen as being most critical?
- Are there any further refinements or improvements that could be made to service delivery or to monitoring and evaluation?

### *Evaluation of impact (various outcomes)*

Impact explores the various outcomes experienced by children, carers, and others and assesses the value they place on these outcomes. Underpinning questions include:

- What types of outcomes are achieved by children and carers?
- What size and scale of change to outcomes are achieved by children and carers?
- What do children, carers, staff, and stakeholders identify as the impacts of the service?
- How are positive impacts derived from the activities provided?
- Are these outcomes sustainable?
- Can these outcomes be directly attributed to the service (or activities within it)?

### *Data used*

The evaluation is based upon evidence from two main sources – newly gathered qualitative data and existing data collected by the programme.

#### *New data*

Over an 18 month period researchers conducted interviews and focus groups to gather diverse perspectives on the work and impact of the project. This included:

- Eight early one-to-one interviews with members of staff.
- Seven one-to-one interviews with kinship carers using Notre Dame.
- A small (suppressed) number of one-to-one interviews with kinship children using Notre Dame.
- A large focus group with the full staff team.
- A large focus group with members of a local kinship peer support group
- A large focus group with leaders of kinship peer support groups from various Glasgow groups.



Data from these activities included audios and transcriptions of interviews, transcription of the staff focus groups, and detailed 'notes and quotes' captured during the focus groups with kinship carers. Together these data provide a rich resource that was analysed qualitatively to identify themes within each of the context, process, and impact focal areas.

### *Existing data*

As part of routine service delivery, Centre staff use a number of standardised measures at key points for each family. Relevant measures are administered during the assessment weeks, and then again, approximately every six months during the family's engagement. As part of the first report from this evaluation, these data were reviewed, and some early recommendations provided as to how to optimize data collection to capture changes that may be attributed to the work of the service. In preparation for this final report, a further analysis was completed, and provides some useful information we present in the 'impact' focal area.

The Notre Dame centre have also collected other data that they were able to share including copies of feedback forms completed by carers, and reflective pieces such as a carer's video account prepared for another purpose. Whilst we have not explicitly analysed these additional data, we have reviewed them after analysing the other materials, their content is closely consistent with our findings and thus provides useful corroboration.

## Evaluation Findings

The findings are organised under the three focal areas (Context, Process, and Impact). Within these areas, a number of themes are discussed. These themes were developed inductively and deductively, for example by interrogating the data for specific issues, and by exploring the data to identify issues that appeared important to participants, were repeated frequently throughout the data, or provided a particular point of insight. Naturally, further analyses of this data might identify other themes.

We present the findings thematically with minimal discussion as we have followed the findings sections with a reflective discussion and conclusions. Where appropriate, we use participant quotes and extracts from field notes to illustrate or exemplify the themes being discussed. The inclusion of this material is necessarily selective; however, we have tried to include sufficient data to illustrate the breadth of each theme and to reflect the body of data fairly. Some extracts are long; we try not to curtail our use of quotes too

much, as it is our belief that readers gain much from experiencing the direct voice of participants. We also appreciate that some busy readers may decide to skip some of this material; we have therefore tried to ensure the description of each theme provides a coherent explanation of its content.

## Findings A: Context

This section identifies the circumstances of the families and the wider context of kinship care in Scotland. This includes the needs and issues that brought these families into contact with the Notre Dame centre. We use extracts from the data, where these help to highlight real-life context.

### *What existing sources tell us about context*

In this short section, we supply some key facts related to kinship families in Scotland. Readers seeking more detail will find a bibliography of abstracts based on the results of relevant searches of academic literature is included as Annex 1 to this report; additionally, a number of useful resources linked to kinship care are available through the CELCIS website - knowledge bank: <https://www.celcis.org/knowledge-bank/>.

Analysis of the 2011 Census estimated 12,630 (1.2%) children were living with kin in Scotland<sup>2</sup>. While most of these children will be in informal kinship care, a proportion are on the child protection register and/or formally looked-after on Compulsory Supervision Orders or under Section 25. Some of these children will be the subject of a Residence Order, Kinship Order, or Permanence Order transferring some parental rights and responsibilities to the kinship carer.

Kinship care differs from foster care in that the placement is agreed because of a familial bond or close relationship with the child<sup>3</sup>. This type of care is often portrayed as being preferable to being placed into care with strangers because it is said to support the child's sense of identity and belonging, provide stability, and embed them in their own family history and culture. Indeed, Scottish Government views kinship arrangements as being the first choice to be explored when children cannot live with their parents<sup>4</sup>. However, kinship care is not always a panacea; assessments of carers' capacity may

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<sup>2</sup> Scottish Government (2016) Children's Social Work Statistics Scotland 2014/15, Edinburgh: Scottish Government.

<sup>3</sup> Kidner, C. (2012) Spice Briefing: Kinship Care. Scottish Parliament.

<sup>4</sup> Scottish Government (2007) Getting it right for every child in kinship care. Edinburgh: Scottish Government.

indicate that another placement would be better for the child, and existing kinship placements can struggle and sometimes break down.

Research shows kinship families are often living in the poorest households; this is true for Scotland and the rest of the United Kingdom.<sup>5</sup> Some kinship families struggle to access financial support to assist them in raising the child:

*In 2007, the Scottish Government signed a concordat with the Convention of Scottish local authorities (COSLA) to provide equivalent support to that of stranger foster carers, to kinship carers bringing up children in State care. However, in terms of payments to kinship carers bringing up children in State care, there is still much variation between the 32 local councils, with most local councils frequently falling short in comparison with payments to foster carers looking after non-kin children. (Wijidasa, 2017. p2)<sup>6</sup>*

### **What interview and focus group data tell us about context**

Some of the centre workers have been there for many years; this allowed them to reflect on changing patterns of need locally. For kinship care families, they clearly noted an increase in demand, but also an increasing intensity to the problems experienced by families accessing support. For example, one worker spoke of seeing more of 'the high-end of problems'. They also attributed demand to growing awareness of the project fostered through links with kinship carer groups, the lack of support elsewhere and difficulty accessing it, and to greater societal awareness of conditions such as ADHD, ASD, etc.

The context within which a service is delivered is critical. There were clearly a wide range of experiences and diverse circumstances, such that each family was unique. However, we describe ten context themes that emerged from the analyses. We describe these themes in turn in Table 1. Each theme is followed by data extracts to provide further depth to the theme. The ten 'context themes' are:

- The impact of trauma, adversity, and exposures
- The child's presenting problems
- The developing child
- Carers' general worries, stress, and abilities

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<sup>5</sup> Nandy, S., Selwyn, J., Farmer, E. and Vaisey, P. (2011) Spotlight on kinship care: Using Census microdata to examine the extent and nature of kinship care in the UK at the turn of the Twentieth century, Bristol: University of Bristol.

<sup>6</sup> Wijidasa, D (2017) Characteristics of children living with relatives in Scotland: Briefing Paper 003 from Kinship Care Revisited - Using Census 2011 microdata to examine the extent and nature of kinship care in the UK, Bristol: University of Bristol.

- Carer guilt
- Carer health, fatigue, and increasing age
- Kinship links
- Parents' behaviours
- Family-level problems: structural disempowerment, difficult living experiences, and financial concerns
- Difficulties getting support

**Table 1: Context themes and examples of underpinning data**

*The impact of trauma, adversity, and exposures*

Most participants attributed current difficulties experienced by the child fully, or in part, to the impact on the child of past trauma, adversity, or exposures. Their earlier lives (and sometimes aspects of their current life) were variously characterised by extreme abuse, disruption, neglect, and the problems of those who lived around them. Families could experience various combinations of drug and alcohol problems, addictions, violence, sexual abuse, deprivation, exposure to crime, ill health (particularly mental health), family breakdown, disagreements, and other traumas. Traumas could be single events, or they could occur repeatedly or as combinations of different traumas. Participants understood that different people might find different things traumatic.

*Um, you're left, when something traumatic kind of happens in your life, your left with some kind of thing, and the thing about when they were young and living with [parents], they didn't always get fed, that was one of the things, they didn't always get fed, right, and the thing was, when they came to live with me after foster care, they got fed, but one of the things it left [child's name] with, was this thing about food [...] a kind of fixation [...] at one point, she would just keep eating, just keep eating until she literally burst. (Carer, interview)*

*This is a child that's been raised in an environment where his parents were doing cocaine, they were, his mum is an alcoholic, and his father, there was domestic violence, and he watched, he heard it, and it was happening again and again. And, the problem is, he now accepts that to be his norm [...] and if you think that's the norm, that is worrying for your future. (Carer, interview)*

*Worker described a case: An adult big sister now caring for little brother, there was serious trauma, mum had serious mental health problems, there was violence from dad, big sister had used a knife to protect her mother. Now a kin carer she could use Notre Dame to check small issues related to her brother's development, etc., and also have the chance to be young herself, make up for her lost childhood, have help processing her own past experiences. They could stay with the project for as long as needed – around 18 months. (Field notes, one-to-one interview with worker)*

*The child's problems can 'usually be attributed to early trauma and attachment' difficulties. The participants suggest that 'carers are trying to be attachment and trauma informed' in their response to the child, 'but their partners do not always understand this'. The child does not have 'a way of coping' as 'they have not yet developed the skills' so the 'child must be put first'. (Notes and quotes, kinship care group leader's focus group)*

*My granddaughter struggled very, very, much, even within our family [...] because the father was abusive, and we used to have to go and rescue them in the middle of the night, and whatever, and then she'd [mother] would take them back again, [child's name] was only wee, she was only about a year old the first time we had to bring them and they stayed for about four months. [...] and it's a long, long, thing for that wee one, when she was three years of age you'd have thought she was thirty-three years of age, 'cos she had to be smart, she had to be on her feet, she had to be thinking what's coming next [...] she was changing nappies, and all sorts of things, and going into the fridge to see what there was to eat and trying to feed her [baby] brother, and things like that. (Carer, interview)*

*Most carers present had one or two children. Most were grandparents, there were also two uncles. Participants had become kinship carers due to range of reasons, they suggested this was often the child's exposure to parental mental ill health, drugs, alcohol, addiction, sexual exploitation, often these things were in combination. (Field notes, focus group during kinship carer group meeting)*

*[Child's name] came to us four years ago, her father was convicted of historic sexual abuse, and it was obvious to everybody that he had at least inappropriately touched her, and was certainly grooming her. And her mother? Her mother, didn't have a clue about being a mother is the nicest way of putting it. (Carer, interview)*

