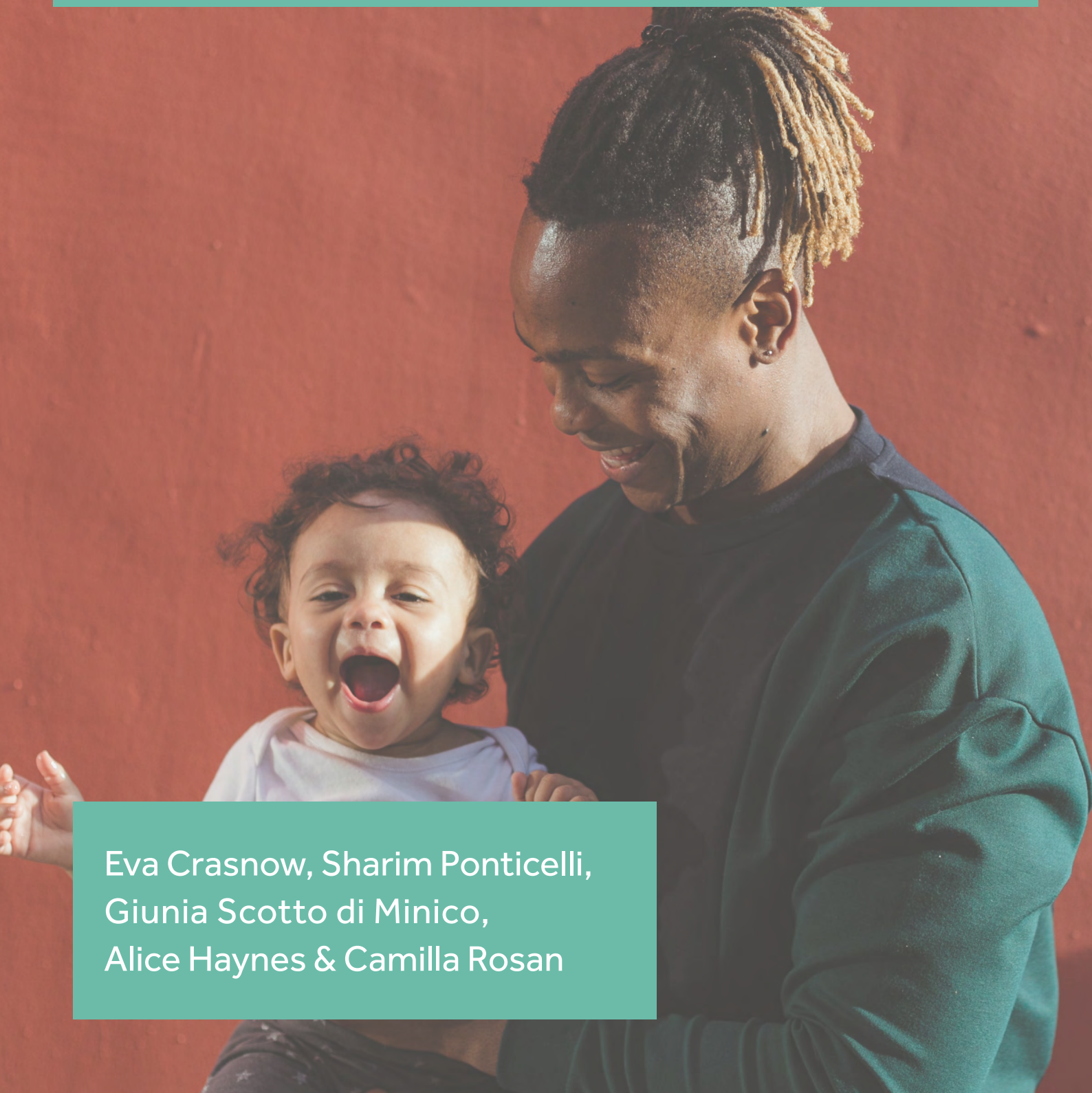
Anna Freud
National Centre for
Children and Families

The Parent-Toddler Group Adoption Project

A feasibility study of a therapeutic play group



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About the Anna Freud National Centre for Children and Families
The Anna Freud National Centre for Children and Families has developed and delivered pioneering mental health care for over 60 years. Our aim is to transform current mental health provision in the UK by improving the quality, accessibility and effectiveness of treatment. We believe that every child and their family should be at the heart of the care they receive, working in partnership with professionals.

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Executive summary

Background

The early years of a child's life lay the foundations for their later development, wellbeing and mental health. Adopted children can have some of the most disturbed and traumatising starts in life. Research tells us that infants and toddlers who have been neglected or emotionally abused exhibit a range of serious cognitive, emotional and behavioural difficulties. Research also indicates that these difficulties can remain without early intervention; however, very few therapeutic services exist to support adoptive families with toddlers or very young children. To fill this gap, the Parent-Toddler Group Adoption Project proposed to adapt and evaluate a therapeutic play group developed at the Anna Freud National Centre for Children and Families (called the Parent-Toddler Group; PTG) to explore its feasibility and any preliminary trends in clinical impact.

Aims

The study's aims were to explore the feasibility of delivering the adapted PTG for adoptive families. The related research questions were:

1. **Acceptability.** What were adoptive parents' experiences of the intervention? Was it helpful? What clinical or practical concerns arose from delivering the intervention?
2. **Preliminary outcomes.** Within the context of a small-scale study, what is the evidence that the adapted PTG is effective in improving clinical outcomes for adoptive families (child development, child externalising and internalising symptoms, parental mental health and parental stress)?
3. **Adaptation.** What modifications to the PTG model are required for delivery with an adoptive population?

Methods

Families were recruited by adoption social workers and their places were funded via the Adoption Support Fund. Their experience of the intervention was assessed using questionnaires and a focus group post-intervention. Preliminary clinical outcome measures were also recorded by collecting outcome measures pre-and post-intervention.

The intervention

The Parent-Toddler Group (PTG) for adoptive parents comprises weekly 1.5-hour sessions over six months, co-facilitated by one qualified therapist and one assistant therapist. The model is informed by psychoanalytic, child development, attachment and trauma-informed theory. The aims of the intervention are to support typical parent-toddler relationship development, as well as those arising within the context of newly formed adoptive families where the toddler is likely to have experienced early maltreatment and trauma.

Seven families (11 parents and 9 children) started the intervention. Six families completed the intervention and five completed all the routine outcome measures across the three time points. Three parents (of four children) attended the focus group.

Feedback data documented high rates of acceptability and feasibility. All parents completing the intervention reported high levels of satisfaction with the intervention, as well as that it positively impacted their understanding of their child's thoughts and feelings. Additional preliminary outcome data indicated positive changes in child development and a positive trend was found for parental mental health and parenting stress across the intervention.

Discussion and next steps

The overall results of this study are very encouraging, suggesting that the PTG for adoptive families with children aged 1–3 is helpful and acceptable, and is associated with clinical trends of improvement in a number of key domains of child development and family wellbeing. The qualitative focus group data combined with clinical considerations identified modifications required to the therapy model in the context of adoptive families, including increased structure in the group and closer co-working with other professionals. However, the small number of participants means that findings should be considered with caution, and the adapted intervention should be evaluated with larger samples to explore its efficacy.

