

“She was accused of colluding with the mother”; the training and support needs of parent-and-child foster carers: A qualitative study

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Abstract

Parent-and-child foster placements are used to accommodate parents with their children, either when the mother is a looked-after child or as a setting for a parenting assessment. Despite this being a specialized role with significant potential for affecting outcomes for disadvantaged families, there is currently a lack of accessible learning opportunities for foster carers on the physical and mental well-being of women with complex needs such as a history of domestic abuse, substance abuse, perinatal mental ill-health, or having a learning disability. Parent-and-child carers experience some unique stresses and value the support of others with similar experiences; this kind of peer support is currently largely absent. This qualitative study has used ten focus groups with foster carers, eight interviews with mothers, and nine interviews with supervising social workers, to inform the development of an online learning resource and a social media-based peer support network for parent-and-child foster carers.

KEYWORDS

foster care, parenting, parent-and-child, peer support, teenage pregnancy, training

1 | BACKGROUND

The use of parent-and-child foster carers¹ has grown in recent years (Tickle, 2017), with these settings accommodating either pregnant teenagers already being fostered or parents living in the community who require a parenting assessment. These families are amongst the most vulnerable, and these placements² amongst the most specialized and complex, requiring additional skills and knowledge. The first author had experience as a teenage pregnancy midwife where she met carers with varying levels of knowledge around maternal and infant health and well-being, and on supporting mothers with particular needs. In her own subsequent experience as a parent-and-child carer for a local authority (LA), specialist training was not offered, and when she tried to source

this, she found that few options were available, and content was weighted towards the observation and recording skills necessary to support parenting assessments.

In addition to accessible and appropriate training, other factors determine the quality of a parent-and-child placement. Inevitably, all placements involve elements of both support and assessment, and assessing a carer's ability to “step back” to allow parents to develop their parenting without feeling overly scrutinized, and “step in” to provide parenting guidance or to challenge poor parenting is crucial. In addition, skilled supervision by the fostering provider is vital, with expectations around issues such as shopping, cooking, babysitting, and cultural parenting practices needing to be clearly established and managed; lack of clarity on these issues is a major cause of placement breakdown (Adams & Dibben, 2011).

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Regarding training, Adams and Dibben (2011) highlight the need for effective training of both foster carers and social workers (p. 17) and cite some examples of more comprehensive training, especially within specialized fostering schemes. For example, input from a specialist midwife to help understand issues around substance misuse, and input from a clinical psychologist regarding supporting parents with learning disabilities (p. 41). A 2014 review that examined a wide range of parent-and-child schemes recommends: "Providing more specialist parent-and-child placements with dedicated training and support, facilitating greater peer-support" (Luke & Sebba, 2014, p. 20). A review of peer support amongst carers in 2013 concluded that it is highly valued, with the perception that other carers can empathize in a way that supervising social workers, friends, and family cannot (Luke & Sebba, 2013).

This qualitative study aimed to understand the experiences of both parents and carers in order to inform the development of accessible and appropriate online learning resources, which could be accessed by anyone working in the field, and to explore options for better peer support amongst carers.

2 | METHODOLOGY

2.1 | Study design

This qualitative study was carried out from March to July 2018 across England. It comprised ten focus groups with 32 carers who had parent-and-child experience within the previous two years, eight semistructured interviews with mothers with experience of parent-and-child placements, and nine semistructured interviews with supervising social workers³. To give some context, in March 2016, there were 235 active parent-and-child placements in England (Office for Standards in Education, 2017).

2.2 | Recruitment

Participants were recruited initially using the social media network of the first author and those of the project's advisory group, drawn from prominent fostering, midwifery, health visiting, and third-sector organizations. Snowball sampling was used to recruit subsequent participants. Focus groups were widely spread across England, including carers from both LAs and independent fostering providers (IFPs). The recruitment of parents was more problematic, with only eight taking part. Because all parents recruited were mothers, the term "mother" is now used throughout. As the research progressed, it became clear that the views of social workers would also be significant. Nine were recruited from four different organizations, both LA and IFP, via professional networks.

2.3 | Procedure

Interviews and focus groups were conducted in foster carers' homes, mothers' homes, and in private rooms within organizations and were

recorded and transcribed with participants' written consent. Mothers were asked about their experiences, both positive and negative, of being in a foster home with their child. Foster carers were asked about their experiences, how well supported and trained they felt, and what content areas of additional training they felt they would benefit from.