*Participants offered common reasons for children becoming looked after by kin, these included: drug abuse, alcohol, neglect, difficult behaviour, poor parenting skills, disability. (Notes, kinship care group leader's focus group)*

*With my children, it was continued abuse over a certain period, you know what I mean? (Carer, interview)*

*...and kinship carers actually have got all this history where their own daughter was the mother of the child and she had died of a drug overdose or... there's been all this, and the granny has experienced domestic abuse but has actually never dealt with it. And so, the granny shouts at the child the same way, you know, and it's passing a lot of things on. But, she is actually trying to do her best and she has maybe mellowed herself. So, she is no longer involved in petty crime or whatever, but she doesn't actually see that what she is doing is destructive for the child, who has witnessed domestic abuse with their parent, do you know? (Worker, one-to-one interview)*

*I guess a lot of the children have come from situations of chaos, drug misuse, drug abuse. Yeah, that chaotic lifestyle. Neglect. And I suppose through that, some sort of early trauma. [...] it's not always the case for all the children. (Worker, one-to-one interview)*

*I couldn't say in front of [child's name] that I had a doctor's appointment, or anything, because that scared the living daylights out of her, she had to be examined, social work have taken her to be examined, and now if I have to take her to the doctor for anything, like we had to go to [hospital] for an appointment for her eyesight, well, we had to go inside and walk round that hospital three times, three times explaining what everything was, what led to where, what was behind that door, before I could get her in to that clinic, that's how bad it was. And I got her into the clinic and go up to the desk and explain to them, the extreme difficulties, and could they say exactly who she would be talking to, what it was about, what they would do to test her eyes, it took them over an hour to explain everything to her, that's how bad that was, she was about six at the time. (Carer, interview)*

*I've got a boy who had a one-off, [...] trauma, so we've been using [EMDR] with him to try and help him move on from that. Just so that, you know, he has quite a lot of flashbacks and things, and he's been finding it hard in school, and I can't be in the class all the time. (Worker, one-to-one interview)*

*The child is grieving, even if parents are still alive. (Carer, kinship care group leader's focus group)*

*And because of attachment and/or trauma issues they do not have the same emotional intelligence as they maybe have cognitively or, certainly, chronologically. So, that gap is sometimes hard for the carer to juggle. And I always think about wearing two hats because you might have a chronological twelve year old who is chronologically, biologically wanting to hit adolescence but emotionally they're way, way, younger than that because of attachment and distortions and that attached relationship. (Worker, one-to-one interview)*

*After talking about favourite teachers in different years. Child: I was born in 2008. Researcher: OK, that's good, were you born in a hospital do you think? Child: Yeah, I was meant to live somewhere else [town name], but my mum was really sick, and then so, I had to live with my Gran. And, my mum lived down there. And then my brother... me, my brother, my dad, my mum, all split up. [...] I haven't seen my mum for a year, I haven't seen my dad for my life. [...] and I haven't seen my brother for one year and three months. [Researcher: OK, how do you feel about that?] Child: Sad... and scared that I would never see them again. [...] I'm getting a baby brother and a baby sister, I said 'what's the point of having two more babies, when she can't even look after me and [brother's name], and she'll just give my Gran more work'. (Notes and quotes, Child, interview).*

### **Child's presenting problems**

The issues that drove families to seek help usually involved emotional and/or behavioural problems experienced by the child. These issues included both internalising and externalising processes. This could become evident through lack of confidence, problems forming relationships, arguments, disobedience, fighting, violence, shouting, tearfulness, extreme clinginess, inability to sleep, nightmares, flashbacks, school problems, etc. Carers could be at a loss of how to help the child, how to parent them, and how to cope with difficult and challenging behaviours.

*...before she wouldn't leave my side, she was stuck to me like a plaster. (Carer, interview)*

*When these behaviours first started to show, I had never experienced anything like it before. (Carer, interview)*

*Things like, yeah, tantrums, screaming and not doing, [...] not going to bed at night, maybe not going to school, refusing to go to school, they want that to be different. (Worker, one-to-one interview)*

*I would say behavioural issues is predominantly the problem. The child may also be struggling with sleeping. The child might be struggling with peer relationships. The child may be struggling with school work, sibling relationships, relationships with the extended family. (Worker, one-to-one interview)*

*I find it really hard getting her into her bed at night, she gets herself so upset it's unbelievable. (Carer, interview)*

*They come along, it is triggered by their behaviours, and they think they can't cope. (Worker,*

focus group)

Children have 'attachment issues', some won't let their carer go out or leave them, or go to sleep in some cases. They 'want attention' and worry about having a family. Some 'feel different from their peers'. (Notes and quotes from focus group at kinship carer group meeting)

When I sat down [child 1] had to be right next to me, and that used to cause no end of trouble with the fights between him and his sister, if I sat down next to [child 2] then he would have to get right in between us, and that carried on right from a very early age, you know, and he's not as bad now, but he has to be around the vicinity or where I am, and as I say, we have since found out he's got ADHD and Asperger's, but if it wasn't for the work that Notre Dame did, they helped [me understand] that. (Carer, interview)

Well I suppose usually the focus is on the child and they are saying, do you know they're, you know "[generic child's] got a problem with, I cannot control him, his behaviour [...]" and "I know such and such has happened to him but I don't know what to do about it." Or, you know "This all happened such a long time ago, why is he acting like this now?". Or "His mum has just come back on the scene, she is wanting contact and it's really screwed him up," or, "you know we are fighting to get permanence" or we. [...] But when they come often the shift is away from maybe the child's behaviour to their own issues. (Worker, one-to-one interview)

Or children in kinship care sometimes just need a space. Lots of the themes are, most of the themes will be about rejection and loss and, they feel rejected. They've lost their parents. Whether that be to drugs, alcohol, death. I mean, some children have experienced the death of [parents]. (Worker, one-to-one interview)

If I can think of one girl in particular who comes to the group, she has real issues about hygiene [...] she wets and she soils, and she smells. And in school situation, she doesn't have many friends. You know, people don't like to sit beside her. They're kind of mean to her, I suppose, because she does smell. She can be intrusive in relationships. (Worker, one-to-one interview)

### *The developing child*

As always, children's problems and issues were set within their stage of development. Often carers and sometimes workers felt that a particular child's development had been restricted or delayed in some way. Participants often related this to traumas experienced by the child. Equally, as the child developed the impact of their earlier life could play-out or re-occur in different ways. Incongruence between developmental and chronological age sometimes challenged the child and carer's expectations and could lead to conflicts.

As the child gets older, different things emerge, traumas act out in different ways in different developmental stages, the child reflects differently on their experiences, they have different questions. At first trauma can be too raw, sometimes it can be processed later. (Worker, one-to-one interview)

And she came from a [...] very neglectful, deprived background. So, she's placed with her dad's brother. Her dad, you know, became involved in drugs, her mum was a drug user who died. But when she was young, [...] I think just ignored. She was kept in her pram, very under-stimulated. Very, I suppose, developmentally delayed to some extent. (Worker, one-to-one interview)

### *Carer's general worries, stress, and abilities*

Whilst carers rarely initiated contact with Notre Dame ostensibly because of their own issues, they did recognise their own problems and worries about their abilities to care for the child; these were also acknowledged by Notre Dame workers. This could include the carers' own emotional distress, and that of other family members, and a sense of sadness related to the loss of an expected lifestyle or anticipation of a different role in relation to the child. Many were deeply worried about their child's wellbeing, stress levels among kinship carers were reported by carers and by workers to be very high, and this affected their ability to deal with the child's issues. Carers sometimes had explicit anxieties about their own parenting skills; workers suggested some had chaotic lives, their own problems, or were using out-dated parenting approaches or struggled to keep abreast of contemporary issues in children's worlds. In addition, carers experienced guilt, ill health, problematic relationships with the child's parents, and family-level problems (disempowerment, financial concerns, etc.) - we discuss these below as separate themes.

*Because a lot of things had come up with the child as obviously it was a family member, and a few times trying to discuss with other family members, you can imagine yourself, either they don't want to hear it, or they get upset and that, it kinda causes ructions within the family. (Carer, interview)*

*When you first take them, you don't really have any insight into what it will be like, but you still do it. I should have been stronger at the start and said what I wanted, I was manipulated, I should have gone to a lawyer straight away. (Carer, kinship care group leader's focus group)*

*... and there is a sense of loss that you had one life, and that very quickly changed to a different life. I'm thinking of a carer that gave up her job, and with her job came her social life, and all that's gone. (Worker, focus group)*

*...some of those grandparents, you know, they've still got something of a chaotic lifestyle. Their parenting skills are maybe not that great which is what caused the difficulties in the first instance with their own children, not being able to look after their children. (Worker, one-to-one interview)*

*You see, kinship care can break-up marriages and relationships, even if there's just a small crack. Because the child has to come first, and the partner comes second. The child's difficult behaviours put stress on the whole household, things like bed wetting, trauma, fighting, and sleeping problems are very stressful. (Carer, kinship care group leader's focus group)*

*Some of them have more insight than others, some have insight but then don't, can't, apply that practically. You know, when you're there in the moment and a child's shouting in your face, it's hard to remember actually, they've had all these things happen to them, they've had all these losses, they've had, developmental trauma, I need to try and be calm. And, they find that really difficult in the heat of the moment, they have some insight, but they can't apply it. From the child's point of view, gran and grandad are still trying to parent them the old-fashioned way, and there's a real generation gap, and that kind of more controlling parenting, that often doesn't work*



*with adolescents. (Worker, focus group)*

*... because a lot of the grandparents can't cope with the academic content [of school work] these days, it's so different, and the children can lose out there as well. (Worker, one-to-one interview)*

### **Carer guilt**

Related to these worries, carers' guilt was mentioned by many participants. Carers often experienced a sense of guilt, even when they objectively knew this was unjustified and they were not responsible. They felt guilty that their child/relative was 'behaving badly' or had not been able to parent the child successfully, they felt guilty for perceived shortcomings in their ability to look after the child, and they felt guilty about the child's pain or on-going problems.