Background

The importance of the early years

Recent years have seen a surge of new research and a growing consensus around the importance of the early years in laying the foundations for long-term child development through to adulthood (Leadsom et al., 2013). Infanthood is a sensitive period, during which an infant's earliest experiences shape brain development, providing the essential groundwork for future learning, behaviour and health (Anda et al., 2006; Bellis et al., 2015; Center on the Developing Child, 2007). This knowledge provides a compelling rationale for focusing on early intervention to help children get the best possible start in life, mitigate health inequalities and promote positive health outcomes throughout the life span (Shonkoff et al., 2012; Hughes et al., 2017).

Vulnerability in the early years

All babies and young children need sensitive, loving and attuned care that allows them to feel safe, nurtured and able to thrive (Cuthbert et al., 2011). Whilst most parents are able to provide the love and protection that their children need, some are not, and babies and young children suffer harm as a result. This can lead to profound negative effects on child development (Palacios et al., 2019).

Babies and young children are disproportionately vulnerable to maltreatment. Children in their first five years of life are most at risk of traumatic death and injury because of interpersonal violence and accidents (Wanless & Fonagy, 2016). Data in England show that very young children are seven times more likely to be killed than older children, and that 20% of children in care and over 40% of children with a child protection plan are under 5 years old (Department for Education, 2015). This data is shocking, not only because of the disproportionate exposure of under-5s to maltreatment, but also because infants' complete dependence on carers for their emotional and physical wellbeing means that the impact is especially damaging when they are subjected to emotional abuse, neglect or physical harm.

The negative impact of abuse and neglect on key aspects of children's growth and development has been documented extensively. Exposure to maltreatment increases the lifetime risk for many psychopathological conditions, such as depression, anxiety disorders, post-traumatic stress disorder, substance abuse, suicide, internalising and externalising symptoms, and physical health problems, such as increased risk of cardiovascular disease (Cicchetti & Doyle, 2016; Hughes et al., 2017).

Children who experience adverse caregiving environments have an increased likelihood of reduced linear growth, weight gain and head circumference (Johnson & Gunnar, 2011). They are at increased risk of neurocognitive deficiencies, impacting negatively on executive functioning, intelligence, memory, language, visual-spatial skills and academic achievement (Kavanaugh et al., 2017; Van IJzendoorn et al., 2008). Maltreated children are at significant increased risk of developing attachment problems, such as insecure disorganised attachments (Howe, 2005).

Adoption in England

Children are adopted when they are not able to live with their birth parents. Most children who require adoptive families have been subjected to abuse or neglect. Many children who are adopted will have previously been in the care of the local authority (termed 'looked after'). During the year ending 31 March 2019, the number of children adopted from care was 3,570 (Department for Education, 2019). Current UK policy prioritises achieving permanence within a lifelong family setting, with particular focus on adoption (Department for Education, 2016).

Profile of adoptive children and parents

In the year ending 31 March 2019, out of the 3,570 adopted children, 52% were male and 48% were female. In terms of age, 74% of children were aged between 1–4 years. The majority of children adopted were of White ethnic origin (83%), with only 11% being of Mixed ethnic origins and 2% or below for all other ethnic backgrounds. In terms of the reason for adoption, the majority of children had experienced abuse and neglect in their homes (74%). Data from previous years show similar trends since at least 2015, with the majority of adopted children being White males aged from 1–4, due to abuse and neglect (Department for Education, 2019).

The majority of children adopted belong to the national population of looked-after children (LAC). That said, only 6% of the total LAC population in England and Wales are in fact adopted each year. These adopted children come from a variety of different ethnic and religious backgrounds.

The demographics collected on adoptive parents are limited. Department for Education data collected between 2018 and 2019 indicate that 74% (2,650) of children were adopted by heterosexual couples and 14% (490) of children were adopted by same sex couples. Of those same sex couples, 71% (350) were male and 29% (140) were female. A further 12% (430) of children were adopted by single adopters, 95% of whom were female (Department for Education, 2019).

Waiting times

In the year 2018–19, the average waiting time between a child entering care and subsequently moving in with their adoptive family was 433 days. In the same year, the average time between a local authority receiving court authority to place a child into adoption and the local authority matching them to an adoptive family was 173 days (Department for Education, 2019).

The different stages in the adoption process carry with them delays and waiting times for both children and adopters (Department for Education, 2018). These include:

- time between the entry of the child into care and the decision to place the child for adoption;
- time between the decision to place the child for adoption and matching of that child with adopters;
- time for adoption approvals;
- time for matching the approved adopter with a child;
- time between the date the child is placed for adoption and the date the child is adopted.

Improvements have been made to the timeliness of adoption over recent years. Nonetheless, there continues to be lengthy waiting times which are likely to exacerbate the vulnerability and distress of children, and cause anxiety to adoptive parents.

Adoption breakdowns

Adoption breakdown refers to the end of adoptive family life together for parents and children under 18, irrespective of whether the legal proceedings have been finalised. No national level data is collected to measure the rate of adoption disruption. UK research from 2000–2011 estimated an incidence of 2–10% pre-order disruptions and 4–5% post-order disruptions (Selwyn et al., 2014). Factors associated with adoption breakdown include child characteristics (including an older age at adoption and therefore greater exposure to adversity, and the severity of a child's behavioural and emotional problems), parent-related factors (including the stability of the couple relationship, and expectations of the adoption experience), and availability of support for the family (including the effectiveness of the assessment process and support with preparation) (Palacios et al., 2019). Where it occurs, adoption breakdown is likely to cause significant distress to both children and parents (Faulkner et al., 2017).

Common psychosocial difficulties for adoptive families in the early years

Adoption has the potential to mitigate the negative impact of early adversity in childhood via the nurturing caregiving environment offered by adoptive parents (Van de Voort et al., 2014). Compared to other possible care options, permanent placement in an adoptive family offers the most personally, socially and legally stable caregiving option for many children (Ballard et al., 2015). Evidence shows that some previously maltreated children are able to make significant developmental gains in growth, attachment and cognitive capacities once adopted (Lloyd & Barth, 2011; Sonuga-Barke et al., 2017; Van IJzendoorn & Juffer, 2006).

For some children, however, the effects of maltreatment can be lifelong (Hughes et al., 2017; Shonkoff et al., 2012) and research shows that adoption is not able to attenuate the impact of all previous adverse experiences. Many adopted children demonstrate social, emotional and behavioural problems (Rushton & Dance, 2002; Selwyn et al., 2014) as a result of their experience of abuse or neglect, the loss associated with the removal from the birth family, and often multiple moves between foster homes (Schofield & Beek, 2006).

Children may be physically aggressive or self-harm, exhibit manipulative and controlling behaviour, and may suffer from night terrors and soiling (Selwyn et al., 2014). Due to the trauma of multiple moves and separations that adopted children experience to a greater or lesser extent, their development is also likely to be delayed (van der Kolk, 2005). Compared with children growing up in traditional family settings, adoptees report higher rates of psychopathology and lower self-esteem (Burns et al., 2004; Fisher, 2015; Gagnon-Oosterwaal et al., 2012; Sánchez-Sandoval, 2015). As well as impacting developmental outcomes, this may also increase the vulnerability of adopted children to adoption disruption.

