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Manuscript title: Developing group-based psychoeducation intervention for adoptive parents and foster carers in a specialist child and adolescent mental health service setting

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Declaration of interest: TA developed the Family Minds intervention.

Developing group-based psychoeducation intervention for adoptive parents and foster carers in a specialist child and adolescent mental health service setting

Children and young people in foster and adoptive families are considered more vulnerable to a high level of mental health need when compared to peers who are not care-experienced or adopted. Acceptance of this view amongst clinical providers and policy makers has necessitated the development of specialist provision and dedicated care pathways within child and adolescent mental health services (CAMHSs). In this provision, practitioner-initiated quality improvement projects help in appraising the effectiveness of clinical interventions in local contexts, as well as identifying areas for service learning and practice reflection. This article reports on evaluation of a mentalisation-based psychoeducation group intervention for adoptive parents and foster carers. The evaluation activity took place in a single CAMHS setting, starting during the COVID-19 pandemic, with the intervention being implemented online via videoconferencing. In the article, after introducing the intervention (based on the Family Minds model), an analysis of clinical data collected pre- and post-intervention is reported. Few results of the analysis regarding the two pre- and post-measures reached statistical significance, indicating only changes in the magnitude of stress in the parent/carer-child system. A series of reflections are posed that consider what this finding means in developing fit-for-purpose support for adoptive parents and foster carers in CAMHS contexts.

Key words: Adoption; Fostering; Psychoeducation; Mentalisation; Group intervention; CAMHS; Service evaluation

Introduction

Children and young people in foster care and who are adopted are considered more vulnerable to a high level of mental health need than peers who are not care-experienced or adopted. Though rates differ by survey and location, between one third and half of children and young people in these groups are recognised as having a clinical level of mental health need, with up to an additional 25% displaying a level of need at the threshold of clinical significance (Duncan et al., 2021; Tarren-Sweeney, 2019). These groups are served by various specialist teams and dedicated care pathways that exist in UK NHS child and adolescent mental health services (CAMHSs) (see, e.g., Archard et al., 2022; Miller et al., 2023; Ratnayake et al., 2014). There can, however, be inconsistency in available provision across areas, especially for very young children (Moriarty et al., 2016), and this inconsistency can be compounded by wider systemic issues, including significant wait times from referral to receiving mental health intervention and gaps between this care and independently commissioned therapy (Crenna-Jennings & Hutchinson, 2018, 2020; King et al., 2019). These challenges are especially frustrating for those seeking to access mental health support, with elevated levels of dissatisfaction noted for foster carers and adoptive parents, especially when they sense that their caregiving is questioned (or critiqued) by mental health professionals (Follan & McNamara, 2014; Monck & Rushton, 2009; York & Jones, 2017).

Considering present evidence in this field, there is scope for improvement in specialist CAMHS care delivery to these groups, specifically when considering parents and carers who may be implicitly viewed as secondary to the child or young person receiving individual therapy. There is also a need for developing the evidence-base regarding interventions to extend support to foster carers and adoptive parents as caregivers (Harris-Waller et al., 2018; Pace et al., 2016).

Against this backdrop, practitioner-initiated evaluation and quality improvement endeavours can be particularly helpful for understanding the effectiveness of clinical interventions and highlighting issues in care delivery within local contexts. Quality improvement reporting is increasingly encouraged to share what is learned in local care contexts and for formalising quality improvement-based scholarship (Matulis & Manning, 2023). A range of methodologies are suitable for this purpose, including the gathering of stakeholders' views, notably parents' and professionals', to appraise what is valued in care delivery, as well as using routinely collected data to quantitatively account for the effectiveness of an intervention in terms of its intended outcome (Epstein, 2009).