*And the thing is, you carry the guilt for that as well, you think, you know, should I have done something sooner, I should have done it sooner, I should have taken some action, you know, if I look back I wish I had done it sooner instead of waiting ten years. (Carer, interview)*

*[at visitation/contact] And she's [the toddler] like 'that's mum, that's mum, I love my mum', but if she falls and hurts herself, she wants Gran, and that causes [tensions with mother], so it's just one of the things you have to cope with as a kinship carer, I tell you. [...] because there's someone somewhere, whether it's your daughter or you son, or nephew, or cousin, or whatever, because there's all sorts of people doing kinship, that person is still a member of your family [and you care about them too]. (Carer, interview)*

*My other daughter was emotionally blackmailing me, because I have two [other grandchildren] her being a bit jealous [...] that [Child] gets more attention than her [children], but then again (Child) has no parents. (Carer, interview)*

*For me, with kinship carers there is often the relationship with their own child (the parent), those issues and being primary carer for a child [...] to hold those issues and talk them through is a major thing. (Worker, focus group)*

*And they're both struggling to bring in enough money. So there's all the, so having a young family, do you know? Plus the other difficulties, plus managing contact with the mother, all that, which is an emotional minefield, because that's that person's sister, there's all the bond. (Worker, interview)*

*And I think there's kind of a guilt thing about the pain of the child, for the grandparent because they've parented the mother or the father, [...] and I wonder if that's why so many want a label put on, you know, that it's not actually come from their parenting or attachment, it's either ADHD or it autism or something like that, because it is so painful to face the damage that's done. (Worker, focus group)*

### *Carer health, fatigue, and increasing age*

Carers and workers were aware that many carers experienced poor health. Sometimes this was related to the carer's age or stage of life. Participants also linked poor health to the amount of energy required to care for kinship children. Many were exhausted, trying to cope with difficulties on a daily (and nightly) basis. A related concern was carer longevity, older carers were acutely aware that they were likely to die whilst the child was relatively young, some were concerned about dying while a child in their care was still a minor.

*Sometimes I get a wee bit tired and whatever, but I am going through the change of life right now, so the hormones are going up and down... (Carer, interview)*

*No, you know, the whole thing's a nightmare, because lots of the kinship carers who come are quite elderly, they have a lot of health problems themselves, lots of health issues, so that's a huge thing, they're actually, their ability to parent young children is limited by the very physical nature of their age and stage, so that is a huge issue, definitely. (Worker, one-to-one interview)*

*Elderly grandparents looking after very young children [...] in terms of health and energy, and maybe at a stage in life where you're looking to wind down a little bit, and not do so much physical, and having a bit of a rest, it can be really quite exhausting. (Worker, focus group)*

*The worry about their own health, and their death, and then children worry 'is my granny going to die?' because they are that much older.[...] and they're worried because there is no one else in the family, so it's added pressure, 'what's going to happen if I do die?'. (Worker, focus group)*

*So, I just think I am passionate about people giving support to kinship care because I think that it is so needed and often people come here, they are almost limping in the door because they are exhausted. (Worker, one-to-one interview)*

### *Kinship links*

Importantly participants acknowledged that kinship carers took children into their care because they were family. This could be presented as a blessing, a commitment/responsibility, and as a lever that could be deployed to persuade them to care for the child. Equally, it seems that children understood that kinship links could offer additional security or provide a sense of identity, we heard of children who sought affirmation of their family status in different ways.

*Well, you take the child, because, well, the social worker has a gun to your head. You have to take them or you may never see the kid again. (Carer, kinship care group leader's focus group)*

*Because [child's name] is family, it was either, um... A kinship arrangement, or adoption outside of the family, were the only choices. So, that's why we said, 'Come live with us and we will just make a brilliant family together', because we were a new family, with no family skills. (Carer, interview)*

*They [children] were said to be seeking 'family affirmation'. Some consistently ask 'can we have a family hug', or 'Do you really love me?'. Some are processing the issues, e.g. 'by repeatedly drawing pictures of "my family"'. They were said to be testing family, checking they will not be left by their kinship carer. Some can 'kick off', can express anger they are testing that 'we're not going to walk away'. Some suggested that foster care can break down often but that kinship care can't break down the same because they are 'family'. (Field notes and quotes, focus group during kinship carer group)*

*Aw, it makes it worth it, when they say they love you, or when you see them getting on better. (Carer, focus group at kinship carer group meeting).*

*You know, I have four children of my own, but it was a very different experience bringing up someone else's children, albeit my daughter's. (Carer, interview)*

### **Parents' behaviours**

One issue raised repeatedly by participants was the impact of the child's parents' actions on the child and the carer. This included past actions and current behaviours. Whilst participants often expressed considerable sympathy for parent's problems, this was matched by hurt, irritation, disbelief, and even anger at some actions. Although carers often remained keen to ensure that children and parents had positive connections, participants often saw parental visitations or contact as being detrimental to children who were struggling to address their own problems, or to find a sense of stability. Workers and carers often expressed that continued exposure to the parents' problems, harmed children, or 'normalised' negative behaviours. Sometimes carer (and workers) felt that parent(s) were undoing good work the carer was doing. Parents actions were sometimes presented as malicious, such as when they were said to 'play the child off' against the carer because of their own anger at the situation. Carers often described their own experiences of extreme hurt, disappointment, or loss, connected to the child's parents. Readers should remember that this study did not ask parents for their opinions, and their views are likely to differ.

*... her mum challenged me at the courts, she would have preferred the wee one to go into care than me have her. (Carer, interview)*

*Also, with dad being in prison, her son, [has an] alcohol problem, he's out of prison, started off with all good intentions, obviously wants to see his daughter again. But yet, the core issues, whatever they were, that led him to alcoholism, he's still, they've still not been addressed so he's*

*still, he's now back to drinking... (Worker, one-to-one interview)*

*And, they're telling him to misbehave, I've seen text messages that say 'just act up and they'll get fed up with you'. (Carer, interview)*

*Even if they think it is the wrong for the child, they [carers/social care] continue with contact [...] they feel is it the right thing because it is the child's parent and they are hoping that they will somehow become a better parent, but it's not, it is just so inconsistent and difficult. (Worker, focus group)*

*And I was always hopeful that my daughter would be able to look after her, I didn't know it was going to be a lifetime thing, I understood that my daughter had bipolar disorder, that she hadn't been well for long enough to be able to sustain that, umm, it's come to my attention lately that there has been episodes of her substituting her medication with other things. So, it wasn't just what I thought. And, I was always living in hope that [mother] would get to a point, and I wasn't just thinking oh I'll stop being a kinship carer [...] it was just that I always thought my daughter would be able to parent [child's name]. (Carer, interview)*

*We were in a court battle with his parents, we were going through the courts to have him stay with us permanently, so what was happening was he was under immense pressure between the two sides. We weren't talking about court cases [...] however, his parents were putting him under immense pressure. [...] He was feeling like he was stuck between loyalty to his parents, and err, loyalty to us I guess. (Carer, interview)*

#### **Family-level problems: structural dis-empowerment, difficult living conditions, and financial concerns**

A range of more generic challenges were experienced by these families. Various structural issues impacted on them. For example, several spoke of having to care for the child without the right to access full information about them, or the right to make critical decisions about their care. For example, some were unable to sign to approve dental or medical treatment, and some did not receive parental information from the child's school. Participants often thought that a lack of access to resources compounded family difficulties. This could take many forms; one carer spoke about extreme difficulties using public transport with a child that was experiencing behavioural difficulties. The unplanned-for nature of kinship care sometimes resulted in pressure on living space or housing that was not suited to raising a child; furthermore, some carers felt that the growth of their kinship family was not fully within their control. Sometimes, carers had had to 'give up' jobs to be able to care for a young child. Additionally, there were direct expenses related to caring for children, especially where they were having troubles or frequently accessing support. We heard of many families who had struggled to get basic benefits or any financial support for the child. More positively, a few carers noted recent improvements in carer allowances that had reduced financial pressures. In this context, carers welcomed support from Notre Dame with travel expenses to attend sessions.

*These kinship carers felt they could be very disempowered. Participant told a story about a child protection issue being reported to social work but not discussed with the kinship carer when*

*school noticed bruising on child's hand, they were often 'not given their place'. Others spoke about not being able to give consent, e.g. signing for dental and health treatment or getting a passport. Some felt that transfer of 'parental rights' should be automatic after child was resident for X years. (Field notes and quotes, focus group at kinship carer group meeting)*

*Because if you've been living on your own and you suddenly get three children, your house might not be suitable. (Worker, focus group)*

*...and often they're caring for, say, one or two children and another baby comes along. And that's happened, certainly, here. And, they're asked to take on the other child and so they've got a gap, maybe, of seven or eight years. And then they're maybe taking on another child who may have something like foetal alcohol syndrome or whatever, which is incredibly challenging, but they're taking that on and they're in their fifties, sixties themselves... (Worker, interview)*

*They did always offer me travel expenses back, [...] and the thing is recently payments have gone up in line with foster care, but it wasn't always like that. It was only October last year. [...] If you have got children that need a lot of care, and you are back and forward to Notre Dame or where ever, that is, is just a bit more of a drag on your finances. (Carer, interview)*

*And I think there's quite a lot of injustice in terms of, you know, I've known people, kinship carers take on family members and then they're told later on, "You'll not get any money from the Social Work Department because it was your choice". But actually, a social worker has gone and asked them to take them, but it has happened so long ago, that now it's too late so you don't get, they won't get a lot of the financial support. It is appalling and it's happened, I've seen it happen and I know it does happen. And, I think to me that's a major injustice. (Worker, one-to-one interview)*

*The wee one wouldn't of gotten to leave the hospital if I hadn't of stepped in, which I did. And now, this is [x] years later and I still have her, but I don't get the kinship [allowance] or anything like that because she wasn't placed by social work. But in a sense she was. (Carer, interview)*

*And the financial implications of that, if they have had to give up a job. (Worker, focus group)*

*That can be a real barrier to having headspace to spend time with a child when you're only thinking about money. (Worker, one-to-one interview)*

*Yeah, [kinship families] get help with travel and some of them really do need that, that can be the kind of 'make or break' when they come here.[...] the taxi gets paid for them, and for some that's really important, you know they might have a child who their behaviour is really difficult and going on public transport is a nightmare, and it's actually a stressful experience. By the time they get here they're ready to... they're in meltdown. (Worker, one-to-one interview)*

### **Difficulty getting support**

The final 'context' theme concerned the difficulties that kinship families experienced in getting help. Some workers and carers saw this as an equality issue, for example, participants asserted that kinship care families received a lower priority to access certain types of support compared to foster families. Social care services were a particularly problematic area, some carers felt anxious about contacts with social workers, fearing the child may be removed; others felt they had been pressured to take the child, but then had been left to cope with little or no support. Carers often said that social workers

were remote and difficult to contact. Participants provided general explanations related to austerity and resource constraints; they also gave specific explanations related to kinship care. One specific understanding was that social care and other services failed to recognise (wilfully or unthinkingly) the extreme needs of the child or their kinship family. Another explanation was that services to meet their needs did not exist, and relatedly, that kinship families often did not meet thresholds or 'the criteria' for services that they believed might be helpful. More positively, participants explained that some kinship carers derived considerable peer support from attending kinship peer support groups across the city. These groups provided information, a listening ear, and friendship. There was evidence that these groups also fulfilled an important advocacy and campaigning role as part of what might be termed a kinship movement. Statistically, it is clear that many kinship families do not attend support groups.