Although local authorities endeavour to prepare prospective adopters for their new role, and draw attention to potential challenges, preparing parents for the day-to-day realities is extremely difficult. According to Rushton and Dance (2002), adoptive parents reported finding children's muted return of affection or rejection, persistent non-compliance, violent behaviour and aggression particularly difficult to cope with. Whilst individual differences in experiences and levels of resilience mean that not all children placed for adoption will

exhibit social, emotional and behavioural difficulties, adoptive parents may struggle to cope where this is the case.

Parents too experience a range of emotional states and behaviours. Becoming a parent is an important transition that can change a couple's psychological wellbeing, relationship quality, and social network relationships (Ceballo et al., 2004; Cowan & Cowan, 2000; Doss et al., 2009; Simpson et al., 2003). Couples' roles and identities are redefined, and personal, marital, family and social changes occur (Cigoli & Scabini, 2006). Adoptive parents face additional challenges as well; in most cases, they have faced infertility (Cohen et al., 1993; Daniluk & Hurtig-Mitchell, 2003), and have become parents later in life (Ceballo et al., 2004).

Despite this, the presence of particular stressors linked to adoption does not necessarily mean that couple relationships are weakened by the circumstances, and there is no research showing that they are at greater risk of divorce (Schwartz et al., 2015). In a study comparing couples with a biological child to those who had an adopted child, Ceballo and colleagues (2004) found that marital quality decreased over time for the biological parents but not for adoptive couples. Another study (Timm et al., 2011) found that women reported feeling that working through challenges in their marriage, particularly those related to core issues like loss and grief, or family integration, had strengthened their relationships with their partners. Nevertheless, these mothers expressed the desire for training and support.

Existing support for adoptive families

Despite the difficulties experienced by both children and adoptive parents throughout the adoption process, external professional support is often delayed in order to allow for the family to get to know each other and embed their relationships. Though these families need time and space to establish their loving foundations, the difficulties of the adoption process, along with the real-life challenge of parenting a child who has experienced trauma, mean that these families may also require timely support, advice and guidance.

The evidence base for improving psychosocial outcomes in adoptive families in the early years

The evidence base in this area is very limited. Therefore, it is necessary to look at approaches that are garnering positive outcomes with high-risk, non-adoptive toddler populations. One intervention that is showing promise in this area is the Parent-Toddler Group (PTG), developed by the Anna Freud National Centre for Children and Families (AFNCCF).

The Parent-Toddler Group

The Parent-Toddler Group (PTG), first developed by the AFNCCF in the 1950s, is a therapeutic play group informed by psychoanalytic, child development, attachment and trauma-informed theory. It aims to support the developmental tasks of toddlerhood (such as developing independence, a secure sense of self, and managing strong feelings of aggression and shame) through strengthening the parent-child relationship (Zaphiriou Woods & Pretorius, 2016). It is aimed at children aged 1–3 and is delivered in weekly, 1.5-hour sessions over 12 months, co-facilitated by one qualified therapist and an assistant (Zaphiriou Woods & Pretorius, 2016).

The approach involves facilitating children's creative play, containing the parents' experience, verbalising the toddler's feelings and wishes, managing aggression and setting limits, exploring parent-toddler closeness and independence, and feeding back observations.

A quantitative study by Camino Rivera et al. (2011) found that reflective functioning improved in a group of 12 mothers as a result of attending the PTG. Reflective functioning refers to the capacity to envision mental states (thoughts, feelings, needs, desires) in oneself and others – in other words, to 'keep the toddler in mind' (Slade, 2005, p.273). Parental reflective functioning is a useful method for measuring PTG effectiveness as it is considered a key factor for healthy child development (Slade, 2005; Fonagy, et al., 2006).

Barros et al.'s (2008) study of the PTG explored the perspectives of parents attending the groups. Interviews with six mothers and one father indicated that parents perceived the group as a nurturing and stable environment that functioned as a 'secure base' (Bowlby, 1988). The stability and safe atmosphere were felt to facilitate parents' reflectivity and fostered trusting relationships and attunement between parents and toddlers. Parents felt they could express ordinary difficulties of parenting, thereby feeling less anxious, ashamed and alone. They also reported better understanding their child's mind by engaging with their child's perspective.

Adapting the PTG for adoptive families

The Parent-Toddler Group Adoption Project proposes to adapt and evaluate the PTG to explore its feasibility and any preliminary trends in clinical impact for adoptive families with children between 10 months to 3 years, when delivered weekly over a six-month period.

The delay in external professional support for adoptive families has created a gap in mental health provision. The aim of this study is to ascertain whether the PTG model has the capacity to fill this gap, by providing direct and ongoing therapeutic contact whilst continually affirming and developing the parent-child bond.

It is hypothesised that the PTG's focus on both parents and children together will support the strengthening of the parent-child bond in adoptive families. This is key to providing therapeutic support for adoptive families, since in the early years it is the parent-child relationship which is the vehicle to supporting further toddler development and which will continue to exert an influence on the child's development, long after the group has ended.

Accessing peer support is a key therapeutic tool in offering a non-shaming approach. The PTG enables authority to be deferred to the lived experience of adoptive parents, who are likely to be undergoing similar challenges to one another. Facilitated by the observational and reflective stance of the group therapist, parents may be able to offer each other valuable insights into family life, which can be heard and received differently to ideas shared by a professional.

Another important aspect of the PTG model is its non-didactic approach. Building a robust therapeutic alliance with families is a crucial foundation on which the therapist can begin to share their formulations and observations. Rather than offering parents an 'expert' view on their child, the non-didactic approach of the model helps develop and boost parental confidence in their own skills and knowledge. This focus on facilitating a sense of parental authority in adoptive parents is an essential aspect of the PTG, making it a particularly beneficial intervention for parents at the early stage in their adoption journey.

Methods

Aims

This study aimed to explore the feasibility of delivering the adapted PTG intervention for adoptive families, which was assessed using experience questionnaires and a focus group post-intervention. Preliminary clinical outcome measures were also recorded. The related research questions were:

1. **Acceptability.** What were adoptive parents' experiences of the intervention? Was it helpful? What clinical or practical concerns arose from delivering the intervention?
2. **Preliminary outcomes.** Within the context of a small-scale study, what is the evidence that the adapted PTG is effective in improving clinical outcomes for adoptive families (child development, child externalising and internalising symptoms, parental mental health and parental stress)?
3. **Adaptation.** What modifications to the PTG model are required for delivery with an adoptive population?

Recruitment

Families were primarily recruited via their local authority adoption social worker in an urban inner-city area. Recruitment was supported via poster and leaflet advertisements. The adverts invited parents to contact the project team if they had adopted a child between 10 months and 3 years, 'would like to meet and play with other adoptive families... who are facing similar issues', and 'want guidance around supporting their child's emotional wellbeing and sense of security'. Families were offered an assessment appointment with the project's lead therapist if they verbally expressed interest to their social workers or called/emailed the project team directly. At the point of recruitment, all families were made aware that their attendance at the group would be funded via a portion of their annual Adoption Support Fund (ASF) allowance.

Participants

Seven families (nine children) were recruited to the project. Five were families adopting single children and two families were adopting sibling groups of two. Family ethnicity was varied, predominantly White and Black British.[1]

The families represented a range of family formations, including single parents, parents in same sex relationships and mixed sex relationships, as well as some parents with their own biological children.