2.4 | Ethical considerations

University ethical approval was sought and granted (study number HR-17/18-5152). The study was advertised via social media using two flyers, for carers and parents respectively, including the first author's study-specific contact details. On first carer-initiated contact, the study was explained regarding eligibility, anonymity, confidentiality and data protection, and questions answered. At the focus group, participants were given copies of the information sheet and had opportunity to ask questions before signing the consent form.

The social media arm of the recruitment strategy was not effective in recruiting parents, who were all recruited through snowball sampling from the first author's networks. Special care was taken to ensure mothers understood they were free to accept or decline participation with no repercussions for their care, and that participation would not be shared with other professionals or their carer. It was explained that if safeguarding concerns emerged, they would be followed up with Children's Services; that participants could withdraw at any time or withdraw their data until a given date; that all data files, transcriptions and audio files would be password-protected and kept according to General Data Protection Regulation (GDPR) regulations; and that names and geographical locations would be removed from transcriptions in order not to identify participants based on family, social group, or address.

Information sheets and consent forms were written using plain English and were summarized verbally to ensure that nonliterate participants would not be embarrassed or excluded. The youngest participant was 16 and used an adult consent form.

2.5 | Data analysis

Focus group and interview data were transcribed by the first author and transferred to NVivo version 12 to assist with thematic analysis. Recordings were listened to and read twice by the first author before coding, and major themes and subthemes were identified and discussed with the second author. The number and geographical range in location of carers was such that there was evidence of data saturation, with no new themes emerging.

2.6 | Participants

For mothers, there was a range of ages (16 to 34), ethnic backgrounds, and experiences; one mother's child had been

removed whilst in placement, two mothers had had previous children removed, three mothers had been moved during the placement and therefore had experiences to compare, and one mother had been in placement with her partner (see Table 1). Although the distinction between placements which provide support and guidance, and those which are specifically for a parenting assessment was not clear cut, four placements were primarily for support of teenage mothers, and four were set up specifically for a parenting assessment on parents for whom there were serious concerns about their parenting capacity. For foster carers, experience varied from having had one parent-and-child placement (their first ever foster placement), which broke down, to having had ten parent-and-child placements and four couple placements. It should be acknowledged that this report does not analyse the data in respect of the type of placement or other factors such as whether other children are in placement; this would merit further research.

TABLE 1 Geographical, organizational, and demographic characteristics of participants

Characteristic	Carers (n = 32)	Mothers (n = 8)	Social workers (n = 9)
Geographical range	From nine counties in six regions	From three regions	From four regions
		2 (25%) NE	5 (56%) SE
			2 (22%) NW
			1 (11%) London
		5 (63%) SE	1 (11%) NE
		11 (34%) SE	1 (12%) London
		4 (13%) NW	
	7 (22%) NE		
	4 (13%) London		
	3 (9%) West Midlands		
	3 (9%) SW		
Ethnic identities	30 (94%) White British	3 White British	8 (88%) White British
	1 (3%) Black British	2 Black British	1 (12%) Black British
	1 (3%) Asian British	2 Black African	1 (12%) Black British
		1 Asian British	
Gender	25 (78%) Female	8 (100%) Female	8 (88%) Female
	7 (22%) Male		1 (12%) Male
Local authority or IFP	13 (40%) IFP	3 (38%) IFP	6 (67%) LA
	19 (60%) LA	5 (62%) LA	3 (33%) IFP

The study aims will be achieved by first presenting the findings from primary research and then discussing these in relation to existing literature to highlight important topics for inclusion in a learning resource.

3 | RESULTS

This study focussed on the perspectives of the foster carers and parents, and the data presented reflect this. The social work views provide some triangulation but are not the focus and are therefore less represented.

When asked about their experiences, mothers focussed almost exclusively on the attitudes of carers; how they were made to feel and how much the carer built or eroded their self-esteem. Carer and social work data were more directly related to training and support needs, with an additional strong element being the unique stresses of the parent-and-child role. Table 2 summarizes these major themes and subthemes.

Within the results, carers, mothers, and social workers are identified as FC 1-32, M 1-8, and SW 1-9, respectively, with gender and age range also identified.