*...for me, the big issue is not necessarily people in foster care, not necessarily adopters, but kinship carers are being left with nothing, they're not being given the support, they're not being given the training. [...] but they certainly get more than kinship carers get. (Worker, interview)*

*One participant outlined her story, social work had not helped her with a child who is evidently having problems including school non-attendance, isolation, 'fights with granddad' and 'agoraphobia'. The family feels 'let down' by social workers and 'have no confidence in them'; they feel they 'get wrong or conflicting advice from professionals' including social workers. (Notes and quotes from focus group at kinship carer group meeting).*

*The group was very friendly and [visiting social work manager] had a reasonable reception, but was forced to 'defend' on a number of points – like social workers not being easy to contact, giving wrong information, being absent, de-prioritising kinship care or not showing up at Children's Hearings, etc. (Field notes, participating in kinship carer group meeting)*

*Noted that groups and services were sometimes established without overt targeting, in part to avoid stigma, but they were quickly withdrawn if targets were not met. But as a kinship family. targeted groups can be difficult to access as you don't fit the criteria or the thresholds to get help can be too high. (Notes and quotes from focus group at kinship carer group meeting).*

*Group members identified various gaps for support, this included respite (emergency and planned short breaks - although they note need to build relationship with children) and practical family support such as help with school runs, etc.) (Field notes from focus group at kinship carer group meeting).*

*Even now, getting access to CAHMS is absolutely shocking, and that's not to get them diagnosed or anything like that, it is just to get somebody to see them. So if Notre Dame wasn't there and doing what it is doing, I really fear for a lot of kinship carers. (Carer, interview)*

## Findings B: Process

### What project monitoring data tell us about process

#### Families served

Seventy-eight children's referrals were accepted into the kinship programme (35 girls and 43 boys).

Of these families, 76 attended at least a first appointment. There was a small drop out over the first few weeks, resulting in 69 families who attended for at least one month. Sixty-two children have completed their engagement and been 'discharged' from the service.

As noted in the qualitative analyses, there was very wide variety in the duration of the intervention up to a maximum of three years or so. More typically, intervention lasted for between eight and fourteen months.

The youngest children at referral were aged 4 and the oldest aged 17. The average (mean) age at referral was 10.1 years. Figure 1 shows the distribution of children of different ages (at point of referral). The figure includes a moving average 'trend-line' to help visualise distribution around the mean.

This distribution represents demand for Notre Dame support; the patterns seen may reflect times of additional pressures, such as those arising from approaching or preparing for the transition from primary to secondary school.

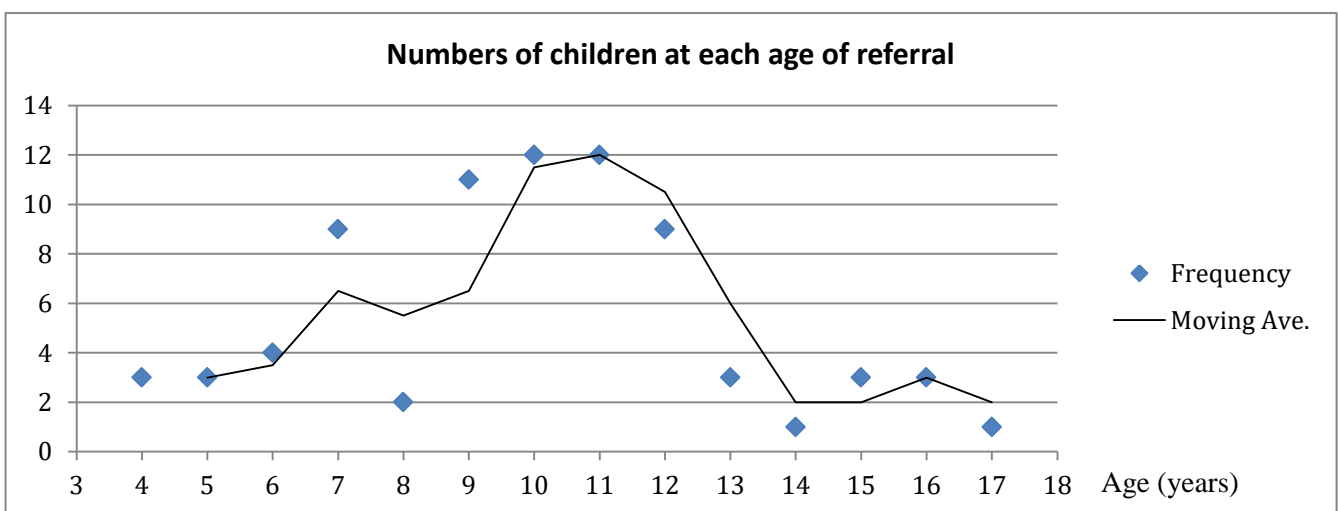


Figure 1: Distribution of ages at referral

Equality data were available for 25 kinship carers who first engaged with Notre Dame between August 2013 and August 2017. It is clear that these carers tended to be females, but beyond this, the number of carers is too small to allow us to determine with certainty how well their profile reflected the local community in other respects. All but two identified as female; all but one identified as White; all but three were aged 25-64 years, with one being younger and two being older. Four were single, nine were married, eight were divorced or separated, and four identified their status as 'other'. Eleven identified with no religion, twelve identified with Christian religions and two with other religions. All but two identified their sexual orientation, most of these were heterosexual and four were lesbian, gay, or bisexual. Six identified that they were a disabled person. No information about socio-economic status is currently available, although it may prove helpful to capture and assess home postcodes against the Scottish Index of Multiple Deprivation (SIMD).

### *What interview and focus group data tell us about process*

Qualitative analysis of data from interviews and focus groups provided rich detailed information about how the Notre Dame service is delivered to kinship families. The themes captured here reflect critical aspects of service delivery. Some of these were said to be somewhat unique to Notre Dame. We consolidated eight process themes, these were:

- Strength-based, respectful, and solution-focussed ethos
- Assessment and reviews
- Inter-disciplinary team, paired-working in parallel
- Theoretical and conceptual underpinnings
- Taking time, building real relationships
- Flexibility and self-referral
- Nurturing, caring, and valuing
- Intensive, reliable, and prioritising families



**Table 2: Process themes and supporting data**

*Strength-based, respectful, and solution-focussed ethos*

There is a clear underpinning ethos of identifying children and families' strengths and building on these. Workers recognise, respect, and care about kinship families, appreciating their difficulties and acknowledging their commitment to conquer these. This ethos appears to make the experience of intervention positive for children and families, and seems likely, to account for the high levels of satisfaction expressed by carers. A related dimension of this ethos is a focus on solutions or goals identified by the family; these may be issues the family initially bring, areas for change identified during the assessment process, or matters that arise during on-going therapy. Workers describe how problems are often broken down into smaller parts, to enable recognition of progress, this process takes time, but it is thought to provide a firm foundation for lasting change.

*I think we're helping, well, I certainly hope. My aims would be it's trying to empower families, to give them sort of strategies and try and see the strengths and resources that they've got already and trying to help them put that into practice with the young people. [...] So, with the young people it's just about helping them, again, see their strengths and helping them understand where some of their behaviours are coming from. [...] so trying to give them a bit of a sense that this is quite normal from your experience, what's happened to you, these kind of behaviours, we see it a lot, and then giving them strategies to help deal with that... (Worker, one-to-one interview)*

*...and I've really enjoyed working with the kinship cases. And, some have been really, really difficult. You know, real difficult situations and, I really admire the strength and resilience and resourcefulness of some of the grandparents and aunties to just get through really challenging times. So, yeah, it's a really fulfilling aspect to the work... (Worker, one-to-one interview)*

*It helps them [carer] to see the child from a therapist's point of view, to find some more ways of managing and supporting the child, some things they had not maybe come across before, and that's the solution-focussed bit. (Worker, focus group)*

*Basically, the strength is that they've come here. They've come, they've trusted me with their time, they've trusted one [of] the workers here, with their child [...] to actually, potentially, post-assessment, open that child up to difficult memories. So, they've given us a great deal of trust. That in itself is WOW. (Worker, one-to-one interview)*

*Researcher: What things did you find most helpful?. Carer: Err, discussing the week just past and any problems with [child's name], and not just negative things, positive things as well.*

### *Assessment & reviews*

Participants described an initial assessment (usually four weeks) during which the child's and the adult's workers explored the issue from the perspective of the family members and completed a number of assessment tools. After the assessment, the paired workers met to reflect and draw up a report suggesting what further work might be helpful. In most cases, work proceeded in blocks of around ten weeks' intervention after which the workers and family members would review progress and decide if further work would be helpful.

*So you have four sessions then you have an assessment meeting, and then, where you discuss, you write a report and then we blend [...] the two reports together, we look at 'what are we both saying, you know, what sort of support's needed here?'. (Worker, interview)*

*And so, basically, if you're doing the play therapy work you're completely focused on the child, which is lovely, and it's really entering into the child's world and seeing what they bring, and trying to see it through their eyes and understand what is going on. Yeah, it's lovely, it's fantastic. And it's assessing as well, you know, is this child open, able to work in this kind of way, and is it going to be beneficial to them, and what appears to be the issues? (Worker, one-to-one interview)*

*... trying to think very much from the child's point of view, and the impact of the experiences that the child has had, what that impact has on their presentation, on their relationship styles, on their behaviour, on how they... their emotional world, how they're managing things. (Worker, one-to-one interview)*

*... and then it's reviewing it after, as I say, the ten sessions, looking at what's happened, you know, what's been the progress. Has there been any change? Is there anything else that we need to be working on that we're missing? (Worker, one-to-one interview)*

### *Inter-disciplinary team, paired-working in parallel*

One feature thought to be an unusual or unique aspect of the Notre Dame intervention is the deployment of two workers, one to work with the child, whilst the other works with the carer. Skills within the team include social work, play therapy, psychology, and counselling. After an initial discussion with the carer, a suitable pair of workers is assigned to work with the family. Participants described their sense that this parallel approach can encourage deeper and more-sustainable progress because child and carer issues are tackled simultaneously. Uniquely, carers' own problems are recognised and supported and they are helped to better understand the child and support their therapy. Workers often felt that the child's difficulties were partially located in the care they received, such that it was essential to address carers' understanding and skills. The unfamiliarity of this approach could initially be disconcerting for carers, and whilst most came to value it highly, it seems that a small proportion may be more ambivalent. Workers valued the parallel approach; in particular, they enjoyed gaining a deeper

understanding and different professional perspectives on the family.