This article reports on the initial evaluation of a mentalisation-based psychoeducation group intervention (based on the Family Minds model: Adkins, 2015). This evaluative activity took place in a single specialist child and adolescent mental health setting, beginning during the COVID-19 pandemic, with the intervention being implemented online via videoconferencing. In the article, following descriptions of the intervention and setting, an analysis of clinical data collected pre- and post-intervention is reported. The findings of this analysis are then discussed with regard to the nature of fit-for-purpose support for adoptive parents and foster carers, and how this type of intervention might be adapted for use in specialist CAMHS care contexts, as well as limitations of the evaluation.

Group-based psychoeducation intervention for adoptive parents and foster carers

Psychoeducation groups for foster and adoptive parents, as a form of psychological intervention, enable parents to learn key parenting and problem-solving skills, and spend time alongside other parents who share similar experiences. Various programmes and interventions exist based on principles drawn from different theoretical frameworks, including attachment and social learning theory, which have been subject to varying levels of

formal empirical evaluation (Fisher, 2015; Golding, 2019; Harris-Waller et al., 2018; Kerr & Cossar, 2014; Lotty et al., 2021). There is an ongoing need for data regarding the comparative effectiveness of these interventions, with some intervention models subject to more rigorous forms of evaluation than others.

Family Minds

One such intervention model is Family Minds - a brief group-based intervention designed to increase the mentalising skills of adoptive parents and foster carers, while focusing on caregiving relationships and their significance in children's development (Adkins, 2015). In this context, mentalising refers, very simply stated, to a form of imaginative mental activity (or mind-mindedness) which enables one to perceive and interpret one's own and others' behaviour in terms of intentional mental states (e.g., desires, thoughts, beliefs, feelings). This can occur consciously or automatically, but one's ability to mentalise is compromised by intense emotion. Mentalisation is applied in the context of parental caregiving and attachment theory, in part, in terms of a recognition that securely attached individuals are more likely to have primary caregivers with more sophisticated mentalizing abilities and thus, themselves, more robust capacities to represent their own internal experience and that of others (Fonagy & Target, 1997; Fonagy et al., 2002).

The Family Minds intervention is structured to be delivered across three or four group sessions via a variety of modalities, including oral delivery by professional facilitators, video clips, and experiential content, such as group-based reflection and discussion-based exercises. Several topics are addressed during the sessions, encompassing principles of reflective parenting and mentalisation, the impact of adverse childhood experiences and trauma (including attention to wider contexts of childhood adversity in social/socioeconomic adversity), the concept of the internal working model in attachment theory and links between

a secure adult attachment style and responsive parenting, and the role of shame in children's challenging behaviour. Parents/carers who participate are asked to reflect on their experiences of attachment and childhood experiences, and the influence this may have had on their approach to caregiving, as well as how it has influenced the relationship with children they care for. A key feature of the program is experiential group activities that progress from general to more personal and emotionally demanding mentalizing activities. Out-of-session work, which includes structured activities between parent/carer and child, is also introduced and reviewed through the group sessions as a means of promoting the application of new learning.

There is developing evidence of the effectiveness of Family Minds to support the mentalising capacities of parents/carers as caregivers, including via a randomised controlled trial (Adkins et al., 2018, 2022; Bammens et al., 2015). Studies undertaken regarding the intervention have reported decreased levels of parenting stress and increased mentalising skills and reflective functioning for foster carers and adoptive parents, post-intervention (Adkins et al., 2018, 2022; Bammens et al., 2015).

Parenting stress is especially important to consider among foster carers and adoptive parents. Elevated levels of stress have been associated with both groups and are thought to manifest through the caring of children who exhibit behavioural and attachment difficulties following early adversity (Goemans et al., 2018). Such stress can impair caregiving behaviour, inhibiting sensitive parenting (Feldman et al., 2007) and the ability to help children regulate their emotions and behaviour (Masten & Coatsworth, 1998). Moreover, improving a parent/carer's ability to mentalize helps them understand the beliefs and feelings that likely underpin their child's behaviours and contributes to an empathic understanding of the reasons for their own responses. As a result, this improves their ability to help manage overwhelming emotions in their child and themselves that arise during difficult parent-child