3.1 | Issues identified by mothers

3.1.1 | Not meeting the carer before moving in

All mothers except one had not met the carer until they moved into the placement, a huge source of stress. In defence, social workers

TABLE 2 Themes identified within study data

Major themes	Subthemes
Issues identified by mothers	<ul style="list-style-type: none"> • Not meeting the carer before moving in • How she made me feel/the importance of empowering communication • "She writes about me and I don't know what she says"
Current support and unmet support needs of foster carers	<ul style="list-style-type: none"> • Unique stresses of parent-and-child role/need for therapeutic input • Isolation and need for peer support • Social media peer support networks
Current training and unmet training needs of foster carers	<ul style="list-style-type: none"> • Assumed knowledge/focus on skills for assessment • Topics identified as important and currently lacking • Training solutions; online and face-to-face

explained that placements often had to be found straight from the family court, but this did not account for all examples, many simply being transfers between placements.

They told me to pack my things into boxes as I was moving out of borough to a foster carer I'd never met. I was already in labour and my mum was supposed to be my birth partner. Later, cos the new carer couldn't drive, I had to go by ambulance to a different hospital and my mum couldn't get there on time. She (the carer)'s seen me naked and I don't even like the woman. I wanted my mum there.⁴ (M8, 18-year-old mother, first child)

3.1.2 | How she made me feel: The importance of empowering communication

Mothers had a variety of experiences. For some, foster care was their first opportunity for a stable relationship with a caring adult, and they had flourished; for others, the experience was overwhelmingly negative. This was largely related to how intrusive the mother perceived the carer to be and her sensitivity in communication:

The first one was wanting to know everything about my childhood, digging into it. The other one was interested but wasn't pushing it and I felt a lot more comfortable to tell her. And she was always there to support me. (M7, 34-year-old mother with fourth child. First three children removed. Left with child).

Regarding supervision and advice, mothers recounted mixed experiences, feeling either criticized and undermined or engaged and encouraged:

And when I'm doing stuff like bathing C, she's always watching me, saying ... "What's wrong with you? How are you not knowing this? You know not to do that." ... I can't deal with that. It's too much for me. I feel too much under pressure, like she's criticises me. (M5, 16-year-old looked-after child).

If she had a problem with the way I was doing anything she would just come across in a nice way like "Darling when you're holding the baby just bring him closer"—just little tips like that. She never came across full-on which is what I loved. (M3, 20-year-old, in care with first baby who she kept. Had second baby in the community).

There were also examples communication, which were overtly abusive:

I actually got discharged on the Saturday ... and she started shouting at me saying "you've just got out of hospital, you need to pick yourself up, get back on track. Don't you dare put a cup on my couch, it's worth a fortune more than you." So she was just really horrible. (M1, 17-year-old previously looked-after child).

or where a lack of knowledge, compassion, and sensitivity were a toxic combination:

Once when I was pregnant, the baby wasn't moving so I asked her to take me to hospital. The baby was fine, but then the next day she was saying "ah, I was really angry cos I couldn't go to my son's first parent's evening, and it was a waste of time going to the hospital when there was nothing wrong with the baby." (M4, 16-year-old looked-after child).

For several mothers, although they valued support and practical help, there was a fine line between this and feeling that the carer was too intrusive. This mother's perception was that the carer wanted her to fail so that she could keep the baby and described her efforts to present herself in a way that would not disadvantage her:

She wanted to do a lot of the feeds, dressing my child, taking my child out without me being around ... she wanted my daughter without me. And her family were saying how they'd love to have her. Like "you can go home" sort of thing. They were trying to have that jokey element ... and I had to (respond) jokingly as well because I didn't want to come across as passive-aggressive or argumentative. (M7, 34-year-old mother, fourth child. First three children removed. Left with child)

3.1.3 | "She writes about me and I don't know what she says"

All carers are used to keeping daily logs; with parent-and-child foster care, these are frequently used as evidence within the family court arena. Although sharing logs with mothers is widely considered best practice (Adams & Dibben, 2011), for several carers, there was no expectation of sharing their logs with the mother, and this was echoed in interviews with mothers:

The only time I saw some of the logs was when I was in court. Other than that I didn't get to see them. (M7, 34-year-old mother, fourth child. First three children removed. Left with child)

In summary, mothers found the idea of a parent-and-child foster placement very stressful, a place where they would be watched and

criticized and where they had to prove they were able to look after their babies with little of the normal help that new mothers need. This stress was reduced when the mother moved into the placement before birth or where she had met the carer prior to the move. Mothers felt easily criticized but described some compassionate sensitive communication, where advice was more likely to be taken on board. Mothers feared the consequences of negative written reports about their parenting but rarely challenged policies where this personal data was not shared with them.