*There's not many posts, anywhere, where you can do that intense therapeutic work. But, even less so is there the opportunity to work alongside someone who's working with the parents. [...] I mean, I supervise a lot of play therapists and none of them have that co-working model where they work. And for me, in terms of the work that we do, I think it's crucial because what you're saying is it's not just this child that's the problem [...] and that the child needs fixed. (Worker, one-to-one interview)*

*It's not just the children that Notre Dame try to support, they tried to support, support the family as well to the best of their ability, and the fact there was someone there to support ME, you know, and explain that to me, what was going on with the therapeutic work with the children [...] they can't tell you everything cause that is confidential with the child, but they could come and say she was quite upset by [parental contact] and things like that. So it does kinda feed back into social work. (Carer, interview)*

*The joint working is definitely 'it' for me is the model, because I have worked places where I only worked with the child and to have that joint working model [...] because it does work so successfully, having that, it's a worker to meet the needs of the adult and to meet the needs of the child at the same time [...] it actually works much better than just working solely with the child. (Worker, focus group)*

*'Notre Dame is a brilliant service'. 'We often link people into them, see, because they support the carer as well as the child'. 'I don't think anyone else does that in the same way'. Participants discussed the value of Notre Dame's parallel working model, which they say is unique. (Notes and quotes from focus group at kinship carer group meeting).*

*This is the first time I have been part of a team [...] and for me it is so refreshing to just be able to ask someone, and to bounce ideas off, or if I forget something, someone's usually there to remind me [...] it makes such a difference, because here we're working with such high-tariff cases. (Worker, focus group)*

*But I think, in terms of the parallel work we do as well, that's very helpful. [...] So as the child is experiencing change, the carer is gaining a better understanding of really what needs to change. And how to help facilitate that change for the child. (Worker, one-to-one interview)*

*For those [kinship] families. I think a strength of them is the parallel model of working. Because for (it could be grandparents, it could be aunties, it could be sisters) often, the pressures on them are huge. And to give them a space and time to talk about themselves and the difficulties that they're having is a huge strength [...] And, you know, lots of services don't really provide that. (Worker, one-to-one interview)*

*Helping the carer to understand that they create the environment, it is not just about expecting the child to change, [...] it is not just the child that does it all on their own actually, it is a whole family dynamic. (Worker, focus group)*

*For some of the older carers it's a bit of a surprise that they get to enter into a therapeutic relationship as well, it's almost like 'just take the child, the therapist takes the child and makes them better while we have a cup of tea', well, no, no, no, they have to do some thinking as well. (Worker, focus group)*

*I think having done [period of time] in family therapy, we did miss the interaction [...] so we found it quite hard at first that she goes away, and we go away, and never the twain shall meet. But, I don't think we would have experienced that if we hadn't done family therapy first. [...] I don't*

*think we got much from it as [carers]. It was nice to have that chance to moan, but we have got mates I can moan at. (Carer, interview)*

### *Theoretical and conceptual underpinnings*

As might be expected from a multi-disciplinary team, workers outlined several different theoretical, therapeutic, or professional stances that underpinned their work. This included Cognitive Behavioural Therapy (CBT), Family therapy, Dyadic Developmental Psychotherapy (DDP), Axline principles, Non-directive play therapy, and Theraplay. Workers also outlined specific techniques that they used on occasions, including Video Interaction Guidance (VIG) and Eye Movement Desensitization and Reprocessing (EMDR). In addition, workers made reference to key concepts including, attachment, resilience, 'holding in mind', and containment. Carers also referred to these concepts, recognising they were important and whilst their detailed knowledge may have been limited, they used concepts such as attachment and containment as a valorised frame in which to understand or rationalise their child and their difficulties.

*I take a very systemic approach, often children are brought to be 'fixed' and my conversation is that the problem is in the entire family and the solution will be in the entire family too. [...] where are the strengths, where are the vulnerabilities, and which bits need strengthened and which bits need toned down. (Worker, focus group)*

*I'd be thinking about an ecological approach, so similar, looking at the family, looking at the school, looking at all the environments that the child operates in, and what's going on there. How does that support or inhibit the bond for the child? (Worker, focus group)*

*I'd be very much child centred as a play therapist, seeing what does the child bring and their interaction with me, and what I'm discovering in the room, and very much based on the Axline principles. (Worker, focus group)*

*So all that's kind of thought about and 'held in mind', and contained, and supported. Yeah, so there's, I think there's also something about here, being a container. There's a lot of thought... thoughts given to people and thought given to their capabilities... (Worker, one-to-one interview)*

*Here, you've got play rooms, the kids come in, it's all set up, it's calm. There is a calmness. There's a containment that is very important to therapeutic work. [...] having a contained, safe environment where the child comes, feels welcomed, and the carer comes together is fantastic. So, that's a big strength. (Worker, one-to-one interview)*

*...often the hide and seek game is a big thing for children coming up because [...] actually, the focus there is not about just playing hide and seek (sometimes being found and sometimes hiding) it's about being found, it's about being reclaimed. It's about focusing on that attachment. So, that bit of work can be, you know, as much as they can get something, for them even to be able to do those bits can be helpful. (Worker, one-to-one interview)*

### *Taking time, building real relationships*

Relationships were seen as critical to achieving positive change. Workers stressed the need to proceed at the child's and carer's 'own pace'; therapeutic work cannot proceed without first building trusting relationships with each of them. Workers explained that carers may at first be resistant and worried about opening up, they related this to the pain that many of them were suppressing, or to previous negative experiences that made it difficult to trust services. Carers and workers acknowledged that it could take some weeks for the child to trust the therapist; some related this to the child's previous experiences with adults. Children acknowledged that at first, it could be difficult or embarrassing to talk to a therapist. Workers expressed genuine care and concern towards the people that they worked with.

*Both [children] were there for just over two years, a good long time they were there. They needed some kind of intervention, it does take children a little time to settle in, it takes easily six or seven weeks to get to know the therapist before they can start to do any work [...] it is about trust, that's the word I would use, trust. When the children who come from that background they have to learn to trust adults again [...] when you're met with a complete stranger, having to learn to trust that person to want to tell them what is going on in your life, so they can then help you. (Carer, interview)*

*And, you know, in play therapy, children come into that room and most of the time they will work away on whatever it is that they need to be doing, and they progress at the kind of pace, I suppose, that they're ready to do that at. So, there's not a kind of set programme of what we do with each child. (Worker, one-to-one interview)*

*...with kinship carers it is for them to bring what they want to that space, for us to make it a non-blaming space, allowing a trusting relationship to be built. [...] hopefully to get away from the more pathological issues [about] behaviours or problems [...] to help them move forward (Worker, focus group)*

*There's a real thoughtfulness. And I don't mean in terms of that we're considerate towards people, but we like to think about what we're doing. So we, for us it's important not to just rush in with things. (Worker, one-to-one interview)*

*I did have a chat with [therapist], I liked that. [Researcher: And was it helpful to have a chat?] yeah, uha. [then looking at a picture of a meeting] We didn't have a meeting, we were just chatting away. [Shortly after this, the child said it was difficult to chat when first started with Notre Dame] (Notes and quotes from Child, interview)*

*After chatting about things that make us scared. [Researcher: oh, were you scared the first time you went to Notre Dame?] Child: Yes, and I was, um, embarrassed! [Researcher: Why?] Child: Oh, sometimes I just get embarrassed. (Notes and quotes from Child, interview)*

*I think the guilt thing that we were talking about earlier in kinship families means that they need that slower pace, and you have to respect that they are carrying huge amounts of pain and need, it's almost a therapeutic process for themselves. (Worker, focus group)*

*They are a bit worried about it initially, a bit resistant about it initially... [interrupt/switch] yes they*

can be guarded, they have perhaps had quite difficult relationships with social workers, so you know it helps for us to be seen as separate from other systems that they view quite negatively [...] sometimes I think I'm starting from below 'ground zero'. (Workers, focus group)

And, really good listening is the key I think, taking time to make them feel understood. (Worker, focus group)

I think really genuinely empathising with them, recognising 'you have had to take on quite a lot', and 'you're doing this' and 'you're doing that' and even just wording that back to them [interrupt/switch] yeah, 'you're doing a really hard job' [...] and then they feel really understood. (Workers, focus group)

I get very connected to my families, and when it ends and you're waving them out the door with a good outcome that's great, occasionally if it has not worked out for them, that's more difficult. (Worker, focus group)

### *Flexibility and self-referral*

Workers described a form of flexibility that underpinned the service, Flexibility included sensitivity not to pressure the family further and was linked to moving on at their pace and to a focus on strengths; this seems linked to efforts to empower the family. For example, carers described how on rare occasions when they needed to cancel appointments, the staff did not make them feel uncomfortable or guilty; similarly, carers described asking for preferred time-slots, and the efforts Notre Dame made to accommodate this. In some circumstances, therapy was suspended whilst the family dealt with various issues and could be resumed when the family were ready. The ability to self-refer to the service was often mentioned by carers, and was something that was clearly recognised across kinship groups; particular value was placed on this because of the context in which they often felt excluded from other supports.

