National Institute for Health and Care Excellence

Draft for consultation

Looked-After Children and Young People (update)

[A] Evidence review for interventions to support care placement stability for looked-after children and young people

NICE guideline NGXXX

Evidence reviews underpinning recommendations 1.3.4 to 1.3.6 and 1.3.8 to 1.3.12 in NICE guideline NGXXX

April 2021

Draft for consultation

These evidence reviews were developed by NICE Guideline Updates Team

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Interventions to support care placement stability in looked-after children and young people

Review question

1.1a What is the effectiveness of health and social care interventions and approaches to support care placement stability?

1.1b Are interventions to support placement stability acceptable and accessible to looked-after children and their care providers? What are the barriers to, and facilitators for the effectiveness of interventions to support placement stability?

Introduction

This review will consider interventions to support placement stability in children and young people who are looked after. In March 2018, 75,420 children and young people in England were looked after. Care placements for looked after children and young people may include: foster placement (73%), residential accommodation (including secure units, children's homes, and semi-independent living arrangements) (11%), placement with birth parents (6%), placement for prospective adoption (3%), another placement in the community (4%), or placement in residential schools or other residential settings (3%). For looked after children and young people only 29% of placements are long term and 50% of long-term teenage placements have been found to break down. Placement break-down is associated with poor outcomes for looked-after children and young people. Interventions that support placement stability in looked-after children could help to improve a wide range of outcomes including educational, relational, and physical, mental, and emotional health and wellbeing.

Local authorities may use interventions to support placements (for example, parent training) in looked after children and young people, however there is uncertainty about which specific interventions work. The (2010) NICE guideline for looked-after children and young people did not include recommendations on specific interventions to support placement stability. A NICE surveillance review found new evidence that indicated recommendations on interventions to support placement stability in looked-after children might be needed.

Summary of protocol

PICO table

Table 1: PICO for review on interventions to support care placement stability in looked-after children and young people

Population	Looked after children and young people, wherever they are looked after, from birth until age 18 and their families and carers (including birth parents, connected carers, and prospective adoptive parents). Also including: • Children and young people living at home with birth parents but under a full or interim local authority care order and are subject to looked-after children and young people processes and statutory duties.

	- Children and young people in a prospective adoptive placement. - Looked-after children and young people on remand, detained in secure youth custody and those serving community orders.
Intervention	Health and social care interventions and approaches to support care placement stability. Including support for: children and young people themselves; birth families (with children and young people under a full care order); foster carers; key workers in residential care units; connected carers; prospective adopters; special guardians; and social care workers. Example interventions and approaches of interest, include: - Interventions to support care planning (e.g. to support transition between care placements; to support continuity of health and social care in new care placements; to prevent crisis situations) - Interventions for preparing a child or young person before entering care or changing placement (not including leaving care) - Approaches and interventions to improve education, information giving, advice, and signposting for carers or LACYP prior to, and during, care placement - Models of multi-agency care placement panel - Interventions to support kinship placements and connected care - Interventions to support keeping siblings together (e.g. supporting sibling relationships and considering the individual needs of siblings) - Interventions to support continuity of significant relationships (e.g. direct and indirect contact with trusted adults) - Interventions and approaches to support positive relationships between LACYP and carer (as relates to placement stability and excluding interventions for attachment disorders) - Mentoring interventions - Day visits and activity-based holidays
Comparator	Quantitative evidence Comparator may include standard care, waiting list, or another approach to support care placement stability
Outcomes	Quantitative evidence - Completion of care placement - Number of placements - Adverse events such as prematurely dropping out of a care placement, transitioning from one care situation to another, absconding, or re-entering previous care situation Qualitative evidence Qualitative evidence related to interventions to support placement stability will be examined. Evidence should relate to the views of looked after children, their carers, and providers who would deliver eligible interventions on: - The accessibility and acceptability of the intervention, including information about the source and type of intervention used. - Barriers to and facilitators for intervention effectiveness in supporting placement stability.