3.2 | Current and unmet support needs of parent-and-child carers

3.2.1 | Unique stresses of parent-and-child role/need for therapeutic input

Carers described unique stressors over and above those experienced by generalist foster carers and highly valued the opportunity to talk about them:

I asked as well for specific parent-and-child support groups, because parent-and-child is completely different—different worries, different concerns. And if you don't talk to other parent-and-child carers, you're out on a limb. My supervising social worker, the last two, have been very newly qualified. Very young. And I'm not knocking that, but I feel like I'm supporting them in their development and they're not there for me. And sometimes when everybody shuts down at the weekend, that's it! So if something occurs at the weekend who you do talk to you? I've had that several times and it's been absolutely dreadful. (FC 16, Female, 50s)

Most of these stresses were associated with the tension inherent in the role, between nurturing a vulnerable mother and contributing to the assessment which decides whether she will leave with her child:

Very very different, very specialist ... sometimes they will say "we don't want you doing this for the mum. They are to do it themselves and you are to record everything" ... I think that's quite off-putting for someone who's nurturing by nature. (FC 17, Female, 40s)

We've had times when our carers have been accused of "colluding with the mother!" Such negative language—what does that even mean? Aren't we all colluding with the mother? (SW 2, CEO of an IFP)

Every carer and social worker cited times when, either implicitly or explicitly, the outcome of assessments had been decided by

the LA before placing the mother-and-child, with the placement merely satisfying court proceedings. The desire to advocate for a mother whom the carer felt needed additional time and therapeutic input to develop "good enough parenting" skills was a huge source of stress, and the feelings of powerlessness that accompanied this were problematic:

I had a very disturbed mum when she first arrived, and for the first three days couldn't go into the kitchen to make the bottles, cos she was just so overwhelmed ... there was a massive history of DV, so she didn't want to go into the kitchen if K (carer's husband) was in there. And that was really difficult to overcome. I had to work really hard with her initially, and all you've got is a social worker coming and saying "So, you're refusing to feed the baby." You just think "Back off!" And a few days later, this same social worker just said "Tell me when. Tell me when to pull the plug, and she's out!" And that was his exact words. And I said "No, no, give us some time, we're working on it." And do you know, she went on to do 7 months and went home with the baby. But they were prepared to write her off. (FC 16, Female, 60s)

Other unique stressors involved having another adult (or two) in the house, the intensity of often 24-hr supervision, and "allowing abuse under your roof," when carers were asked not to step into a parent-child interaction in order to provide evidence for separation:

This child, I just felt so sorry for her. You just thought "How long? How long can I leave it?" Cos you know they want the evidence for emotional abuse cos it's very hard to get. (FC 14, Female, 30s)

For other carers, very deep issues were raised by their involvement with such troubled families; one couple talked about their 18-year-old son having a breakdown a year after a baby left the family for adoption. Another older carer talked about the pain she experienced when a baby moved on to adoption at 4 months:

When I was with my first husband, we had a little boy and we lost him (to SIDS) at four-and-a-half months. And that was the same age as when the baby was taken away. So I was sort of reliving what had happened all those years ago. (FC 5, Female, 60s)

Despite the enormous emotional burden clearly being carried by carers in this role, there were no examples of professional therapeutic input or counselling being available as a standard part of parent-and-child carers' support package.

3.2.2 | Isolation and lack of face-to-face peer support

With some notable exceptions, there was a dearth of opportunities for peer support amongst parent-and-child carers. Most LAs and IFPs had only a handful in post and the constraints of the role meant that peer support opportunities were difficult to organize; several carers attending focus groups had never met another parent-and-child carer. However, where good peer support was in place, this was used as a first port of call, rather than using their organizational support systems.

3.2.3 | Social media-based peer support

During the research process, the first author became familiar with various social media groups for foster carers. They vary in size, emphasis, and joining criteria. For some carers, these groups were important for instant advice, avoiding the delay involved in using the more established channels:

You post on there ... sometimes it's a really practical thing, like about benefits. It's really helpful. Much more than ringing up your agency or LA and waiting four weeks to get an answer to something. (FC 18, Female, 40s)

However, there were several instances described of peer support groups, whether in a physical or remote format, becoming overly negative:

We had a Whatsapp group that was really really negative and detrimental. It was really a bitching group. (SW 3, Female, IFP)

I sometimes wouldn't ask them to look after my dog, let alone a child. Some of the language on the blogs! (FC 15, Female, 40s)

There was a feeling that these groups were too much about "normal" fostering, with little understanding of the specialized role with its unique challenges; discussion of a specialist-closed Facebook group was met with enthusiasm.