They do feel quite special because of that, they don't need to go through an outside agency.[...] I always explain that we're a third sector organisation and this is why we can do this work, because we've been lucky enough to get the lottery funding. (Worker, focus group)

That's incredibly empowering for them [...] to say you can just lift the phone, speak to [manager] and you're in, basically, and there's offer of help with travel, I mean how empowering is that, 'we really want you to get here'. (Worker, focus group)

...so she's their auntie so she has taken on her two nieces and she would be able to refer by herself quickly but she doesn't necessarily want to get involved in social work because she's maybe had a bad experience or she's [done] with social work, she feels she's had enough of that and so that she can then decide, 'Well I actually feel I need this support.' (Worker, one-to-one interview)

I think we're all really flexible, if they're late or miss a session or something like that, we understand [...] it not like 'three strikes and you're out' kind of thing. (Worker, focus group)

My nephew is not open to talking about what was going on at their house, he'd say 'whatever was in my head, I've gotten it out' [...] but for me, I sensed that he was holding back. [...] he would

*only go so far and then he would just close up [...] he found it too hard to face up to what was happening and didn't want to talk about it because that meant that he had to think about it, so he needed to have a break, yeah. The earliest we're going to be able to go back now, because of the counsellor's availability is going to be [month]. (Carer, interview)*

*And, in a relatively small team with all the various different interventions, we can shift what we do, without needing re-referrals elsewhere, we can shift the focus of our work without having to go through other hoops [...] matching the needs of the case with the services that can be offered. (Worker, focus group)*

*One of the other things about Notre Dame is it's not time-limited, in so many therapeutic services you are only allotted a certain amount of time [...] it takes the pressure off [...] you can be truly child centred. (Worker, focus group)*

*Notre Dame were really good to use because I actually said that [child's name] was not going to go unless it was after school, because I really didn't want that disruption of her coming out, because during the four week assessment, it was every [x-day] afternoons, so she was missing school on [x-day] afternoons. And, I thought, if we do a year of this, at schools she's already different, I don't want to make it even more different and for [child's name] to have to explain every [x-day] why she was away. So, Notre Dame were brilliant and accommodated that for us. [...] so that was very good, and the frequency was just about right. (Carer, interview)*

*The lovely thing is that people can refer themselves directly [...] people are the best judge of when they need some support. (Worker, one-to-one interview)*

### **Nurturing, caring, and valuing**

Workers and carers frequently described the ways in which the service nurtured children and families. This was related to flexibility, the priority given to families, and the value placed on 'real' relationships; but it also demonstrated the provision of time and space for each individual. Participants described that by offering this resource, the service showed carers and children that they were both important in their own right.

*It's a bit more nurturing, it think than say if you were going to CAMHS it a bit more clinical, there's a softer side, and I think that is more nurturing. (Worker, focus group)*

*In Notre Dame it is very much about the child, so both went [two siblings], but on different days, the child feels that that session is theirs, and they had different therapists as well. (Carer, interview)*

*So I was able to go along to somebody at Notre Dame and speak to them about things that were arising [as a result of contact visits]. So, it was good to be able to go to Notre Dame and talk it over with the person there. (Carer, interview)*

*You know, the coming here and the going home and, because often [...] the carer sees exactly how the child is when they come out of a session and they see how they are when they come in. And there's the build-up, and the trust established, and that feeling of they're both being nurtured together. You know, it's not just the child that's getting all the attention. (Worker, one-to-one interview)*

*Conversation after chatting about a sheet of 'emojis' and their meanings...Researcher: So when*

*you were at Notre Dame, how did you feel about it? Child: I felt REALLY good. And, the reason I liked it, I got to miss all of the work at school! [Giggles]. Researcher: Hhuuh!?! Did you not have to catch up when you got back to school? Child: No, because it [Notre Dame] was important. But, if it had been an assessment [school test], I had to do it. (Notes and quotes, Child, interview)*

*And so, like, for one person who's a Gran looking after her Granddaughter, I felt she, there's a lot of domestic abuse and it appeared like she's kind of really not able to play, not able to listen, not able to be attuned to the child, partly because of her own emotional stuff and, actually just 'be'. When she was in the room, she actually wanted to just play herself... (Worker, one-to-one interview)*

### *Intensive, reliable, and prioritising families*

Workers explained that another area where the Notre Dame service differed from other services was in the extent to which the service was delivered intensively, Carers also noted attending weekly, although they acknowledged that this was a big commitment of their time and effort, they valued this level of intervention. Workers suggested that weekly contact helped to support the development of relationships and keep things moving forward; additionally, some explained that specific techniques such as EMDR were more likely to be successful if repeated on a weekly basis. Participants contrasted Notre Dame with other sources of support, such as social work that could be intermittent or could often be cancelled at short notice, making the family feel they are given a low priority.

*Having weekly sessions, same time, same place, it makes them feel valued, we're never late. Where maybe social workers turn up late for their appointment, things are cancelled [...] here I think that uninterrupted time for you, it goes a long way to making that relationship and to feel we're very reliable. (Worker, focus group)*

*Really frequent compared to other places. Yeah, that it's once a week and they know that they're getting that. [Knowing] That they're being kept in mind, that you're seeing them every week. (Worker, one-to-one interview)*

*Some [external] educational psychologists can [are able to provide EMDR], but probably they don't have contact with the young people regularly enough, we see them every week so it can make a difference. (Worker, focus group)*

*Attending Notre Dame itself is a big commitment, there are weekly sessions, and carrying on changes in between, they need to be regular, many [carers] want to know from the start how long they will need to come, but it is hard to tell this. They find it especially difficult if they work, so the fact that they come suggests they do value what they are getting, it is an effort. (Field notes, one-to-one interview with worker)*



## Findings C: Impact

The impact of a project can be viewed as its overall effect; that is, it can be seen as the sum of achievement or non-achievement of a range of different planned and unplanned outcomes. Researchers assess these outcomes in different ways; for example, they might assess a selection of anticipated outcomes via pre-post administration of standardised measures (with or without a comparison group). More generally, they may assess the full range of outcomes through detailed qualitative work with beneficiaries and others closely involved in the service. Researchers often use these approaches in combination, as in this study.

### *What the project monitoring data tell us about impact*

The project collects data using a number of different standardised instruments. The selection of the set of instruments used has tended to be reactive to funder requirements for a specific tool, rather than a planned development of tools most suited to the project. The advantages, disadvantages, and suitability of each of these measures was discussed in the interim report.

As discussed in the interim report, there have been some difficulties encountered in the analysis of data collected by the project. Although latterly there have been renewed efforts to administer scales at appropriate times, frequencies, and in the prescribed way, earlier administration was patchy. In addition, to be reliable for evaluative purposes, instruments need to be administered according to particular procedures. Because in this case, workers completed these tools around service delivery, optimal administration was not always possible. In our experience, this is not uncommon, time and resources are short, and the administration of measures, particularly repeated measures, can be squeezed out by other activities. Where they were used, workers often integrated the tools into assessment sessions and completed them discursively with family members. This approach undoubtedly provided valuable input and prompts to the assessment process; however, doing so may reduce the validity of measures that are designed to be completed independently or without excessive influence. The sample size is low because of the relatively small size of the project and completion rates.

The issues above prevent us from conducting many of the analyses we would otherwise have completed to produce inferential statistics that might show whether the results are statistically significant to a given confidence level.

We are keen, however, to maximise the value of the information that the project has collected; we have therefore completed a curtailed and cautious descriptive analysis below. The following analyses are limited to those we feel are unlikely to provide misleading results; the findings are broadly promising, but readers should view them with caution.

#### *Parent-completed SDQ*

An initial and at least one follow up parent completed SDQ had been gathered for 30 children across years 1-4. Working only with the initial and the most recent total difficulties score, we can see that the mean value dropped from 20.3 to 17.0. Whilst this appears to show a shift towards fewer difficulties, the scores remain high when compared to the British norm value of 8.4.

#### *Child-completed SDQ*

An initial and at least one follow up child-completed SDQ had been gathered for 17 children from years 1-4. Working only with the initial and the most recent total difficulties score, we can see that the mean value dropped from 17.0 to 13.0. This again appears to show a shift towards fewer difficulties, and encouragingly, the scores begin to approach the British norm value of 10.3.

#### *Teacher-completed SDQ*

An initial and at least one follow up child-completed SDQ had been gathered for only three children in year 4. We conducted no analysis other than to note that scores for two of these three children showed decreases for their difficulties.

#### *The Warwick-Edinburgh Mental Well-Being Scale (WEMWBS)*

An initial and at least one follow up WEMWBS score had been gathered for 11 carers still engaging during year 4. Working only with the initial and the most recent score, we can see that there was an increase in the mean of 2.5 points. This appears to show a small overall shift towards greater wellbeing, bringing the mean score to 50.1, this compares closely to a Scottish population norm of 50.7 (all ages).

#### *Clinician completed - Child Global Assessment Scale C-GAS*

An initial and at least one follow up completed C-GAS had been gathered for 12 children still engaging during year 4. Working only with the initial and the most recent score, we can see that the mean value increased from 58.0 to 68.6. This appears to show a shift towards improved functioning, and begins to approach the normal range of 70 and

above. We note however that the mean masks the fact that scores for three of the 12 children showed a drop.

### *What interview and focus group data tell us about impact*

As discussed, children and family difficulties were varied; the data obtained from interviews and focus groups provided many examples of impact, some of which will already be apparent to readers. In this section, we focus on seven areas of outcome:

- Positive outcomes for the child
- Fundamental and sustainable changes
- Ownership, control, and empowerment
- Up-dating, developing, or consolidating parenting strengths and skills
- Experiencing nurture
- Linking to other forms of support and realising secondary impact
- Filling a gap and providing value

**Table 3: Impact themes and examples of underpinning data**

#### *Positive outcomes for the child*

Participants noted many positive outcomes for the child, underpinning these, workers and carers suggested that the child was accommodating or coming to terms with earlier traumas. Carers and workers felt this enabled a further range of important outcomes, such as, having a greater sense of self-worth and confidence, being more contained and able to function better at home and school, making and maintaining friendships, and experiencing positive relationships at home with more secure attachments with carers. Carers and workers explained that the child's behavioural problems reduced, for example, there were fewer tantrums, sleep was better, and children were more able to cope with routines. Workers, and sometimes carers, explained that changes in carers and their approach to parenting were also driving the child's changes; key to this, participants suggested that home environments were calmer and more stable, potentially increasing a sense of security or permanence for the child and carer.