The children were aged 1–3 years old. At the start of the group, the youngest was 1 year 5 months and the eldest was 3 years 8 months. Five children were female and 4 were male. Two families had their children placed with them from infancy, whilst the majority had had their children living with them for only a few months, or even weeks, by the time the group started. Two children were already adopted when the group started, and three adoption orders were granted over the duration of the group. The remaining children were expected to be formally adopted the month following the end of the study. One child was diagnosed with autism.

One family withdrew from the group after two months, and the remaining six families completed the group. Of those six, five completed all the routine outcome measures that formed the raw data for the quantitative evaluation.

Procedures

Families who consented to take part in the study received an initial 90-minute clinic-based, pre-intervention appointment. During the visit, the parents and infants completed the baseline questionnaire measures (Time 1) and a clinical assessment.

Following this, the intervention ran weekly over a six-month period, at the same time and day each week. This included 23 group sessions and 3 individual family sessions per family. The groups lasted an hour and a half and were co-facilitated by a qualified female child and adolescent psychotherapist and a male assistant psychologist. An individual 90-minute, clinic-based review appointment was scheduled at weeks 11 and 12 (on 19th and 26th September 2019), where the same battery of outcome measures were re-administered (Time 2). This was also done for a final time after the intervention had completed (Time 3). All families were offered closing review appointments, which took place for six of the seven families.

The group was intended to be conducted independently from the families' relationship with the local authority social care team, in the hope of giving parents a therapeutic space that felt different from the highly scrutinised process they had undergone as part of their assessment to adopt. Therefore, within the normal limits of confidentiality, communication between the local authority and the co-facilitating therapists was limited to sharing any child protection concerns if they arose.

At the end of the intervention, all the participating parents were invited to take part in a focus group. The focus group was facilitated by a research therapist that the families did not know and took 90 minutes. The responses were recorded and transcribed.

[1] This section has been kept intentionally high level to protect the anonymity of the families who took part.

LOGIC MODEL
PARENT-TODDLER GROUP ADOPTION PROJECT

1. TARGET: who is the intervention for?

Adoptive parents with a toddler 1 to 3 years old

3. CHANGE MECHANISMS: how and why does the intervention work?

- Observing, practising and learning about child-led creative play and sensitive behaviour management
- Observing and practising the process of understanding parental and child behaviour within the context of mental states and putting them into words
- Practising finding balance between self focus/care and attending to the world through the toddler's eyes
- Strengthening social networks through peer-to-peer support and connecting to parents in a similar situation
- Experiencing containment through the group
- Experience of positive reinforcement and confidence building
- Sense of safe space allowing open and confidential communication
- Observing an attuned, respectful relationship modelled through the group leaders' relationship

2. INTERVENTION: what is the intervention?

- Based on the Anna Freud psychoanalytic parent-toddler group. Group themes cover:
  1. Child-led creative play
  2. Exploring parent-toddler closeness and independence
  3. Putting a child's thoughts and feelings into words
  4. Sensitive behaviour management
  5. Sharing experiences and creating connections between families
- 26 x 1.5-hour weekly group sessions (2-week break over the summer). A structured snack time is included in each group session
- Maximum 8 families (16 parents and 8 toddlers) per group
- Groups are led by at least one trained parent-toddler psychoanalytic psychotherapist and another trained assistant psychologist

4. OUTCOMES: what differences will it make?

Feasibility

- Parental experience. Positive parental experience of the service (measured by **ESQ** and **focus group with parents**)
- Parental engagement. Good attendance in the group (measured **by cancellation and non-attendance rates**)

Child outcomes

- Toddler developmental outcomes. Improved cognitive, language, physical, social, emotional and behavioural development of toddler (measured by **ASQ/ASQ:SE**)

Adoptive parent outcomes

- Parental mental health. Improved mental health (measured by the **CORE-10**)
- Parental stress. Reduced parental stress (measured by the **PSI-SF**)

5. MODERATORS: what factors will influence the change process?

- **Parent engagement** – willingness of parents to attend and to participate
- **Fidelity to the intervention model/group facilitator skills** – how closely group leaders keep to the intervention model and whether group sessions are adequately facilitated to ensure all parents are able to participate
- **Implementation issues** – training of group leaders, ensuring they have time for preparation, delivery and reflection, access to venue space and refreshments

Outcome measures

Below is a brief description of the outcome measures used for this evaluation. For more detail on these measures, please see Appendix A.

Child development

Ages and Stages Questionnaires, third edition (ASQ-3)

The 'Ages & Stages Questionnaires (ASQ): A Parent-Completed, Child-Monitoring System' is designed to identify potential developmental delay in children aged between one month and 5.5 years in five domains (communication, gross motor, fine motor, problem-solving, and personal-social).

The Ages & Stages Questionnaires: Social-Emotional (ASQ:SE)

The ASQ:SE is a subsequent adaptation of the ASQ, with a focus on social-emotional behaviours. It was developed to be used alone or in conjunction with the ASQ, and it focuses on infants' and young children's social and emotional development (Squires et al., 2009).

Parental stress and mental health

Parenting Stress Index - Short Form (PSI-SF)

The Parenting Stress Index (Abidin, 1995) is a widely used self-report questionnaire comprised of 120 5-point Likert scale items. It is based on the concept that parenting stress is a complex combination of parental, child and family context factors. A shorter version, the Parenting Stress Index – Short Form (PSI–SF; Abidin, 1990) consists of 36 items divided into three 12-item empirically derived domains: Parental Distress (PD), Parent-Child Dysfunctional Interaction (PCDI), and Difficult Child. The short form was used here.

Clinical Outcomes in Routine Evaluation-10 (CORE-10)

The CORE-10 is a brief outcome measure comprising 10 items drawn from the CORE-OM, which is a 34-item assessment and outcome measure. The CORE-OM measures commonly experienced symptoms of anxiety and depression, and associated aspects of life and social functioning, and has been widely adopted in the evaluation of counselling and the psychological therapies in the UK.

Qualitative family feedback

Experience of Service Questionnaire (ESQ)

The ESQ consists of 12 items and three free text sections looking at what the respondent liked about the service, what they felt needed improving, and any other comments. This was completed by parents following the end of the group.

Focus group

The focus group was guided by a semi-structured schedule that was designed to explore the study's research questions linked to acceptability and feasibility. The parents were asked about facilitators and barriers to joining the group, their experiences of taking part, their perceptions of any changes made, and their ideas for improvements to the group, as well as what other support would be helpful.

Data analysis

The transcribed qualitative data was analysed using thematic analysis (Braun & Clarke, 2012). Following familiarisation with the data, initial codes were generated based on what might be pertinent to the original research questions. These codes were then collated into potential overarching themes, which were then reviewed, refined and named.

As this was a feasibility study, the primary objective was not to achieve statistical power for hypothesis testing. However, clinical improvement data were considered a useful and informative secondary outcome. Group descriptive statistics were reported for each of the measures to compare any change across the intervention.

Ethical approval

As this was a service evaluation outside of the NHS, it was considered that ethical approval was not required. However, ethical considerations were embedded in all aspects of the project. Written consent was sought from all the families that took part, and they were made aware of the aims of the study, benefits and risks of taking part, consent and withdrawal processes, data storage and confidentiality processes.