In summary, parent-and-child carers experience some unique stresses and highly value the support of others with mutual experience. There is currently little recognition of the need for additional therapeutic support, despite the huge emotional burden these carers carry. Many are isolated, having fewer opportunities to meet with peers, mostly for logistical reasons; they are often widely spread geographically, and the levels of supervision required for some placements mean that they cannot take time away without respite, which they prefer to use for time with family. Social media is a popular form of peer support, but groups differ in quality of

moderation and are all generic, with no specialist forum currently operating.

3.3 | Current training and unmet training needs

Although a minority of participants reported being given high-quality specialist training, the overriding view was that training specific for the parent-and-child role was either absent, ad hoc, or run by generalist trainers without appropriate knowledge:

I've asked for 3 years now for specific parent-and-child training, and it just doesn't happen. There isn't any. "X" is the only place that does any, and it's rubbish. (FC 14, Female, 30s)

It's like the blind leading the blind because they haven't got the experience. (FC 16, Female, 50s)

They could identify topics within generic training that were relevant but with little or no application to the parent-and-child setting. For example, training on infant attachment was aimed at understanding children who have been separated from a parent rather than promoting attachment between a parent and their infant.

3.3.1 | Assumed knowledge/focus on skills for assessment

When asked how parent-and-child carers were selected and trained, there was a strong reliance on "previous knowledge" acquired through their own parenting or through experience of "normal" foster care. Carers saw this as insufficient for the role, citing examples of where advice had changed:

I was just using my personal way and experience but that was 35 years out of date. (FC 5, Female, 60s)

I think they think if you're a parent, you can do all these things. It doesn't matter what comes up, they think we know it all. We don't know it all. (FC 6, Female, 40s)

3.3.2 | Topics identified as important and currently lacking

Carers completed a questionnaire where they were asked to rate a number of topics for importance for the parent-and-child role and to identify other areas not currently covered in training. The following areas were identified:

- Encouraging a healthy pregnancy, birth preparation, and being a birth companion

- Parent/baby attachment, breastfeeding, and cosleeping
- Maternal mental health, the complexity of women with serial removals, maternal drug use, and the effect of alcohol/drugs in newborns
- Domestic abuse

In discussions around these topics, as well as the need for information, the need for understanding the advocacy role came out strongly:

I would say "It's her human right, and that baby's human right to be fed by its mother. But it caused trouble (when baby was taken to contact with father) and the social workers tried to stop her feeding ... that made me mad. (FC 18, Female, 40s)

The obstetrician had massive hands and she (the mother) took one look at him and had a complete and utter freak. I had to literally take him outside and say, "What are you doing?" ... I had to explain to him that she had a learning difficulty and had been horrifically sexually abused ... and that he needed to change his attitude and come with a much more gentle approach ... to deal with the uniqueness of who she is. (FC 6, Female, 50s)

Other topics raised by the carers were as follows:

- How to manage endings—when a baby is removed

I've had no training on how to remove. That was a really hard thing. I came home (from court) and helped her pack. We spent the day in the park, feeding the swans, taking loads of pictures. And then I had to drop her home with her baby in my car, to her mum. And then her mum went mental cos she didn't want to lose her grandchild. No training! (FC, Female, 40s)

- Sharing logs with mothers in a positive way

(Referring to logs) I always talk through concerns and usually at the end of the day there will be a time where it's like "You did this really well," talking about the positives first. And then saying, "You need a bit of work on this side of things." It's a vital piece of work. You're talking lives! (FC 22, Female, 50s)

- Working with mothers with learning disabilities and autism

They allow carers with disabilities to foster, or they're working with children with disabilities, but they'll not train you to work with mums with disabilities. (FC 15, 40s)

3.3.3 | Training solutions: Online and face-to-face

As would be expected, a mixed picture emerged about the relative benefits of face-to-face training versus online learning. A commonly voiced issue with face-to-face training related to the difficulty of being able to attend when the mother-and-child needed 24-hr supervision. Other objections were that the trainer was unlikely to be an expert on the topic and sessions were often boring. However, where carers had attended face-to-face training delivered by an expert trainer, this was very highly valued. Several social workers proposed a blended learning approach so that sessions could be planned around an online module, with activities for group supervision incorporated into the package.