*So, it really starts off with this girl whose presenting problems, it was like she was fighting with everybody in school, she was fighting in the family home. That has got a lot better. You know, if you look back at the referral, those issues have been addressed, the more deeper issues have been addressed as well, and then for us often it's the time to let go. (Worker, one-to-one interview)*

*And when that bit of his life was dealt with, he could come to terms with it a bit. (Carer, interview)*

*And the school used to say, there's so much going on in [child's name's] head that she cannot concentrate on her school work, now that has definitely, going to Notre Dame, has definitely helped her to decipher all that going on in her head, and let her get on with other things and take in things. (Carer, interview)*

*This was a girl that was bullied in primary. Peer relationships were really difficult for her. Had no friendships. Went on to secondary school and things just got better, and better, and better. She was achieving more academically, had sustained friendships, had a group of friends, and just much more confidence, more belief in herself, more belief that she was a person of worth. (Worker, one-to-one interview)*

*She's liked, people enjoy her company, people look to her to show them things, she's totally accepted in that group. And the impact of that on her has been tremendous in terms of her building [...] a different sense of herself, a more positive view of herself for her, is quite tremendous. (Worker, one-to-one interview)*

*She actively wants to behave, she wants to be a good girl, she wants to be grown-up, although that's not my wishes – there's plenty of time for that, umm, I think I probably understand her better, know her better, I think it's been a learning curve for me this last few years at Notre Dame, at first I thought it was all about [child's name], when in actual fact, you know, we are a couple, a match. (Carer, interview)*

*I did a bit about hide and seek and all that, and a bit about the work at home, spending that special time with the child. You could see it, you can see it now, that their relationship has got better, so their attachment's grown stronger. (Worker, one-to-one interview)*

*...but certainly they will come back and say, they do feel things are calmer in the house, or it's, the young person's done whatever and I've been able to praise them. (Worker, one-to-one interview)*

*And Notre Dame, they did a lot of work around that with her. Going into the unknown and that, and they did a lot of work around that. She's more confident about it now. (Carer, interview)*

*They've attached amazingly to their grandparents and they've been able to be solid for them. And, if they weren't able to do that, the children might not be so... managed to have been so securely stable. (Worker, one-to-one interview)*

*One of the big things that Notre Dame did for us was to get [child's name] to accept that I was the person who had to do all these things, she was the child, and was allowed to be a child [...] and it was a tough one, for me to get in and take that role, her to accept I was the adult and I would protect her. So I found Notre Dame were a big help there. (Carer, interview)*

### **Fundamental and sustainable changes**

Change was sometimes incremental or slow; workers and carers related this to tackling deep-seated issues and producing fundamental and lasting changes. Sometimes the slow speed of change made it difficult to appreciate the scale of change, especially as new issues would sometimes come to the fore. Consequently, it was felt important to step back and review progress from time to time.

*They will work for as long as it takes, they build trust with the child until they are ready to do the*

therapy. (Carer, focus group at kinship carer group meeting)

*The older one, she used to have terrible nightmares, terrible nightmares due to the things that had gone on, and not right away going to Notre Dame, but latterly and whatever else, it HAS. And she's worked through what was going on, and go better, she still won't go into a group, like a dance group unless she knows somebody that's in that, unless somebody comes along with her as company, she still can't do that and she's [teenage] [...] but it's definitely much better, she can go to her bed at 8 o'clock at night and I'm still shouting her at eight o'clock in the morning to get her up, I start at seven. (Carer, interview)*

*We ended up being there near-on two years and I've seen a big difference in her over these last two years [...] I would say the first year was quite rocky, but after that I began to see a change in [name of child] in the way she was, before she kept lashing out, and lashing out, at me and public transport was a nightmare. [...] and she's blossomed beautifully since then, it's been all positive, you know. (Carer, interview)*

*...people come and they start off with 'this' and they forget that that's where they started. And so, they might actually, there's maybe been loads of change, but they get hung up on the newest thing and they forget that, actually, when this child started here they were wetting the bed every night, every single night. And, that changed to only two nights... (Worker, one-to-one interview)*

*This girl's behaviour has been really, really, uncontained. She's been just spilling out, even coming in here she's like wanting to run everywhere, [...] boundaries and limits have to be so, so, tight for her. And, that has got better in the past month, really, really recently. [...] It could be a slow one. And families are different and, so, yeah, that's probably not that it's not gone well, it's just, I suppose you hope for quicker. (Worker, one-to-one interview)*

*And, she's made a lot of progress. And what, I guess, I'm beginning to think is she's probably made as much progress. I mean, there's room for a wee bit more progress, but in terms of her, living in the environment she lives in, she's probably done as much work as is possible now. (Worker, one-to-one interview)*

*Well, there is a grandmother and a granddaughter and they've been coming for, I think it's almost a year. [...] I think now, they're starting small shifts of progress. But that's something the therapist and I talk about a lot - 'Is this the best progress that we're actually going to get?'. (Worker, one-to-one interview)*

### **Ownership, control, and empowerment**

Workers and carers highlighted that another important outcome was the sense of ownership and control that individuals had over their engagement with Notre Dame. Importantly, this reflected Notre Dame's recognition and 'claiming' of kinship families and echoed a sense of ownership that the kinship community appeared to have for Notre Dame. Notre Dame belonged to kinship and kinship belonged to Notre Dame. Participants suggested this empowered kinship families, consolidated and validated their place in the world, and provided them with a sense of belonging. In this context, engagement itself can be viewed as a positive outcome, either because families have previously been resistant to working with services, or they have been unable to coordinate aspects such as child care for other children.

*Kinship carers feel a sense of ownership about this project, they feel it is their place, they have some control over the service, involvement is their choice, it's empowering. (Worker, one-to-one interview)*

*...the report goes to them because they referred themselves [...] they are the central pivot in the whole thing. (Worker, focus group)*

*Whereas lots of the [other] families that come here, it's like they feel 'somebody told me to come, they said we should, I don't really know why I'm here' (Worker, focus group)*

*...and it's interesting the number that want to fundraise or help. (Worker, focus group)*

*Well, if the carer's feeling much better about themselves and feeling more stronger and empowered then they're much more likely to be able to, you know, take a step back when somebody's shouting in their face... (Worker, one-to-one interview)*

*I think it was really good for [child's name] to be able to... she obviously controlled it, she was able to control how much she said to [worker] and she could control stopping it, whereas again with [carers] if your child reveals some deep seated thing, [we'd] say let's talk about this, let's problem-solve it, and so on. So I loved the fact that [child's name] was actually in control. (Carer, interview)*

#### **Up-dating, developing, or consolidating parenting strengths and skills**

Participants explained how carers are helped to understand the child's challenges and their own response to the child. Carers were able to update their parenting skills and better understand the context in which the child is growing up. Sometimes, workers were able to recognise strengths and reassure carers where they were doing a good job. Less often, carers felt they did not gain further practical parenting skills, having already gained this elsewhere.

*'Well, it's the simple things they can tell you to do, they educated us really'. 'They give you ideas of how to respond simply to the child's difficult questions'. 'The communication between the play therapist and the adult was good; they had a way of letting you know if it had been a tough session for the child.'* (Carers, focus group at kinship carer group meeting).

*So, we did relaxation techniques with him, [...] and just seeing this big man you know [...] I thought he'd say it's all rubbish because he's very cynical. But, he totally got into it, and the progress that's being made is his reaction to that girl [...] because she is quite a handful, he's much more containing of her than he used to be before. (Worker, one-to-one interview)*

*And actually, some of the child's growth and change will occur because the carers are changing. (Worker, one-to-one interview)*

*I can see a difference in that type of work because they're very clearly with grandparents who, you know, have got strong foundations, who [...] are able to offer the nurturing, and the boundaries, and the so on, with some support from here. And, you see a much healthier and quicker progress and change with those. (Worker, one-to-one interview)*

*Or, Grans are not really aware of actually how well they're doing. [...] So they could come for an*

assessment, and actually the conclusion of the assessment might well be that they don't need any [more] work. But, they're trying to provide the best that they can for these children that they've been left to look after. (Worker, one-to-one interview)

And it turns out [child's name] has ADHD [...] I always knew there was something else with him, and not just his early life and the trauma, I always knew there was something else. And that, in some ways, him going to Notre Dame and get this counselling for what he had experienced and that, it then sort of took away from the other, you know, it helped to separate it out if you know what I mean. (Carer, interview)

In therapy she was able to play-out daddy/daughter games that she would not of been able to do at home, because we had very strong views about her father. [...] So there was that benefit to it, her being able to explore those emotions and things. (Carer, interview)

...trying to help them make sense of their [child's] world as it is now, it's so far removed from what they knew, what they experienced themselves, and how things were when they were bringing up the parents. (Worker, focus group)

...there was no practical advice. [unlike when we did family therapy] in terms of try this, do this, read this, why is that, there was no challenging really. (Carer, interview)

### **Experiencing nurture**

Family members generally enjoyed the experience of attending Notre Dame. Often participants appeared to find that attending, in itself, was a therapeutic and nurturing experience. Workers and carers indicated that a weekly experience for an hour of being 'taken care of' was itself an important outcome; in addition to enjoyment and direct benefit, this experience potentially provided a model that could be generalised to home and other settings.

It's a bit more nurturing, it think than say if you were going to CAMHS [which is] a bit more clinical, there's a softer side, and I think that is more nurturing. (Worker, focus group)

You know, the coming here and the going home [...] the carer sees exactly how the child is when they come out a session and they see how they are when they come in. And, there's the build-up, and the trust established, and that feeling of they're both being nurtured together. It's not just the child that's getting all the attention. (Worker, interview)

I've got a teenage boy who comes and I'm always surprised that he will openly say "I love coming here. I love coming." And his carer will say "My God, he's been talking about coming here all week." [...] And I'm surprised, I'm thinking, "gosh, if I was that age I wouldn't be saying that in front of people". [...] It would be totally uncool, exactly. (Worker, interview)

### *Linking to other forms of support and realising secondary impact*

Participants explained that an important task for the centre is for the manager to attend kinship groups across the area to speak to kinship carers about what the centre can offer, how to access support, or to provide basic support. It was clear that some strong and helpful links now exist. Workers described how during their ongoing engagement with Notre Dame, families were signposted, referred, empowered, and supported to access other sources of support including specialist and generalist resources. Resources importantly included kinship carer (peer) groups; these can offer information, peer support, and links to an ever-wider range of supports. Specific secondary outcomes included receipt of specialised services including CAHMS, addiction advice, legal advice, etc., and access to specific kinship activities (homework clubs, trips, holidays, etc.). General secondary impact includes feeling further supported, gaining increased knowledge of rights, and securing a network of family friendships.