interactions and the parent tolerating or successfully managing a child's dysregulated emotions or behaviours (Berthelot et al., 2019; Georg et al., 2018). For example, a foster carer experiencing parenting stress might be unable to successfully mentalize their child, leading them to become negatively triggered by the child's behaviour - assigning negative intentions rather than being able to tease out the myriad of underlying reasons for the child's behaviour. In this way, an intervention such as Family Minds that is designed to improve parental mentalizing, also has the potential to positively impact parenting stress, reducing a risk factor for family well-being (Belsky, 1997; Teti et al., 1991).

Adoptive parents have been found to demonstrate more sensitive parenting behaviours than foster carers, with parental stress considered to be a mediating factor (Bickell, 2012), highlighting a need to attend to the two groups separately when considering parenting interventions (van den Dries et al., 2009).

Setting

In the service evaluation reported here, a group intervention based on Family Minds was implemented in a single specialist CAMHS team. The team supports care-experienced and adopted children and adolescents, as well as children and young people from other groups considered vulnerable to high level of mental health need but poorly served by generic care pathways (e.g., children involved with youth justice services). In the team, the principal motivation for introducing the intervention was based on an identified need to augment care offered at the 'front door' of specialist care delivery.

Prior to the COVID-19 pandemic, the idea of introducing a wait list intervention for parents and carers whose children were under the care of the team had been considered in the team. Staff deemed this support to be a valuable means to supplement support for adoptive and foster families and provide it more promptly, sustaining relationship-based care. This was

deemed particularly appropriate given the challenges involved in working amidst funding constraints and the fragmentation of therapeutic and mental health care to the detriment of joined-up support for families (see, e.g., Featherstone et al., 2018; King et al., 2019; Stevens et al., 2020)

Longer (i.e., 5-15 session) psychoeducation-based groups for parents and carers had been provided by staff periodically. However, these groups were usually made available to parents/carers after several months on a waiting list. Consequently, it was anticipated that a wait-list intervention following initial involvement with the team could also provide a meaningful way of enhancing caregiver knowledge, supplying a common vocabulary for clinicians and caregivers to make use of in future support.¹

Method and materials

Measures

As part of routine delivery of clinical care, outcome measures were deployed pre- and post-intervention to determine progress among the parents/carers who accessed the intervention, and to subsequently appraise the intervention's effectiveness. The pre-measures were collected within 14 days of the first session. Post-measures were administered no later than three months following the third and final session. These were completed independently by parents/carers if accessed via post, or with support/clinical staff if completed over the telephone. Parents/carers were made aware that data collected via these outcome measures would be used to inform clinical care and for the purposes of audit/service evaluation.

The two measures administered as part of routine clinical care utilised in evaluating the intervention were as follows:

The Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997). The SDQ is a 25-item behavioural screening questionnaire for children aged four to 17. It can be

administered with children, parents, and teachers. In this instance, the parent/carer version was used given the focus of the intervention. The SDQ consists of five subscales, each underpinned by five items. The respective subscales assess emotional symptoms (e.g., “many worries, often seems worried”), conduct problems (e.g., “often has temper tantrums or hot tempers”), hyperactivity/inattention (e.g., “restless, overactive, cannot stay still for long”), problems in peer relationships (e.g., “rather solitary, tends to play alone”), and prosocial behaviour (e.g., “considerate of other people’s feelings). Parents/carers are required to indicate for each item whether the statement is “not true”, “somewhat true” or “certainly true”. The SDQ is widely used in clinical service evaluation and exhibits good levels of reliability and validity (Vostanis, 2006).