In summary, current parent-and-child training lacks content on supporting the mother's and child's mental and physical health and attachment relationship or on advocacy. Although expertly delivered - face-to-face training is highly valued, it is scarce and localized. Online learning is seen as an acceptable alternative, especially if it covers specialist areas not commonly available. Participants believed that there would be added value and richness if online learning content could also be used in group supervision sessions.

4 | DISCUSSION

Many of the parents placed in parent-and-child foster care will have histories of child abuse or neglect, with associated mental health vulnerabilities, including drug dependencies (Pawlby, Plant, & Pariante, 2017), and poor attachment with their own mothers may have put them at risk of difficulties in forming healthy adult relationships, often associated with domestic abuse.

Against this backdrop, data from this study show that new parents are required to leave their support networks and move in, often against their will, with a carer whom they have never met, and prove that they are fit parents, often with explicit restrictions to practical help, and under 24-hr scrutiny, where written records can be used as evidence for child removal. Unsurprisingly, this is immensely stressful.

4.1 | Nature of current peer support

A review of peer support amongst carers concluded that it is highly valued, providing emotional support, a source of useful information, practical help, feedback on how carers deal with specific situations, and alleviating isolation (Luke & Sebba, 2013). This current study resonates strongly with these findings, with a key factor being that carers wanted support from other parent-and-child carers rather than

generic carers who they felt could not understand the distinct pressures of the role.

4.2 | Support needs and options

A recommendation for practice in the 2013 review was to explore the benefits of online support. In the current study, it was felt that well-moderated closed groups were helpful for support and information but that the existing groups were too generic. A proposed next step is a parent-and-child-specific closed group with a clear code-of-conduct and effective moderation and an emphasis on sharing resources and training opportunities.

4.3 | Quality of current training

Although some parent-and-child carers may have been recruited to a specialist scheme with comprehensive specialist training and input from allied specialist professionals, this is not ubiquitous; others will be generic foster carers, or this may be their first placement. They will have attended the generic Skills to Foster training but may only have been deemed fit for parent-and-child placements because they are “sensible” or “have had children” (statements made by social workers, quoted by carers). It is possible that no additional training has equipped them for this complex therapeutic and advocacy role, for example, to be a supportive birth partner; to promote responsive feeding; to understand that a mother’s lack of responsiveness to her newborn is due to her own neglect as a baby and advocate for parent–infant psychotherapy; or to appreciate that her “unwillingness to take advice” may result from the haze and confusion of postnatal depression. At best, these carers may be motivated to read, seek out relevant self-funded training, and have learnt to communicate with compassion. At worst, they may see their role merely to compile evidence for a court hearing, the outcome of which has been presumed by the LA before the placement began, with alternative views expressed by the carer deemed as “colluding with the mother.”

4.4 | Unmet training needs

Discussions with mothers, carers, and social workers and a review of the current literature on improving infant and maternal well-being have highlighted issues to include in training for parent-and-child carers.

4.4.1 | Healthy pregnancy, birth preparation, and being a birth partner

Young mothers and mothers with other disadvantages are at high risk of smoking, drinking alcohol, or misusing other substances in pregnancy, all with potential long-term health consequences for their

developing baby (Donkin & Marmot, 2018). Having greater understanding of these risky behaviours as coping mechanisms, developing a nonjudgemental approach, and being supportive of behaviour change strategies would add value to the parent-and-child role. In addition, research has shown that parents seeing their baby as a person with a mind of their own (often referred to as “mind-mindedness”) during pregnancy predicts the quality of the postbirth relationship (Barlow, 2017). Carers with this knowledge could maximize on repeated gentle opportunities afforded by the role and make appropriate referrals to interventions such as Mellow Bumps (Puckering, 2018).

In the absence of other sources of support, carers may be present at births, and this presents significant risks to both women if the carer lacks understanding of a woman’s needs in labour, has unresolved trauma associated with her own births, or is unprepared for the advocacy that the role engenders. Simple training with opportunities for reflection with peers would enable carers to both provide more sensitive support and advocacy, and mitigate risks to themselves associated with previous birth experiences, either by declining the role and making alternative arrangements or by resolving issues through reflection and therapeutic support.