1 ## SPIDER table

2 **Table 2: SPIDER table for review on interventions to support care placement stability**
3 **in looked-after children and young people**

Sample	Looked after children and young people, wherever they are looked after, from birth until age 18 and their families and carers (including birth parents, connected carers, and prospective adoptive parents). Also including: • Children and young people living at home with birth parents but under a full or interim local authority care order and are subject to looked-after children and young people processes and statutory duties. • Children and young people in a prospective adoptive placement. • Looked-after children and young people on remand, detained in secure youth custody and those serving community orders.
Phenomenon of Interest	• Health and social care interventions and approaches to support care placement stability
Design	• Including focus groups and interview-based studies (mixed-methods studies will also be included provided they contain relevant qualitative data).
Evaluation	Evidence should relate to the views of looked after children, their carers, and providers, who would deliver eligible interventions, on: • The accessibility and acceptability of the intervention, including information about the source and type of intervention used. • Barriers to and facilitators for intervention effectiveness in supporting placement stability.
Research type	Qualitative and mixed methods
Search date	1990
Exclusion criteria	• Mixed-methods studies reporting qualitative data that cannot be distinguished from quantitative data. • Countries outside of the UK (unless evidence concerns an intervention which has been shown to be effective in reviewed quantitative evidence) • Studies older than the year 2010 (unless not enough evidence, then progress to include studies between 1990 to current)

4 ## Methods and process

5 This evidence review was developed using the methods and process described in
6 Developing NICE guidelines: the manual. For further details of the methods used see
7 Appendix N. Methods specific to this review question are described in this section and in the
8 review protocol in Appendix A.

9 The search strategies for this review (and across the entire guideline) are detailed in
10 Appendix B.

11 Declarations of interest were recorded according to NICE's 2018 conflicts of interest policy.

Effectiveness evidence

Included studies

The search for this review was part of a broader search for the whole guideline. After removing duplicates, a total of 36,866 studies were identified from the search. After screening these references based on their titles and abstracts, 181 studies were obtained and reviewed against the inclusion criteria as described in the review protocol for interventions to support placement stability (Appendix A). Overall, 25 studies, reporting on 21 original studies, were included. 156 references were excluded because they did not meet the eligibility criteria.

The evidence consisted of 13 randomised controlled trials, and 8 qualitative studies. See the table below for a summary of included studies. For the full evidence tables, see Appendix D. The full references of included studies are given in the reference section of this chapter. These articles considered 11 different interventions to support placement stability in school-aged looked-after children.

Excluded studies

See Appendix J for a list of references for excluded studies, with reasons for exclusion.

1

2 ## Summary of included studies

3 ### Quantitative Evidence

4 ***Table 3: Summary of included quantitative studies***

Study (country – study design)	LACYP population	Intervention	Comparator	Number of patients who completed study	Outcomes reported (follow up f/u)
Akin 2015 (USA - RCT)	Foster care, children identified as having serious emotional disturbance (aged 3 to 16 years)	Parent Management Training-Oregon (PMTO)	Care as Usual (CAU)	PMTO: 78 WL: 43	Placement instability rate (number of placement/days in foster care over 6 months observation)
Bergstrom 2016 (Sweden - RCT)	Out-of-home care meeting diagnostic criteria for conduct disorder (aged 12 to 17 years)	Multi-dimensional Treatment Foster Care for adolescents (MTFC-A)	CAU	MTFC-A: 19 CAU: 27	Number of out-of-home placements (1-year/3-year follow up) Negative treatment exit (1-year/3-year follow up)
Berzin 2008 (USA - RCT)	Foster or Kinship care at risk of placement moves/placement in higher level of care (aged 2 to 12 years)	Family Group Decision Making (FGDM)	CAU	FGDM: 31 CAU: 19	Mean number of placement moves (assessed over a 5-year period)
Fisher 2011 (USA - RCT)	Entering new foster care placement (aged 3 to 6 years)	Multi-dimensional Treatment Foster Care for preschoolers (MTFC-P)	CAU	MTFC-P: 57 CAU: 60	Time to placement disruption (over 12 months) Number of children who experienced placement disruption (over 12 months follow up) Number of placement disruptions (over 12 month follow-up)
Kim 2011/Kim 2013 (USA- RCT)	Girls in foster care in the final year of elementary school	Middle School Success (MSS)	CAU	MSS: 48 CAU: 52	Number of placement changes (over 36 months)
Landsman 2014/2016 (USA- RCT)	Foster care (aged 0 to 17)	Family Finding Intervention (FFI)	CAU	FFI: 130 CAU: 123	Number of placement changes (over 3-year observation period)