The Parenting Stress Index- Short Form (PSI-SF; Abidin, 2012). The fourth edition of the PSI-SF was used to evaluate the magnitude of stress in the parent-child system. The 36-item short form is comprised of three subscales, consisting of 12 items each: parental distress (e.g., “I feel trapped by my responsibilities as a parent”), parent-child dysfunctional interaction (e.g., “When I do things for my child, I get the feeling that my efforts are not appreciated”), and difficult child (e.g., “My child makes more demands on me than most children”). Stress is indicated by respondents on a five-point Likert scale ranging from a score of “strongly disagree” (1) to “strongly agree” (5). The PSI-SF has been used in prior evaluation of the Family Minds intervention (Adkins et al., 2018, 2022; Bammens et al., 2015), as well as evaluations of other comparable psychoeducation interventions and research examining parenting stress amongst adoptive parents (see, e.g., Harris-Waller et al., 2016; Lotty et al., 2021; Selwyn et al., 2016), with adequate levels of reliability noted (Chorão et al., 2022).

While it would be beneficial to utilise additional measures, notably regarding child-reported outcomes, resource and time constraints circumscribed what was possible. The SDQ

was already being utilised in service delivery and the PSI-SF opted for due to being used in comparable evaluative work.

Procedure

For this project, adaptations were made to Family Minds, as a manualised intervention. The intervention was facilitated via three (three-hour) sessions completed on a fortnightly basis over a six-week period in accord with the prescribed structure of three or four sessions.

However, due to a need for physical distancing during the COVID-19 pandemic, the sessions were delivered online via videoconferencing to ensure accessibility. Social work, psychology and nursing professionals in the team who led the group sessions were experienced in delivering group-based support within a CAMHS setting. At the time of the evaluation, these staff had, though, only completed an initial, introductory training in the intervention. Due to being delivered online as a wait list intervention, with variable take-up by carers/parents signposted, group sizes varied, with between three and 11 carers/parents attending a session. Such issues with take-up also meant variability in the extent to which the prescribed session material was used, with some elements tending to be only partially covered. In accordance with what is known about how Family Minds and psychoeducation support may help foster carers and adoptive parents (Adkins et al., 2018, 2022; Bammens et al., 2015; Harris-Waller et al., 2018), it was anticipated that the intervention's success would be in terms of outcomes for carers/parents experiencing caregiving differently and, potentially, changes for children in emotional symptoms and behaviour.

Ethical considerations

To ensure the evaluation was conducted in an ethical way, a proposal and protocol for the work were submitted for review by the quality improvement department in the NHS trust in

which the team is based, with the project being categorised as a service evaluation developed from efforts at local iterative care improvement. Consequently, and aligned with quality improvement ethical adherence, when clinical data was abstracted for the purposes of statistical analysis, identifying information was removed. The SQUIRE 2.0 standards for reporting healthcare quality improvement initiatives were also utilised in writing this report (Ogrinc et al., 2016).

Results

For the first six groups, twenty-seven adoptive parents/foster carers who accessed the intervention completed at least pre-intervention measures, seven of whom were fathers (25.9%) and 20 mothers (74.1%). Twelve were foster carers (44.4%), 14 adoptive parents (51.9%), and one parent identified as a relative of the children's birth parents who had taken on a primary caregiver role ($n = 1$, 3.7%). Most parents/carers ($n = 22$, 81.5%) attended three sessions of the intervention, with the remainder attending two ($n = 5$, 18.5%). Attendance at the six groups ranged from three ($n = 1$, 3.7%) to 11 ($n = 11$, 40.7%) attendees.

A series of Wilcoxon Signed Rank Tests were conducted to determine any statistically significant difference in participant scores across the PSI and SDQ between time one (i.e., pre-intervention) and time two (i.e., post-intervention) for the overall sample. Median scores for each measure and their respective subscales are presented in Table 1.

<Table 1 to be inserted approx. here>

There was a statistically significant increase for PSI parent-child dysfunctional interaction ($z = 2.14$, $n = 9$, $p < .05$) following accessing the intervention, and a statistically significant reduction was observed in the SDQ prosocial subscale ($z = -2.07$, $n = 13$, $p < .05$).