Findings

The quantitative and qualitative findings are organised around the following two research questions:

1. **Acceptability.** What were adoptive parents' experiences of the intervention? Was it helpful? What clinical or practical concerns arose from delivering the intervention?

2. **Preliminary outcomes.** Within the context of a small-scale study, what is the evidence that the PTG is effective in improving clinical outcomes for adoptive families (child development, child externalising and internalising symptoms, parental mental health and parental stress)?

The third research question, 'What modifications to the PTG model are required for delivery with an adoptive population?' will be addressed in the discussion section.

Acceptability

Experience of Service Questionnaire

All parents in the pilot reported very high levels of satisfaction. In response to the question 'What was really good about your care?' parents reported feeling safe, understood, listened to and supported. They reported appreciating the quality of advice given by the staff and the professional level of understanding on particular behaviours of the children. Some of the parents valued the interest shown by the staff in getting to know them and the good relationships that were established between the therapist, the clinical assistant and the families. The regularity of the setting and the frequency of the meetings were also welcomed.

To the question 'Was there anything you didn't like, or anything that needs improving?', one family proposed changes to enable staff to meet individually with the parents more in the group sessions and in private meetings. These proposals included longer individual meetings for families with siblings, more sharing of clinical observations with parents and provision of more direct practical strategies for parents to adopt in difficult situations with the children. The remaining parents did not respond. The majority of parents did not answer 'Is there anything else you want to tell us about the service you received?'. One parent reported always feeling respected and valued as a member of the group. Another parent wrote that she found it very helpful knowing that help is there if needed, and always being able to be honest and open inside the group.

Focus group

Three parents (from six families) attended a focus group held at the AFNCCF a month after the ending of the group.

Three main themes emerged: support, authority and expectations.

Support – "We learn from each other"

This theme was comprised of narratives about how parents experienced the group, which was overall positioned as highly positive. There are three subthemes within this theme: **parent to parent**, **child to child** and **parent to child.**

The participants spoke about the benefits of **parent-to-parent** support where others had similar circumstances. They described finding other parents' views helpful, but moreover found that being with others whom they felt understood their context was a support in itself, beyond explicit strategies or 'tactics' shared. Relationships formed in the group were drawn on outside of the group for support, and the parents expressed a wish for these relationships to continue.

> *"This is great, to be able to sit down with adoptive parents on different parts of their journey with their different stories"*

It is important to note that the parents attending the focus group did so voluntarily, and therefore may be assumed to have had a positive enough experience of the intervention in order to participate. Other parents who did not attend voiced differing views about support from parents, which are detailed in the Discussion section.

Parents spoke about the children's relationships with each other as a major area of development and success for the family. Positive pro-social acts and behaviours between children were cited as a way the group fostered **child-to-child** support.

> *"[My child] seemed to connect to quite a lot of children in the group"*

Toddlerhood is a developmental stage where children are learning to master their own aggression and move more into relationships outside of the parental ones. However, this finding is particularly interesting because for each act of kindness and care between

Table 1: Summary table of qualitative themes from the focus group with parents

Theme	Subthemes
"We learn from each other" [support]	Parent-to-parent support Child-to-child support Parent-to-child support
"Things were pointed out to me" [authority]	Parental authority Professional authority
"...that's setting you up" [expectations]	Cost expectations Expectations of therapy

the children, it is likely there was at least one of conflict, and these conflictual (and developmentally appropriate) child-to-child interactions were not spoken about. This might be due to the levels of parental anxiety still present in wanting to present a 'smooth' and 'good' narrative to themselves and others.

A dominant story about group support was the **parent-to-child** relationship. This was mostly framed through parents' experiences of being able to observe their child and find out different perspectives or capacities of their child.

> *"I liked the fact that we've gotten to know each other's children and seeing how they interact together with our children"*

In turn, the child experiences the parent as an interested and caring other which strengthens their bond. This is the rationale for the parents and children attending the group together, so their relationship is the vehicle to support toddler development. After all, it is the parent-child relationship that will continue after any intervention has ended. It is of interest that this aspect of support was salient for parents in the focus group, as it is this aspect of the Parent-Toddler Group model that was a key factor in choosing this intervention for adoptive families at this point in their family life.

Authority – "Things were pointed out to me"

Throughout the focus group, parents spoke about what is titled here as authority – namely the status, knowledge and worth of professionals working in the Parent-Toddler Group Adoption Project as well as themselves as parents. The two subthemes of the authority theme are: **parental** and **professional**.

Parental authority was communicated in a range of ways; for example, ownership over the children, "our children", and being the holders of particular knowledge about the child's personality and behaviours. Parental pleasure in observing their children develop was authentic and moving, in particular when citing examples of their children linking to other children in empathetic and kind ways.

> *"[My child] seemed to connect to quite a lot of children in the group [...] there was a time when a little boy came in and he was getting quite upset [...] and he always, always played with a fire truck and [my child] found the fire truck and went and gave it to him to calm him down, so it was really nice to see the behavioural change"*

Supporting and developing parental presence (Newman et al., 2013) is a core aim of the Parent-Toddler Group model. The aim is that the group will deepen parents' sense of themselves as good and effective parents. This is an internal process, and the therapeutic challenge is how to contain parents as they arrive at their own sense of internal authority, deriving from experience and self-worth rather than external platitudes. This, of course, is a continuous and fluctuating process in parenting. Adoptive parents have additional layers of complexity within their identity journey as parents, due to their own experiences of being parented and their unique routes into adoption. These factors are in addition to the actual child they have, whose personality and experience will interact with their own to create particular family dynamics.

Professional authority was articulated in terms of expert knowledge. This type of authority was often spoken about in diagnostic terms, with regard to the assessment of mental disorder, and exact instruction of how to 'fix' problems.

> Interviewer: *"What are the things you think changed for yourselves or for your children as a result of coming to the group?"*
>
> Participant: *"I could look at behaviours that [my child] has and that professionals were saying to me 'that's a really lovely characteristic and it's a really unusual characteristic to see being exhibited in a child that has suffered with [developmental difficulty]"*

These two positions – **parental authority** and **professional authority** – can be seen to support and disrupt each other within the focus group data. For example, parental authority is undermined by positioning professional authority as the 'expert' and holding knowledge and authority about the child which the parent lacks. Concurrently, the professional authority is undermined by the parental stance that they have the 'special' knowledge about the child and can state what the child needs therapeutically. These positions support each other in the holding of the tension that there is a particular knowledge about the child that will be an 'answer'. The reality is more complex than this; that there are many routes to understanding and each family will be distinct and find different approaches helpful at different times.

Expectations – "...that's setting you up"

This theme reflects the multiple narratives in the data about what parents expected from the group, the staff, themselves and their children. Expectations of external reality were expressed, as well as expectations and hopes about being a parent, family life, feeling let down and the tensions arising from these complex emotions. Two subsections of this theme bring out the complexity of this issue: **cost** and **therapy**.

Considerable time was spent on discussing the **cost** of the group, and whether parents were aware of how much of the child's annual allocation of funding was spent on attending the group. Parents who felt their children did not require additional therapeutic input beyond the group were satisfied with the costing of

the group. Others felt strongly that their children needed additional therapy services (as recommended by the AFNCCF staff) and were therefore dissatisfied with the allocation of resources toward the current group, which may then impact on funding for recommended further assessment and treatment.