Study (country – study design)	LACYP population	Intervention	Comparator	Number of patients who completed study	Outcomes reported (follow up f/u)
Maaskant 2017 (Netherlands - RCT)	Foster children with emotional or behavioural problems (4 to 11 years)	Parent Management Training Oregon (PMTO)	CAU	PMTO: 30 CAU: 33	Number of placement breakdowns (four-month follow up)
Macdonald 2005 (UK – RCT)	Foster care (no age restrictions)	CBT-informed Parent training programme (CBT-PTP)	Wait list (WL)	CBT-PTP: 67 WL: 50	Number of unplanned breakdowns of placement (6-month follow up)
Pasalich 2016/Spieker 2014 (USA – RCT)	Foster Care 1-3 grades behind (age 14 or older)	Promoting First Relationships (PFR)	Early Education Support (EES)	PFR: 105 EES: 105	Number of placement changes (2-year follow up)
Price 2008 (USA - RCT)	Foster care new placement (age 5 to 12 years)	KEEP foster parent training (KEEP)	Training as Usual (TAU)	KEEP: 359 TAU: 341	Negative exits from care (over 6.5 month follow up) Number experiencing no change over follow up (over 6.5 month follow up)
Taussig 2012 (USA - RCT)	Placed in foster care due to maltreatment in the prior year (no age restrictions)	Fostering Healthy Futures (FHF)	CAU	FHF: 56 CAU: 54	Incidence of placement change (over 18-month observation period) Negative placement change (over 18-month observation period)
Van Holen 2017 (Belgium - RCT)	Foster parents with new foster children with long-term perspective and behavioural problems (3 to 12 years)	Social learning theory-based training (SLT)	CAU	SLT: 30 CAU: 33	Breakdown in placement (3 month follow up)
Van Holen 2018 (Belgium – RCT)	Foster-care placements with a long-term perspective (>1 year) and children with behavioural problems (children aged between 6 and 18)	Non-Violent Resistance training (NVR)	CAU	NVR = 31 CAU = 31	Breakdown in placement (3 month follow up)

1 **Qualitative Evidence**

2 ***Table 4: Summary of included qualitative studies***

Study (country)	Intervention	LACYP population (age)	Setting and context	Type of analysis	Perspectives (n)
Akin 2014 (USA)	Parent Management Training Oregon	Project partners defined the target population as families of children in foster care with serious emotional and behavioural problems. (age of looked after children not reported)	Kansas. Kansas Intensive Permanency Project (KIPP). KIPP was one of six cooperative agreements in the federal Permanency Innovations Initiative (PII), which sought to reduce long-term foster care and improve permanency outcomes.	Interviews by phone. Semi-structured. Topics included 1) practitioner background, 2) EBI training, 3) EBI coaching, 4) EBI practice with families, 5) family's response to the EBI, and 6) administrative and organizational supports. Theoretical thematic analysis was performed using multiple analysts.	Practitioners involved with delivering Parent Management Training Oregon (30).
Augsberger 2014 (USA)	Family Team Conferencing	Youth involved in permanency planning conferences (aged 18 – 21)	Two foster care agencies in a large urban area.	Post-observation semi-structured interviews with foster care youth and post-observation interviews with conference facilitators. Thematic analysis, multiple analysts, triangulation, member checking, and peer debriefing was used.	Foster care youth (18) and conference facilitators (10)
Castellanos-Brown 2010 (USA)	Treatment Foster Care	Youth transitioning from group settings (age not reported)	A private social service agency serving youth from several public systems, including child welfare, mental health, and juvenile justice.	Semi-structured interviews with thematic analysis. Multiple analysts were used.	Treatment foster care parents (22)
Frederico 2017 (Australia)	Treatment Foster Care (the Circle Programme)	"Traumatised" children allocated to the Circle Programme (Treatment Foster Care) (Age not reported)	a Therapeutic Foster Care Program introduced in Victoria, Australia	Case-assessments focus group interviews, and interviews with therapeutic specialists. Focus groups were mixed groups including therapeutic foster carers and generalist foster carers, foster	Therapeutic foster carers and generalist foster carers, foster care workers and therapeutic specialists (43)