Applying Cohen's (1988) criteria, a large effect size ($r = .57$ to $.71$) was found for the significant results. Regarding the remaining variables, there was no significant difference in scores from time one to time two (in all cases, $z \leq -1.51$, $p > .05$).

Further Wilcoxon Signed Rank Tests were performed to determine change in SDQ and PSI scores across the two time points for the foster carers and adoptive parents, separately (the carer who identified as an extended family member in a caregiving role was not included in the analyses due to being a single case). Median scores for both samples are presented in Table 2. Few results reached statistical significance. However, it was noted that, for foster carers, PSI parental distress ($z = 2.03$, $n = 5$, $p < .05$) and PSI dysfunctional interaction ($z = 2.02$, $n = 5$, $p < .05$) increased between time one (i.e., pre-intervention) and time two (post-intervention). A large effect size was noted for significant findings ($r = .91$ to $.92$). All remaining variables did not reach statistical significance for either of the groups (in all cases, $z \leq 1.48$, $p > .05$).

<Table 2 to be inserted approx. here>

Splitting the data into adoptive parents and foster carers showed consistently higher scores for the adoptive parents across measures at time one and time two. Moreover, across both groups, there was considerable range in the data at time one and time two, particularly with scores on the PSI. For example, when considering the overall PSI pre-intervention, the lowest score was 84 and highest, 164; a difference of 80 (Mean = 116.41, SD = 20.37). A range of 58 was noted for overall PSI post-intervention, with the lowest score being 94, and highest, 152 (Mean = 121.00, SD = 15.29).

Discussion

The service evaluation activity reported here was undertaken in a single setting and is therefore specific to that CAMHS team, though representing useful learning for the development of “front door” care delivery to adoptive parents and foster carers. The evaluation assessed changes in the level of emotional and behavioural problems in children and young people after their parents/carers received the intervention. It also assessed if there are any changes in magnitude of stress in parent-child system following the intervention. In these respects, the analysis should be of interest to professionals in specialist care settings elsewhere and the work is comparable to other published evaluations regarding group-based psychoeducation interventions with adoptive parents and foster carers (Brown, 2014; Gurney-Smith et al., 2010; Holmes & Silver, 2010).

Few results regarding the two pre- and post-measures reached statistical significance, indicating only changes in the magnitude of stress in the parent-child system, specifically in parent-child dysfunctional interactions and a decrease in child prosocial behaviour. While not statistically significant, parental distress also appeared to increase, and adoptive parents consistently scored higher on both measures as compared to foster carers. Considering the implications of these findings, certain limitations and caveats need to be acknowledged, particularly given the Family Minds intervention has been previously found to beneficially impact parental reflective functioning and decrease parental stress, when compared to other interventions (Adkins et al., 2018, 2022; Bammens et al., 2015; Lotty et al., 2021).

A high level of parenting stress was captured pre- and post-intervention. PSI scores were noticeably higher than those identified by other researchers with alternative interventions for parents/carers (such as Gusler et al. (2023) who noted a mean PSI score of 64.52 among foster carers and adoptive parents (n = 84) prior to intervention, and 47.34 post intervention). This would suggest that those parents/carers who accessed the intervention

were experiencing significant levels of stress, which may be attributed, at least in part, to the intervention's introduction and data collection during the COVID-19 pandemic. While children in foster and adoptive families are known to display higher levels of emotional and behavioural difficulties, which have an impact on parents/carers (see, e.g., Adams et al., 2018; DeJong et al., 2016; Fisher, 2015; Harris-Waller et al., 2018; Schofield et al., 2013), during the pandemic, parents and carers were contending with a range of challenges, being under a greater level of strain and spending more time with children following the closures of schools and other community resources (Christie et al., 2022; Skripkauskaite et al., 2023).