4.4.2 | Attachment and parenting

Poor attachment is an intergenerational phenomenon; infants of mothers without secure attachments themselves are at higher risk of insecure attachments. Therapies to address attachment difficulties give opportunities for parents to observe, understand, and interpret their child’s behaviour and to reflect on the origin and impact of their reactions and responses to their child’s needs (Barlow, 2016). In this current study, several carers had advocated strongly for parent–infant psychotherapy but perceived this to be discouraged by the LA, who had “already decided” to remove the child prior to the placement, and described how advocating for therapeutic support had required them to “put their head above the parapet.”

4.4.3 | Breastfeeding and other postnatal support

Breastfeeding confers a lifetime of health benefits yet only 56% of mothers aged under 20 initiated breastfeeding in 2010, compared with 87% of those aged 30 or more (McAndrew et al., 2010). A key success criterion is the support of a partner or close family members, a concept described as “breastfeeding teamwork” (Abbass-Dick & Dennis, 2018). Most mothers in parent-and-child placements have very limited access to this family-based support and should therefore expect it from the carer. However, her ability to fulfil this role is purely one of chance, with no additional training provided, and due to the common perception that the carer should not share baby care with the mother because “she will have to manage by herself when she leaves”; the practical support that all other new mothers are encouraged to take up may not be forthcoming. A further barrier is the prohibition of cosleeping. Whereas other mothers make informed choices

based on their beliefs and risk factors, for women in parent-and-child placements, bedsharing is immediately seen as a safeguarding issue. It is unsurprising that these exhausted women often stop breastfeeding prematurely.

4.4.4 | Perinatal mental health

The impact of perinatal mental health problems on the developing fetus and child is well established, with lasting effects on behavioural, intellectual, and social development (Glover, 2014). Risks are high for mothers in parent-and-child placements. For example, around 60% of looked-after children have some level of emotional and mental health problem (NICE, 2010) and around 40% of teenage mothers suffer from postnatal depression (DfES, 2010). Recognition of these risks should mean that support from a knowledgeable, sensitive carer is a basic requirement for parent-and-child placements.

4.4.5 | Domestic abuse

Some women in parent-and-child placements have been in an intimate relationship that puts their child at risk of significant harm. The placement provides an opportunity to reflect on the abuse and develop strategies to reduce these risks in the future, giving space to envisage a different way of living. This study included examples of several women who had attended empowering groups such as the Freedom programme (Craven, 2008), who acknowledged for the first time that their relationship was abusive. Carers would benefit from a better understanding of how women can be supported to recognize and leave abusive relationships.

4.4.6 | Working with mothers with learning disabilities and autism

Many carers in the study had looked after mothers with a learning disability or autism. In 2008, 12.5% of parents in care proceedings in England and Wales had learning disabilities (Masson, Pearce, & Bader, 2008). These mothers often struggle to understand abstract concepts, feel alienated by resources relying on literacy, and find organizing routines challenging. They are faced with negative stereotypes and a public and professional perception that they cannot learn to parent (Tarleton, Ward, & Howarth, 2006). Spending several months with a knowledgeable carer working on new skills would be a clear advantage to these parents, because even when a decision is made for alternative care, the parent-child relationship often persists.

4.4.7 | Working with fathers and couples

Within the research into parent-and-child foster care, the voice of fathers is largely absent, and this was the case in this study. This might

lead to the assumption that a father in a foster placement is very rare. However in this study, eight foster carers (25%) had had fathers placed with them, three of whom were placed alone. They all talked about feeling unprepared for this scenario. Where couples were placed, there were additional issues around privacy and having four adults in the house. On the other hand, in scenarios where a mother was struggling with parenting but had a supportive partner not in the placement, foster carers felt frustrated that the father's strengths were not being taken into consideration as part of the assessment. Further research is needed into the experiences of fathers in foster care.

4.4.8 | When a baby is removed

Recent research has done much to highlight the issue of mothers who have their babies removed into state care (Broadhurst et al., 2018). Despite recommendations by family court judges for therapeutic interventions post removal to address underlying issues, these rarely materialize, and grief-stricken mothers typically use their risky behaviours to cope with their grief, increasing their chances of future pregnancies resulting in removal at an earlier stage. Amongst factors that made the removal of a subsequent baby less likely is a consistent and supportive adult relationship (Broadhurst & Mason, 2017). Initiatives such as PAUSE (Humphreys, 2018) have built on this finding, providing relational support for around 18 to 24 months to women who commit to the use of long-acting contraceptives during this period.