Study (country)	Intervention	LACYP population (age)	Setting and context	Type of analysis	Perspectives (n)
				care workers and therapeutic specialists. Thematic analysis was used.	
Kirton 2011 (UK)	Multidimensional Treatment Foster Care (MTFC)	Looked after children involved with an evaluation of multidimensional treatment foster care (most were aged 13 or older)	Local evaluation of MTFC within one of the pilot local authorities.	Semi-structured interviews. Unclear how data was analysed).	Foster carers (8), children's social workers (6), supervising social workers (2), individual therapists, birth family therapists, skills workers (3), social work assistants, programme supervisor (1), programme manager (1), members of the management board (4)
McMillen 2015 (USA)	Treatment Foster Care for Older Youth	Older foster care youth with psychiatric problems who had been hospitalized for psychiatric illness in the past year or were receiving psychotropic medications (aged 16 to 18 years old)	Part of a pilot RCT for Treatment Foster Care.	Semi-structured interviews. Sample questions and prompts with youth included the following. “Tell me about your experience with this part of the program.” “What do you like about it?” “What do you not like about it?” “What could be done differently to make this part of the program better?” Foster parents were asked about successes, how the provided training helped or did not help them foster the youth in their home, what things the staff did that were found to be helpful and what could be done differently to make the program better? Thematic analysis was used	Youth randomised to TFC (7), matched youth who were followed after care as usual (7), Foster parents, life skills coach,
Lee 2020* (USA)	Treatment Foster Care	Looked after persons in Treatment Foster Care	A project in the USA focused on building collaborative relationships	Semi structured interviews. The semi-structured interview protocol was focused on the	Professionals with significant practice and

Study (country)	Intervention	LACYP population (age)	Setting and context	Type of analysis	Perspectives (n)
			between mental health therapists and child welfare workers.	current landscape of TFC practice, the competencies needed by TFC parents, and innovations or best practices in providing training to TFC parents. Thematic analysis was performed by two researchers. Respondent validation was performed.	administrative experience in TFC (11) University-based researchers (7) Experts primarily knowledgeable about best practices in training and knowledge transfer in child welfare (5)
Tullberg 2019* (USA)	Treatment Foster Care	Looked after persons in Treatment Foster Care	New York City Atlas Project TFC programs	Focus groups were loosely guided by a semi-structured protocol designed to elicit feedback from participants in three broad topic areas: (1) relationships and communication with foster care agency staff; (2) tools and training; and (3) mental health services and clinical care. To ensure rigor, two authors independently reviewed content and reached agreement via discussion on the major themes.	Treatment Foster Carers (75)

1 See Appendix D for full evidence tables

Summary of the evidence

Quantitative evidence

Evidence from 17 studies (and 13 original RCT studies) considered the effectiveness of interventions to support placement stability in looked-after children and young people.

Table 5: Summary GRADE table (Parent Management Training Oregon (PMTO) vs Care as Usual (CAU)) (Akin 2015/Maaskant 2017)

Outcome	Sample size	Effect size (95% CI)	Quality	Interpretation of effect
Placement instability rate over 6-month observation (assessed using administrative data, annualised placement rate = (number of placements/days in foster care)*365))	121	**MD -0.30 (-0.60 to -0.00)**	Very Low	**Effect favours intervention group but may be less than the MID**
Number of Placement breakdowns over 4-month follow up (unclear how assessed)	88	OR 0.52 (0.09 to 3.06)	Very Low	Could not differentiate

Table 6: Summary GRADE table (Multi-dimensional Treatment Foster Care for adolescents (MTFC-A) vs CAU) (Bergstrom 2016)

Outcome	Sample size	Effect size (95% CI)	Quality	Interpretation of effect
Number of out-of-home placements at 1-year follow up (changes in out-of-home placement e.g., foster home or residential care - excerpted data from social case record)	46	MD -0.10 (-0.54 to 0.34	Very Low	Could not differentiate
Number of out-of-home placements at 3-years follow up (assessed as above)	46	MD -0.30 (-1.64 to 1.04)	Very Low	Could not differentiate
Negative treatment exit at 1-year follow up (placement breakdown or exiting a minor treatment facility to enter a more secure one e.g., leaving foster care and entering institutional care - excerpted data from social case record)	46	OR 0.24 (0.04 to 1.25)	Very Low	Could not differentiate
Negative treatment exit at 3-years follow up (assessed as above)	46	OR 0.78 (0.24 to 2.56)	Very Low	Could not differentiate

Table 7: Summary GRADE table (Family Group Decision Making (FGDM) vs CAU) (Berzin 2008)