"I would have thought you'd cost this on the basis of what it costs, rather than the basis of how much money there's been"

There is a very real and pressing need for adoptive families to have access to therapeutic services at the point of need. What is complex about expectations relating to cost is that it speaks to parents' desire to have all the possible information about their child's needs available at the very start of their family life together. This perhaps clashes with the messier reality that as parent and child get to know each other and settle into family life, disturbances can calm down, emerge or increase in severity.

The therapy model of the group had been described to families in meetings before the group started; however, this information had not been consciously retained, and participants spoke in depth about how the intervention was not what they had expected.

"There wasn't any kind of showing us how we can play with our children in a way that could help them"

The **therapy** model used in the group draws heavily on the skills of observation and establishing a therapeutic alliance with families. This means that positive relationships are built with families, which enables staff to share observations of children that expand and develop the parental view of the child, enriching the relationship while promoting the parents' confidence in knowing their child. However, parents did not see the model as 'therapy', which was positioned as something that was 'done to' families, via didactic teaching or 'surgeries'. They positioned staff as the experts and related to them as either holding all the knowledge or withholding the answers about their children.

This makes sense in the context of early adoptive family life, where people are still getting to know each other in the family and the levels of anxiety about 'doing it right' are very high. There are many forms of therapeutic intervention that are more didactic than the Parent-Toddler Group model. However, at this point in the family journey, it is beneficial for some families to have a non-directive approach which can develop and boost parental confidence in their own skills and knowledge.

Preliminary outcomes

Ages and Stages Questionnaires

The **ASQ-3** data indicated general positive trends across the duration of the Parent-Toddler Group Adoption Project in all five areas: communication, gross motor, fine motor, problem-solving, personal-social.

The children who showed critically low scores at the beginning of the group progressed throughout the six-month period and all children exhibited on-track development in every domain at the end of the group. This is with the exception of the child with the diagnosis of autism (who also showed increasing scores in all areas, albeit within ranges indicating developmental delays).

Table 2: Children's ASQ-3 subscale scores pre- and post-intervention

Subscale	Children in clinical range pre-intervention	Children in clinical range post-intervention
Communication	38% (3 out of 8 who completed measure)	None
Gross motor	None	None
Fine motor	13% (1 out of 8 who completed measure)	None
Problem-solving	17% (1 out of 6 who completed measure)	None
Personal-social	17% (1 out of 6 who completed measure)	17% (1 out of 6 who completed measure)

The most significant improvement was in relation to communication and personal-social areas (see **figure 1** and **figure 2** below).

The mean communication skills scores of the six children who completed measures at both T1 and T3 show a positive trend across time. 38% of children were in the clinical range at T1. Mean scores improved at all three time points and exceeded normal cut-off scores by T3 (**figure 1**). This indicates an overall group improvement in communication after the Parent-Toddler Group intervention.

Figure 1. Mean scores for ASQ-3 communication subscale

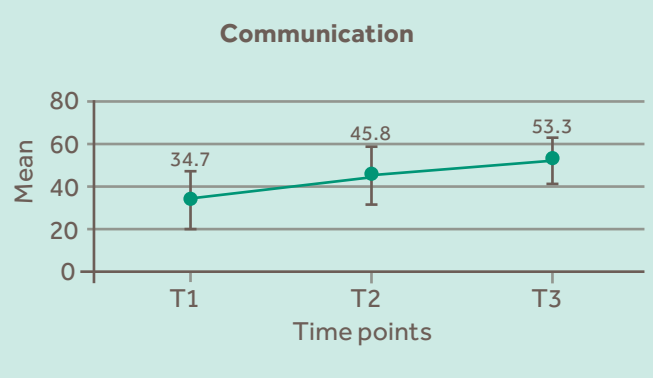


Figure 2. Mean scores for ASQ-3 personal-social subscale

The mean personal-social skills scores of the six children who had paired measures at T1 and T3 significantly improved from T1 to T3. This shows an overall group improvement in the personal-social domain after the Parent-Toddler Group intervention (**figure 2**). One child started and remained in the clinical range; this was the child diagnosed with autism.

Parents reported negative trends in **ASQ:SE**, which indicates improvement in their children's socio-emotional skills across the six-month period. 38% of children (3 out of 8 children who completed the measures) were in the clinical range at the beginning of the intervention, and two of these same children remained in the clinical range. One of these children had a diagnosis of autism and their score can be understood in the context of that diagnosis. The other child's scores, though showing less improvement than their peers, was within the healthy range of development.

Parenting Stress Index (PSI) Short Form

Scores for the PSI fluctuated across the three times of administration and the three focus areas of the measure (parental, child and family stress), generally remaining within the typical range. At the beginning of the intervention, two parents presented clinically relevant scores in 'parental distress'. These high scores could well reflect the difficulties in adjusting to the new transition to parenthood (at the time when the PSI-SF was first administered, their children had been with these families only for six and two months respectively). Throughout the duration of the group, these scores decreased considerably, while the lower scores reported by the other parents remained fairly stable.

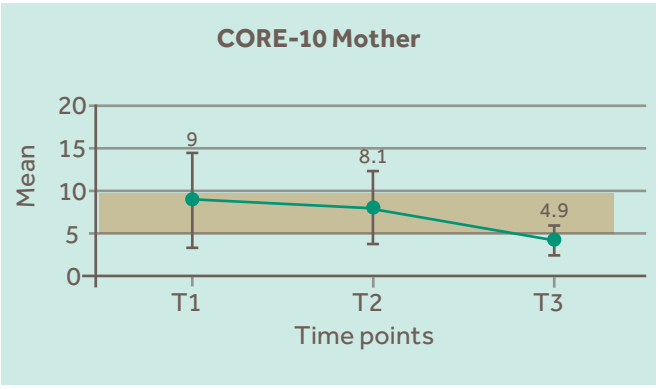
At the end of the group, two mothers reported high levels of stress linked to their perception of their children as particularly difficult to take care of ('difficult child'). These were the parents whose children were signposted for further assessment and support.

CORE-10

The general trends in the score of global distress fluctuated across the different times of outcome measure administration. At the start of the group, critical levels of global distress were reported. By the end of the group, no parent reported critical levels of global distress. At this time, all scores taken together were considerably lower than Time 1 and Time 2 (see **figure 3** and **4** for CORE-10 group mean scores in mothers and fathers, respectively), remaining within the healthy range. The exception was one parent reporting low level problems. This parent left the group halfway through the intervention due to an unplanned move and came back to attend the final session with her daughter. For this family, the gap in attendance lasted for five consecutive weeks. It might be that the reduced attendance for this parent meant they were less able to access the support offered by the group.