A parent-and-child placement provides an opportunity for a relationship with a stable, loving adult, possibly for the first time in a parent's life. Indeed, a policy shift of starting parent-and-child placements in pregnancy to give women who are at risk of removal more time to address their difficulties emerges as a strong recommendation. In this study, relationships between the mother and carer often continued informally after the placement had ended in removal; carers were often incredulous that the only support the mother received post removal was from the carer herself. This issue needs to be addressed more systemically than simply training parent-and-child carers. However, at the very least, there should be opportunity for reflection and for thinking through strategies around life story work for both the mother and baby as they move on.

In summary, parent-and-child placements are currently a lottery. It is chance alone that determines the quality of the relationship and the input that parents receive. With no recognized minimum requirement for training, carers themselves may need to source training that will equip them to do the job they want to do, providing a supportive, informed, and therapeutic environment to nurture parent-infant relationships that have floundered, due primarily to the effects of poverty and intergenerational maltreatment. They want to play their part in breaking cycles of abuse, but this unique role is not often recognized in terms of the additional skills, training, or support that it requires. Some of the issues identified require systemic change: the lack of support for parents when the placement ends, delayed prebirth planning meetings that result in a new mother having to move in with total

strangers straight after birth, the lack of professional therapeutic support for these carers, and the blinkered focus on the child in isolation from family ties (Featherstone, White, & Morris, 2014). This study has identified the nature and content of additional training and support needed for parent-and-child carers and makes additional wider policy recommendations.

4.5 | Limitations and strengths of the study

The main limitation to this study was the inherent responder bias; those carers who participated were more likely to be interested in personal development and research as they were prepared to travel to and participate in focus groups. It could be argued, however, that the twelve carers who cared for the eight mothers interviewed were more representative. Of this group (who, it must be remembered, were not participants), four were subjectively viewed by mothers to be particularly poor in terms of their communication style and understanding of the mother's needs and feelings. Indeed, the information disclosed during one mother's interview prompted a safeguarding referral that led to the mother and baby being removed from the placement. There was also the possibility of responder bias with the recruitment of mothers; recruitment was through the first author's professional network, and it is possible that mothers who agreed to participate were motivated by a desire to be heard about a particularly negative experience. Another potential limitation was that the most successful strategy for carer recruitment was via social media, suggesting a preference towards social media-based support and online learning. However, for several of the focus groups, there was one carer who had seen the information on social media and had invited others who were not necessarily interested in social media, mitigating this potential bias.

Notwithstanding these potential limitations, the findings from this study give rise to a number of recommendations for practice in this area.

4.6 | Recommendations

This publication has focussed on upskilling the current fostering workforce. An accessible, online learning resource that could also be used to bring guided reflection into group supervision, and the development of online peer support could improve the quality of this specialist role, with the ultimate aim of improving the experiences of the parents and children in these placements.

However, a number of additional recommendations for best practice have emerged:

- Early prebirth assessment, plan, and placement
- Careful consideration of a woman's birth plan
- Where at all possible, parent and carer to meet before placement starts
- Normal support of a new mother not being withheld
- Provision for settling-in time before parenting assessment starts, with clear expectations and time frame
- Logs shared with the parent, giving opportunity for discussion
- An emphasis on life story work, especially where baby is likely to be removed
- Appropriate referrals made for therapeutic input for parent or parent–infant dyad
- Care for the carer; having available professional therapeutic support for parent-and-child carers

5 | CONCLUSION

Specialist training for the parent-and-child fostering role is not ubiquitous. Where it exists, it appears to prioritize skills such as observation and recording, with less on perinatal physical and mental health, or promoting attachment and sensitive parenting for those with difficult personal histories. A new, freely available online learning resource (www.fosteringhope.co.uk) has been developed to contribute to addressing this deficit, with embedded reflection tools and group learning opportunities within the material.

The parent-and-child role brings a unique set of rewards, challenges, and stresses; carers highly value peer support but struggle to attend physical groups. Social media groups are currently aimed at generic carers, providing information, advice, and emotional support. A new closed Facebook group has recently been established as an output of this research.⁵

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ENDNOTES

- ¹ Throughout this document, the term “carer” refers to foster carers.
- ² Although the term parent-and-child “arrangements” is now used to acknowledge that these may not be “placements” in the legal sense, “placements” is the term commonly used in the field.
- ³ Throughout, the term “social worker” is referring to “supervising social worker.”
- ⁴ This quote is part of a supplementary case study.
- ⁵ The Fosteringhope closed group can be found and accessed through the Fosteringhope website.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section at the end of this article.

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