Outcome	Sample size	Effect size (95% CI)	Quality	Interpretation of effect[a]
Mean number of placement moves over 5-year observation period (mean number of placement moves – administrative records)	50	MD -0.01 (-0.84 to 0.82)	Very low	Could not differentiate

1

2 3 ***Table 8: Summary GRADE table (Multi-dimensional Treatment Foster Care for preschoolers (MTFC-P) vs CAU) (Fisher 2011)***

Outcome	Sample size	Effect size (95% CI)	Quality	Interpretation of effect[a]
Time to placement disruption over 12 months (placement disruption defined as exiting the current placement for a negative reason e.g. removal deemed in the best interest of the child or requested by the caregiver. Not including nonnegative reasons for placement disruptions e.g. changing circumstances in the home unrelated to child behavior, clinical transitions, permanent foster placements, adoptions, and biological family reunifications- placement records from child welfare system).	137	MD -0.63 (-1.85 to 0.59)	Low	Could not differentiate
Number of children who experienced placement disruption over 12 months (assessed as above)	137	OR 0.53 (0.18 to 1.61)	Very Low	Could not differentiate
Number of placement disruptions over 12 months (assessed as above)	137	MD 0.00 (-0.11 to 0.11)	Moderate	**No meaningful difference**

4 ***Table 9: Summary GRADE table (Middle School Success (MSS) vs CAU) (Kim 2011/2013)***

Outcome	Sample size	Effect size (95% CI)	Quality	Interpretation of effect[a]
Number of placement changes over 36 months (placement disruptions assessed using child welfare system records)	100	MD -0.43 (-0.94 to 0.08)	Very Low	Could not differentiate

5 6 ***Table 10: Summary GRADE table (Family Finding Intervention (FFI) vs CAU) (Landsman 2014/2016)***

Outcome	Sample size	Effect size (95% CI)	Quality	Interpretation of effect[a]
Number of placement breakdowns over 3 year observation period (placement disruptions assessed using case records and administrated data)	243	MD -0.08 (-0.67 to 0.51)	Very Low	**No meaningful difference**

7 8 ***Table 11: Summary GRADE table (CBT-informed Parent Training Programme (CBT-PTP) vs CAU (Macdonald 2005)***

Outcome	Sample size	Effect size (95% CI)	Quality	Interpretation of effect[a]
Number of unplanned placement breakdowns over 6 months (caregiver-reported number of unplanned breakdowns)	89	OR 0.80 (0.19 to 3.42)	Very Low	Could not differentiate

1 2 ***Table 12: Summary GRADE table (Promoting First Relationships (PFR) vs Early Education Support (EES)) (Pasalich 2016/Spieker 2014)***

Outcome	Sample size	Effect size (95% CI)	Quality	Interpretation of effect[a]
Placement stability at 2 years (remained with the study caregiver with no temporary intermediate moves- child welfare administrative database)	210	OR 1.19 (0.63 to 2.27)	Very Low	Could not differentiate

3 4 ***Table 13: Summary GRADE table (KEEP foster parent training (KEEP) vs Training As Usual (TAU)) (Price 2008)***

Outcome	Sample size	Effect size (95% CI)	Quality	Interpretation of effect[a]
Negative exits from care over 6.5 months (foster-parent reported negative reasons for the child's exit from the home e.g. moved to another foster placement, a more restrictive placement, or child runaways)	700	OR 0.83 (0.54 to 1.29)	Very Low	Could not differentiate
Number experiencing no change over 6.5 months (foster parent reported no change in placement)	700	OR 0.73 (0.52 to 1.03)	Very Low	Could not differentiate

5 6 ***Table 14: Summary GRADE table (Fostering Healthy Futures (FHF) vs CAU) (Taussig 2012)***

Outcome	Sample size	Effect size (95% CI)	Quality	Interpretation of effect[a]
Incidence of placement change over 18-month observation period (change in placement – assessed using administrative records)	156	OR 0.68 (0.40 to 1.16)	Very Low	Could not differentiate
Negative placement change over 18-month observation period (new placement in a residential treatment centre – assessed using administrative records)	156	**OR 0.29 (95%CI 0.09 to 0.98)**	Very Low	**Effect favours intervention group but may be less than the MID**

7 8 ***Table 15: Summary GRADE table (Social Learning Theory-based Training (SLT) vs CAU) (Van Holen 2017)***