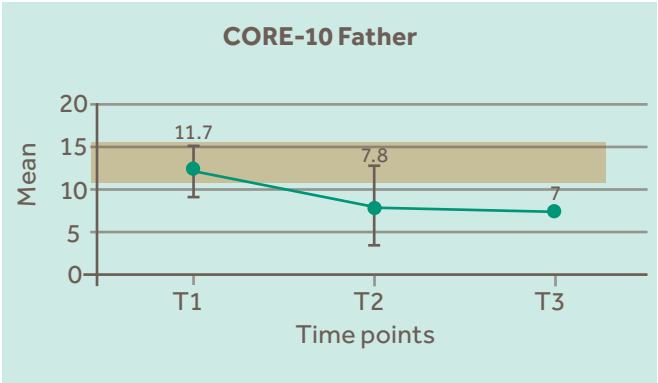
The CORE-10 group mean score for mothers significantly improved across the three time points as shown by the negative trend (where lower scores indicate better mental health) (**figure 3**). Though T1 mean scores were already below the clinical cut-off (area highlighted in orange represents 'mild clinical range'), they underwent further improvement after the group intervention ended at T3.

Figure 3. Group mean CORE-10 scores of mothers across three time points



The CORE-10 group mean score for fathers significantly improved across the three time points as shown by the negative trend (where lower scores indicate better mental health). The group mean score was initially in the 'mild clinical range' (area highlighted in orange) at T1, and by T3 fathers' CORE-10 group mean score improved as shown by the fact it is in the 'non-clinical' range (**figure 4**).

Figure 4. Group mean CORE-10 scores of fathers across three time points



Discussion

This section brings the findings together to examine each research question. The evaluation findings suggest that the Parent-Toddler Group Adoption Project is a well-liked and effective intervention for toddlers and their adoptive parents.

1. What were adoptive parents' experiences of the intervention? Was it helpful?

The data from the focus group and ESQ suggested that families generally found the group helpful. Parents reported experiencing help both through their relationships with staff and other families.

There are different ways to understand what made the group helpful. One factor may be the consistency of a weekly group with a predictable setting outside of the home. Family life with children under 4 years old is often challenging, and most of these families were negotiating parenting a toddler whom they had met only recently. Additionally, the child/ren came to their adoptive families with varying levels of trauma, from their early moves to abusive experiences. The regularity of the intervention and its delivery outside of the home provided a stable environment in which families could focus on each other during what could feel like chaotic family times.

Another factor in what made the group helpful is likely to be the therapeutic relationship parents and children built with staff. Much has been written about what makes a professional relationship therapeutic. Key components are feeling known as a person (rather than only a list of symptoms) and the time it takes to establish this type of knowing (Shattell et al., 2007). The group ran for six months which is adequate for establishing this relationship with families who attend consistently (Winnicott, 1960).

An additional factor might be the support of other parents, very specifically parents with adopted toddlers, most of whom were usually at the start of their family life with their children. During the group, parents spoke a lot about feelings of shame and perceived judgement from members of the public; for example, when their child displayed difficult behaviours in public. Many parents feel embarrassed or exposed in public with a dysregulated child but the additional layer of being an adopted family is highly significant. Issues such as developing parental confidence and authority, worries about the trauma and psychological damage a child might bring with them from their past experiences, and a range of feelings carried over from the parental assessment process for adoption make feeling highly vulnerable in the public gaze more likely. Coming to a group where all the families are the 'same' in having an often newly adopted toddler gave some parents the freedom to feel less judged by others.

These factors are important but must be understood in the context of what was less helpful about the intervention.

While feelings of shame, as outlined above, were mitigated by a solid therapeutic relationship and peer support from others, it remained present in the functioning of the group. Shame is understood as a potential barrier to families connecting. Some people felt an easy affinity to other participants, but others found it more difficult to connect, perhaps due to internal struggles about their journey to adoption, mixed feelings about their child or feelings of comparison and envy over which children are the 'most disturbed'.

'Splitting' professionals from each other (extolling one person while denigrating the other) was a common occurrence. Splits of this kind are usual in systems under extreme stress, of which newly adoptive families are one. The process of splitting is used as a psychological defence

when difficult or unbearable feelings are present; for example, shame and worry. The distance between the local authority and the AFNCCF was intended to support a therapeutic space, but this gap actually seemed to enable splitting, which was unhelpful.

Findings show that some parents did not find peer support useful. Those who reported not finding the peer support useful had lower attendance rates to the group than those parents who did find the peer aspect of the group helpful. It is possible that the the more frequently people attended the group the group, the greater sense of connection and support they felt. Conversely, group therapy is not suitable for everyone, and therefore consideration should be given to the assessment process for the group.

An important issue relating to the 'helpfulness' of the intervention is what the term 'help' means to whom in the family. Professionals have a different perspective on family life and often assess need and help in the context of a long-term view. This translates to families as needing to allow time for settling in and getting used to each other. However, families in the midst of their lived experience often articulate the need for help now – help meaning the immediate resolution of conflict, difficulty and uncertainty.

The focus group exposed ongoing issues with expectations about the intervention, in particular cost. This can be resolved in future groups through clear communication about funding and implications of this on a child's ASF allocation.

2. Was the PTG effective in improving clinical outcomes for adoptive families?

The quantitative data from the outcome measures suggest that the intervention was effective in terms of supporting child development, improving parental mental health and reducing parental stress (though the small number of participants means that findings should be considered with caution).

The children's scores for difficulties decreased over the course of the group. The PTG is a therapeutic intervention aimed at toddlers and their parents directly, so essentially the child benefits twice: from

the direct intervention of mental health staff on a weekly basis for six months; and from the ongoing environment their parents provide that enables them to establish a place of safety internally and externally. Parents are supported by the group to boost their capacity to provide this environment.

The improvement in the ASQ:SE scores was noteworthy. This intervention can contribute to mitigating the children's adverse experiences that led to their adoption, by supporting their social and emotional development, which will impact on their mental health from childhood to adulthood. One way the group supported the change in social and emotional development is through the consistency of the setting (same place, time, day, staff) and how this allows for small and managed 'hellos' and 'goodbyes' week to week as well as at the time the child leaves the group. When children have experienced multiple moves and losses, the opportunity to experience a planned and managed ending is a therapeutic task in itself.

The agent of change for the effectiveness of the group was experienced by parents to be primarily the support from other parents. The focus group data details repeated examples of the therapeutic interventions of staff; for example, observing the child's behaviour and thinking about what this might be communicating to parents. This observational stance made some parents able to consider different perspectives on their child's experiences and as such deepen their understanding of their child and their needs.

The facilitation of the group by a highly specialist mental health professional who adheres to the therapeutic model may be a key factor in its effectiveness. Universal provision for children under 5 has many play groups and drop-ins for families which are of great value. The PTG model is a different type of group that aims and achieves change in emotional development for toddlers and their parents through the strengthening of their relationship.

Over the course of the group, staff were able to develop complex and in-depth knowledge of the children. These formulations have been shared with parents, where appropriate, in order to inform next steps for therapeutic assessment or treatment where that was deemed to be necessary. Clinical judgement in these cases was reinforced by the quantitative data arising from the outcome measures making the same conclusions.

3. What modifications to the PTG model are required for delivery with an adoptive population?

The qualitative focus group data combined with clinical considerations have identified the following modifications required for the AFNCCF Parent-Toddler Group therapy model in the context of adoptive families.