*It's almost as if Notre Dame has become synonymous with kinship, people link us with kinship, especially the kinship groups, and we probably do most work with kinship across the city because we have got the funding. (Worker, focus group)*

*I think sometimes if we can't help, it is being an advocate for the carer, for example with the school [interrupt/switch] or other services that are outwith our remit like housing is another, or maybe signposting people. (Workers, focus group)*

*Or, we can provide a report that goes along with it, saying what the situation is. (Worker, focus group)*

*Sometimes it's about encouraging them to go along to the kinship groups, because the kinship groups are quite empowering. [...] The groups are quite motivated and they can get lots of support, for example, holidays in caravans and different kinds of things. (Worker, focus group)*

*Yeah, I think a lot of them they're overwhelmed and they can only see their own circumstance and actually when they go along to a kinship care group, it's a fantastic support, because they hear other people in the same circumstance and they might hear something about, "Well did you know that you can apply for such and such?". (Worker, interview)*

*The group helped link members to services that might help, they had speakers most weeks. They have a dedicated homework club with input from students from [teacher training college]. Also dedicated annual holidays at [location]. Participants describe a group that is very friendly and shares information 'in confidence' someone who will listen and understand. 'You can just sound off, then you feel you're not alone'. (Notes and quotes from focus group at kinship carer group meeting).*



### *Filling a gap and providing value*

Finally, references that carers made to the fact that Notre Dame filled a significant gap in service provision signify an important outcome. They, and workers, also asserted that Notre Dame potentially diverted children from statutory services. Linked to this, several participants highlighted a belief that Notre Dame provided value by successfully tackling fundamental issues that not only resulted in better outcomes for the child, but savings to the public purse.

*And I want to get this in, Notre Dame does, and HAS, filled a big gap that's missing out of psychological services for children, see unless your child is [mumble] or threatening to stab people, your no going to get any psychological services, and it's not fair because I've got children from a very troubled background, and a lot of the kinship kids do, and they're not getting helped. They are moving away when they are five or six, but they are not actually getting help until they are teenagers, when it's puberty, and their hormones and that are kicking in and they cannot cope anymore and start to go really AWOL but nine times out of ten it involves the police having to be involved and whatever else. [...] if it was not for Notre Dame, and the few that manage to get to Notre Dame and they do as much as they can, I believe that, you know the statistics, well my two would've become them, it has helped them move away from that type of life. (Carer, interview)*

*I think they must save other services a lot of time, especially CAMHS. (Carer, focus group at kinship carer group meeting).*

## Discussion and conclusion

Throughout this report, we have presented three focal areas, 'context', 'process', and 'impact'. Context allows us to understand the reasons kinship families seek help from the Notre Dame Centre, the circumstances they find themselves in, and wider issues such as the size of the kinship population. Process allows us to understand the detail of how the service operates and how those involved experience the intervention. Impact provides an overview of the results of the service, exploring outcomes for different groups of people.

### Context

Existing evidence points to the large and growing numbers of kinship families in Scotland, and the qualitative work demonstrated the difficulties faced by the clients of Notre Dame. Some of the stories we heard were harrowing accounts of children's past traumas and current difficulties. Carers' also described their own issues, although these were not usually their first motivation in approaching Notre Dame. Family history and

dynamics often added further challenge to coping, and to raising the child. Over all, the data reveal a high level of need and complexity.

Context themes identified were:

- The impact of trauma, adversity, and exposures
- The child's presenting problems
- The developing child
- Carers' general worries, stress, and abilities
- Carer guilt
- Carer health, fatigue, and increasing age
- Kinship links
- Parents' behaviours
- Family-level problems: structural disempowerment, difficult living experiences, and financial concerns
- Difficulties getting support

## Process

Quantitative evidence helped to provide a picture of the population of children and families using the service in terms of age, gender, engagement, and so on. This provides useful background to our qualitative analyses, which identify that the Notre Dame Centre consists of professionals from different backgrounds including social work, child and adult psychotherapy, play therapy, and counselling. The centre delivers services according to an interdisciplinary parallel working delivery model, whereby children receive therapy whilst the carer receives listening support and advice around the issues they are dealing with. This involves identifying and working with family strengths to find solutions that are sustainable over time. The approach is flexible, responding to the particular needs and preferences of each family, this is often time-intensive as the workers take great care to build a genuinely caring therapeutic relationship and to proceed at a pace that suits the child and carer. Process themes identified were:

- Strength-based, respectful, and solution-focussed ethos
- Assessment and reviews
- Inter-disciplinary team, paired-working in parallel
- Theoretical and conceptual underpinnings
- Taking time, building real relationships
- Flexibility and self-referral
- Nurturing, caring, and valuing
- Intensive, reliable, and prioritising families

## Impact

The evidence considered in this study suggests the service produces important positive outcomes for children, carers, and possibly other family members. Our tentative analyses of the standardised measures appear to demonstrate positive impact, and our qualitative analysis strongly supported this finding. Participants often saw outcomes for children as cumulative in nature; in particular, social and behavioural outcomes built on fundamental building blocks that often included tackling the legacy of earlier traumas and addressing the care and parenting given by the carer. The work of the Notre Dame centre is highly valued by kinship carers. Impact themes identified were:

- Positive outcomes for the child
- Fundamental and sustainable changes
- Ownership, control, and empowerment
- Up-dating, developing, or consolidating parenting strengths and skills
- Experiencing nurture
- Linking to other forms of support and realising secondary impact
- Filling a gap and providing value

## Conclusions

The study demonstrates a highly valued and valuable service that is meeting the needs of a group of children and families who have significant difficulties. These families may otherwise find it difficult to get support. There is variation and the intervention is time-intensive for some families, but the outcomes obtained are likely to provide enduring benefits for children, families. Equally, it is not easy to see how else these particular outcomes could be obtained, and clearly, the participants in this study felt there were no short cuts. As such, we feel this resource represents a good investment.

We also suggest there is a moral argument for providing support for these families, as various structural issues have excluded or disempowered them. Notre Dame has invested considerably in creating a strong identity and network among kinship carer groups; those groups feel a sense of ownership of the project, they are invested in it, and would be keen to facilitate the continued success of the project.

## Reflections on this study

This was a relatively small-scale evaluation of an intervention that serves kinship families from across Glasgow and the surrounding areas. The study began after the intervention

had begun and, consequently, we needed to maximise use of existing measures. In the context of meeting the needs of this group, and the limitations of resources available for the study, there was not scope for a larger study or experimental study design such as using matched controls or wait-list approaches. We adopted a pragmatic study design informed by 'realistic' evaluation and incorporated mixed-methods approaches. All studies have attendant strengths and limitations. In this case, the quality of the quantitative data is less than ideal, and inclusion of a wider range of participants (notably more children) would have enhanced the qualitative work further. Strengths include the sheer volume of data collected, participants were very generous with their time, and reflected deeply on the issues covered. In addition, the fact that we collected data over a period of 18 months, used focus groups and interviews, and revisited some participants adds strength as these allowed a developing understanding of the project, and give greater confidence and reflected experiences at more than a single point in time. Furthermore, the researchers had no prior connections with Notre Dame and have a wider remit to generate learning for the child and family sector; we are therefore confident that the evaluation is as objective as it can be. We believe that readers can be confident of the findings.

## Recommendations - Data measures

We made some recommendations in the interim report concerning monitoring of Notre Dame's work, these would also be relevant to other similar interventions, and so we revise and repeat these here. A number of key principles about what we saw as being important for the use of measurement scales in the evaluation of interventions shaped our recommendations. These included:

- Measurement should be proportionate and avoid excess burden for users or workers
- Including a range of perspectives is helpful (e.g. practitioners, carers, children, referrers)
- The tools used should:
  - measure the relevant things
  - be sensitive enough to capture significant changes
  - be administered in the right way at the right time
- Data gathered should be actively used:
  - by practitioners to support individual intervention
  - by managers to improve service delivery and
  - by evaluators to evidence the impact of the service
- Changes to measurement schedules should be minimised to avoid loss of continuity

Notre Dame has used a number of different tools and instruments, often asked for by specific funders. The insights we have gained during this evaluation allow us to understand the likely impacts of the service, whilst also understanding the likely capacity that the service has to administer these measurement tools. In finding a compromise, we would recommend the following slightly revised schedule of data collection.

### **Rolling measures -**

- 1** Child-completed SDQ for children ages 11+: at initiation, repeated each six-nine months and at termination of the intervention.
- 2** Carer-completed SDQ: at initiation, repeated each six-nine months and at termination of the intervention.
- 3** Carer-completed BPSE (Brief Parental Self Efficacy Scale<sup>7</sup>): at or near initiation, repeated each six-nine months and at termination of the intervention.

### **Start and end only –**

- 4** Teacher-completed SDQ: at initiation, and at termination of the intervention.
- 5** Carer-completed WEMWBS: at or near initiation and at termination of the intervention.
- 6** Practitioner-completed CGAS: after initial assessment (4-6 session) and at termination of the intervention.

## **Annex**

We supply this report along with a separate annex document containing a bibliography of articles that have proved useful during this study and other work related to kinship care. Readers who are interested in a particular resource, but are not able to access it should contact CELCIS for assistance.

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<sup>7</sup> Five item scale that assesses a parent's belief that he/she can effectively perform or manage tasks related to parenting. It is freely available from CORC and suited to children aged 18 month – 17 years. The tool is widely used in research and practice. For example, in evaluation of nurturing attachment groups with adoptive parents (Selwyn, Golding et al. 2016) and in the evaluation of parent training and developed by Wolgar (National Academy of Parenting Research, King's College London).

## Closing remarks

Earlier in this report we acknowledged the help given by participants, we repeat our thanks and add that CELCIS, in particular the author of this report, are grateful to Notre Dame for giving us access to their service; we have learned a lot. We hope that the Centre finds this evaluation to be helpful and we would welcome any feedback on the study.

Equally, we feel there is general learning in this study that will be beneficial for others delivering similar services, or services that may operate in similar ways. It fits into a growing evidence-base around the importance of relationships when working with children and families, and in particular with looked after children. Within the assurances given to participants, we will continue to use our learning to improve understanding around the lives of kinship families.



## About CELCIS

Our goal is simple. We want to make a difference. Taking a multi-agency, collaborative approach with everyone whose work touches the lives of looked after children and young people, we work to break down barriers and forge new paths. We change thinking and ways of working. For more information:

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