For the evaluation, returns of the PSI and SDQ questionnaires were also limited, which may also be an artefact of elevated stress amongst the parents/carers involved. Completed surveys were often only obtained following additional efforts from support staff. Consequently, the analysis cannot be considered representative of all parents/carers accessing the intervention, and the high levels of stress noted may result in a misleading impression regarding effectiveness, particularly, with this analysis, considering the range in PSI scores.

Linked to this, the two measures were only used at two points in time and the longer-term effects of the intervention were not appraised. Conceivably, greater change may be anticipated three to six months following the intervention, or longer if considering the impact of the pandemic, after which time a carer/parent's approach to parenting a child will have had a greater influence on the child's behaviour – potentially also lessening the level of parenting stress experienced.

As touched on above, the results reported here do also need to be interpreted as arising from a local service evaluation of a programme of support to adoptive parents and foster carers, which was informed by the Family Minds intervention model rather than a full implementation of it. This is to say the service evaluation does not constitute a formal assessment of the effectiveness of the Family Minds model given delivery did not involve full

fidelity to the intervention manual. Rather, the analysis reported represents formal learning from introducing wait-list support and evaluating it, which did not involve deviating from care-as-usual in providing timely support to parents/carers, and thus did not require additional investment from the team and service (aside from initial training in the intervention model). In this way, the implications to take forward primarily relate to further evaluation and adaption of the intervention in CAMHS settings, whilst also highlighting the need for robust research across several sites.

Methodologically, there are several avenues to consider for extending and augmenting the work, notably by incorporating the analysis of measures of parental reflective functioning, as well as the assessment of child mentalizing and child-reported outcomes (Midgley et al., 2021). Other available clinical data might also be utilised. For example, material from case records regarding significant extra-therapeutic events in the lives of the families would potentially help in identifying mediating variables influencing outcomes, as well as for discerning aspects of the intervention that were beneficial (Fontaine et al. 2020). Through such work, additional hypotheses might also be proposed based on what was learned here regarding levels of parental stress as well as from conclusions drawn in other evaluations which report apparent increases in parenting stress and changes in children's behaviour (e.g., Selwyn et al. 2016). One hypothesis is that this type of intervention may prompt parents/carers to spend more time with children which may lead to dysfunctional interaction patterns increasing at around the time of initial involvement with CAMHS. Via increased time spent with a child/children, a parent/carer may become more aware of the extent of difficulties and challenging behaviour (hence also, potentially) the recorded decrease in perceived prosocial behaviour in the analysis of the SDQ scores with this analysis). Another hypothesis is that while parents/carers may prefer accessing this type of intervention online (Archard et al., 2022), accessing the sessions from home may mean that they are not

sufficiently removed from challenging circumstances there, which may impact their motivation and ability to reflect. Managing sessions with a larger group of parents and carers in an online space is also more demanding for group facilitators, for example in encouraging engagement from all and dealing with any technical issues.

It would also be helpful to evaluate the intervention as delivered in person to discern any differences and consider how the intervention may be combined with other forms of support within the team or longer-term group-based intervention. Interestingly, the experience of the staff who facilitated the groups for this work was that many parents/carers who accessed were viewed as benefitting from a lessening sense of isolation after being alongside others in similar situations, and this was linked to enthusiasm from parents/carers for access to a longer-term support group. At the same time, many parents/carers were initially amenable to accessing the intervention due to only needing to commit to attending three sessions.² Gathering the views of professionals and parents, and other stakeholders, should be prioritised in any further evaluative work. In gathering these views, other advantages the intervention may confer can be considered, as well as consideration of timing and how longer-term therapeutic support may be delivered via partnerships between local authority children's social care services and CAMHS provision.³

Conclusion

In reporting the evaluation of the introduction of a mentalisation-based psychoeducation group intervention for adoptive parents and foster carers in a specialist CAMHS setting, this article highlights challenges involved in developing fit-for-purpose support for these groups in this context. It also demonstrates some of the value of quality improvement and service evaluation activity in considering the real-world effectiveness of targeted interventions and

supporting service learning regarding the support of parents/carers in CAMHS whilst avoiding premature judgements about intervention effectiveness.