Increase session structure: The model of free play that characterises the AFNCCF Parent-Toddler Groups required some adjustment during the pilot with adoptive families. Families reported coming into the room and moving into play without more structure from staff unsettling. The group leader, experienced in facilitating Parent-Toddler Groups with different populations, also felt that the level of parental anxiety was high, and this was a barrier to moving into free play without professional 'holding'. To meet this need, a 'welcome circle' and 'goodbye circle' at the start and end of each group was facilitated, including parents sharing their highs and lows of the week. The introduction of the circles was successful, with the parents reporting feeling more contained and subsequent conversations were started with more confidence. Including the circles from the start of the group would be recommended for future groups.

Closer co-working with other professionals: An area for development arising from the pilot is increased access to professional opinion. Families were managing highly anxiety-provoking situations in the context (mostly) of the first months of the relationship with their children. Some families in the pilot group required additional appointments and support from the group leader with regard to concerns over behaviours, moving into nursery and future assessment of therapeutic need. Future groups would benefit from easier direct access to a professional outside of the group for support and guidance as needed. One way to do this, and keep the group leader role as group focussed, would be to partner closely with a worker from the Regional Adoption Agency (RAA). The two professionals could see the families for the pre-, mid- and post-group meetings, with the group leader offering weekly support in the group and the adoption agency worker providing support to families outside of the group as needed, in partnership with the group leader.

Recruitment: Of the seven families recruited for the pilot, six completed the group. The recruitment process was broad, and therapeutic staff were not part of the process. As such, some families recruited to the pilot were not best suited to a group intervention and would have been better suited to a one-to-one model. The family that left the group cited travel and clashes with nursery as the reason; however, it is possible that a group setting did not feel appropriate to them. If therapeutic staff can work with the adoption agency staff from the beginning of the recruitment process for future groups, it is likely that families who will gain the most from the group intervention will be offered this resource. Another benefit of working closely with the agency staff in the recruitment process is that families can be given a full idea of what to expect from the group in terms of the method of intervention, aims of a group setting and the role of staff. This could work to meet and manage the disappointment voiced by some parents about the 'play group' aspect of the intervention.

Slow open model: For this pilot, group members started and ended the group together, over a six-month period. This design took into account the application for funding process available via the Adoption Support Fund, which requires you to apply for the whole group funding ahead of the group and for the duration of the group. Many parents expressed sadness about the group ending and spoke of their awareness of further developmental tasks facing them as a family for which this type of group intervention would be helpful. A slow open model, where children enter and leave the group according to age, could allow for less sudden entries and departures for families who have experienced many forms of loss. A modification of this group design would require different funding to allow for the slow open model rather than funding being linked to each individual child.

Limitations of the study

This was a small-scale feasibility study. Five families completed all the routine outcome measures in the evaluation and three parents from those families attended the focus group. Therefore all findings must be interpreted with caution. In addition, follow-up measures were not employed to enable an understanding of whether the positive impact of the intervention was sustained over time.

Recommendations for future development

Although the small number of participants means that findings should be considered with caution, overall the positive trends suggest that the intervention achieved the desired outcomes in improving parental distress and toddler behavioural and social-emotional development. Given the positive findings of this feasibility study, the approach is being expanded to seven local authorities in the vicinity of the study's central recruitment site. This will help the model to be evaluated with a wider group of parents in order to develop its evidence base.

If you are interested in learning more about using the model in your area, please contact: EarlyYears@annafreud.org

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Appendix A: Outcome measures

Child development

Ages and Stages Questionnaires, third edition (ASQ-3)

The 'Ages & Stages Questionnaires (ASQ): A Parent-Completed, Child-Monitoring System' is designed to identify potential developmental delay in children aged between one month and 5.5 years in five domains (communication, gross motor, fine motor, problem-solving, and personal-social).

The ASQ-3 has excellent test-retest reliability (ICC=.75-.82), adequate interrater reliability (ICC=.43-.69) and has poor to excellent internal consistency (Cronbach's Alpha= .51-.87 for age intervals from 2-60 months across five domains) (Squires et al., 2009). A review of psychometric properties of the tool shows that in terms of predictive validity/sensitivity, the ASQ-3 correctly identified 85.9% of children aged 27–36 months at risk of developmental delay. In terms of discriminant validity/specificity, it correctly identified 85.7% of children aged 27–36 months not at risk of developmental delay (Rosthstein et al., 2017; Halle et al., 2011).

The Ages & Stages Questionnaires: Social-Emotional (ASQ:SE)

The ASQ:SE is a subsequent adaptation to the ASQ, with a focus on social-emotional behaviours. It was developed to be used alone or in conjunction with the ASQ, and it focuses on infants' and young children's social and emotional development (Squires et al., 2009).

Validity, reliability and utility studies were conducted for the first version of the ASQ:SE between 1996 and 2001 in order to determine the psychometric properties of the screening instrument. Normative studies included 3,014 preschool-age children and their families, distributed across the eight age intervals. Internal consistency ranged from .67 to .91, indicating strong relationships between the questionnaire total score and individual items. Test-retest reliability, measured as the agreement between two ASQ:SE questionnaires completed by parents at one- to three-week intervals, was 94%, suggesting that scores were stable across time intervals. Concurrent validity, as reported in percentage agreement between ASQ:SE and concurrent measures, ranged from 81% to 95% with an overall agreement of 93%. Sensitivity ranged from 71% to 85%, with 78% overall sensitivity. Specificity ranged from 90% to 98% with 95% overall specificity (Squires et al., 2009).

The ASQ-3 and ASQ:SE have previously been used with adopted children (i.e. Jones & Schulte, 2019; Welsh & Viana, 2012; Tarren-Sweeney, 2019).

Parental stress and mental health

Parenting Stress Index - Short Form (PSI-SF)

The PSI (Abidin, 1995) is a widely used self-report questionnaire comprised of 120 5-point Likert scale items. It is based on the concept that parenting stress is a complex combination of parental, child and family context factors. A shorter version, the Parenting Stress Index – Short Form (PSI-SF; Abidin, 1990) consists of 36 items divided into three 12-item empirically derived domains: Parental Distress (PD), Parent-Child Dysfunctional Interaction (PCDI) and Difficult Child. The short form was used here.

Several studies reported appropriate internal consistency coefficients for the scale (Barroso et al., 2016; Canzi et al., 2019; Pérez-Padilla et al., 2015). Specifically, a study on parenting stress during early adoptive parenthood (Canzi et al., 2019) showed good internal consistency, both for mothers (Cronbach's alpha=.88) and for fathers (Cronbach's alpha=.88). With respect to the evidence of validity, results reported suggest that the total PSI-SF score, but not the two subscales, could be useful to differentiate between different groups of mothers with different levels of risk (Canzi et al., 2019, Pérez-Padilla et al., 2015).

Clinical Outcomes in Routine Evaluation-10 (CORE-10)

The CORE-10 is a brief outcome measure comprising 10 items drawn from the CORE-OM, which is a 34-item assessment and outcome measure. The CORE-OM measures commonly experienced symptoms of anxiety and depression, and associated aspects of life and social functioning, and has been widely adopted in the evaluation of counselling and the psychological therapies in the UK.

The CORE-10 has been shown to be an acceptable and feasible instrument with good psychometric properties (Barkman et al., 2012). Comparison between clinical and non-clinical samples revealed a large and clinically significant difference between the two populations. The internal reliability (alpha) is .90 and the score for the CORE-10 correlated with the CORE-34 is .94 in a clinical sample and 0.92 in a non-clinical sample.

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