This type of group psychoeducation intervention may serve as fit-for-purpose support for adoptive parents and foster carers as an optional waiting list intervention, i.e., one that they choose to access or not depending on self-appraisal of their needs at the point of accessing care. However, local adaptations may be necessary for it to be effectively implemented to best meet the needs of these groups.

Funding

No additional funding was provided for this service evaluation project.

Notes

1. Also, due to being connected to a practitioner post in the team (occupied by a senior social worker) dedicated to adoption and work with parents/carers, the intervention's introduction additionally afforded an opportunity to further develop evidence-informed care delivery in the clinical area via a network of colleagues based in clinical practice, quality improvement and research.
2. As such, the introduction of the intervention may be best supported by the use of smaller groups when working online to allow more time for individual parents/carers to share their experiences.
3. An important issue to address given the long wait times there can be for CAMHS care and individualised support/assessments once under the care of a service, and extent to which engagement with services can be an additional source of stress for families (see, e.g., Featherstone et al., 2018).

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Table 1. Median scores for all measures and respective subscales at time one and time two.

Variable	Time one: pre- intervention (n)	Time two: post- intervention (n)
Overall PSI	111.00 (27)	120.00 (13)
PSI parental distress	35.00 (27)	31.00 (9)
PSI parent-child dysfunctional interaction	36.00 (27)	43.00 (9)*
PSI difficult child	44.00 (27)	49.00 (9)
Overall SDQ	24.00 (27)	25.00 (13)
SDQ emotional problems	8.00 (27)	7.00 (13)
SDQ conduct problems	6.00 (27)	7.00 (13)
SDQ hyperactivity	8.00 (27)	8.00 (13)
SDQ peer problems	4.00 (27)	4.00 (13)
SDQ prosocial	6.00 (27)	5.00 (13)*
SDQ internalising	11.00 (27)	12.00 (13)
SDQ externalising	13.00 (27)	13.00 (13)

Note: *denotes statistically significant change from time one to time two at $p < .05$ level.

Table 2. Median scores for all measures and respective subscales at time one and time two by parent group.

Variable	<u>Foster carer</u>		<u>Adoptive parent</u>	
	Time one: pre- intervention (n)	Time two: post- intervention (n)	Time one: pre- intervention (n)	Time two: post- intervention (n)
Overall PSI	108.50 (12)	116.50 (6)	117.50 (14)	123.00 (6)
PSI parental distress	26.50 (12)	31.00 (5)*	39.50 (14)	37.00 (4)
PSI parent-child dysfunctional interaction	36.00 (12)	43.00 (5)*	38.50 (14)	40.50 (4)
PSI difficult child	43.50 (12)	50.00 (5)	44.00 (14)	44.50 (4)
Overall SDQ	23.00 (12)	23.50 (6)	24.00 (14)	25.50 (6)
SDQ emotional problems	4.00 (12)	5.50 (6)	8.00 (14)	7.00 (6)
SDQ conduct problems	6.50 (12)	7.00 (6)	4.50 (14)	5.50 (6)
SDQ hyperactivity	6.00 (12)	7.50 (6)	9.00 (14)	9.00 (6)
SDQ peer problems	4.00 (12)	3.00 (6)	3.50 (14)	4.50 (6)
SDQ prosocial	4.50 (12)	4.00 (6)	6.50 (14)	6.00 (6)
SDQ internalising	8.00 (12)	8.50 (6)	11.00 (14)	12.00 (6)

SDQ externalising	13.00 (12)	14.00 (6)	13.50 (14)	13.50 (6)
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Note: *denotes statistically significant change from time one to time two at $p < .05$ level.