Outcome	Sample size	Effect size (95% CI)	Quality	Interpretation of effect[a]
Breakdown in placement over 3 months (Temporary (e.g. short stay at child psychiatric unit) or permanent (move to other care) breakdown over follow up – foster care worker reported)	63	OR 0.52 (0.09 to 3.06)	Very Low	Could not differentiate

9 ***Table 16: Summary GRADE table (Non-Violent Resistance vs CAU) (Van Holen 2018)***

Outcome	Sample size	Effect size (95% CI)	Quality	Interpretation of effect[a]
Breakdown in placement over 3 months: foster-carer reported (unclear how defined)	62	OR 0.77 [0.19, 3.19]	Very Low	Could not differentiate

10 11 12 *(a) No meaningful difference: crosses line of no effect but not line of MID; Could not differentiate: crosses line of no effect and line of MID; May favour: confidence intervals do not cross line of no effect but cross MID; Favours: confidence intervals do not cross line of no effect or MID*

1 See appendix F for full GRADE tables.

1

2 **Qualitative evidence**

3 ***Table 17: Summary CERQual table (Experience of practitioners delivering Parent Management Training Oregon)***

Themes	illustrative quotes	Studies	CERQual concerns	CERQual explanation
Benefits to therapeutic practice (practitioners) All participants reported that PMTO benefited their therapeutic practice. Most of them noticed that after PMTO training, they were more hopeful and strengths-oriented, even becoming aware of their own strengths. Specific improvements involved being: a better listener, less confrontational, more insightful and "in the moment," more active and "hands-on," more agenda-driven in sessions, and more conscious of time restrictions. Other participants asserted that they had better relationships with clients, understood that silence can be useful, improved their teaching skills, and learned to problem-solve with parents, not for parents. Many respondents felt satisfied with the results as they applied PMTO in their practice.	*"I'm more agenda-driven, which is extremely effective and helpful. I feel like I was always strength-based but I'm even more strength-based now…I do more encouragement and more praise so that has been extremely helpful. I'm more planful in my sessions. I come to a session ready with activities, ready to go."*	**1** Akin 2014	ML: No concerns C: Minor concerns A: Serious concerns R: Minor concerns **Overall: Very Low**	Only 1 study contributed to this theme. Study from outside of the UK. Theme covered several ways in which PMTO had improved their practice.
Barriers to applying the PMTO model in clinical practice (practitioners) A few participants had no previous clinical experience, whereas a couple of participants mentioned that they initially had to navigate their education and clinical experience with PMTO. They noted that PMTO training poses challenges to experienced therapists, as it emphasizes self-reflection and continual professional growth. This	*"I believe I was set up for success with putting this into practice through the trainings that we received and the way the trainings were delivered. Of course, there was some anxiety, like normal, put something new into practice that you're not a hundred percent trained in yet. But I definitely feel even my first session with my first family I was more prepared and had direction and structure than I*	**1** Akin 2014	ML: No concerns C: No concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Study from outside of the UK.

training process, however, changed these participants' practice style and revealed areas for growth.	*had in my past."*			
Customisability of the intervention (practitioners) Gaining experience in using PMTO with families contributed to practitioners' comfort with the model. A couple of practitioners struggled with using role-plays and some families disliked them, whereas a majority reported that roleplays were readily applied in the practice setting. Giving directions, active listening, and limit setting were among the most straightforward and uncomplicated topics to implement. Most participants reported that they could customize PMTO to match each family's needs, staying true to the model. A minority of respondents initially considered the model rigid and difficult to adapt and noted that coaching facilitated this adaptation.	*"Well, you're just able to customize it for each family, without straying from the model. I mean, I don't know, the way you're able to work with the families, you're able to take their specific situation and specific things that their kids are doing and going through…"*	**1** Akin 2014	ML: No concerns C: Minor concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Study from outside of the UK. Some inconsistency with a minority of participants finding PMTO to be a rigid model of care.
Response by targetted families (practitioners) According to participants, most families responded positively to PMTO. PMTO's powerful effect was evident in the rapid improvement that families experienced, even if it was small. Even though some families felt skeptical at first, their confidence increased as they used the skills and advocated for themselves. A couple of participants noted that families recommended PMTO to everyone, even teaching PMTO skills to friends, and that teenagers reported better communication with their parents. Family response was	*"The five-to-one ratio, fives positives to one negative…that's a huge cultural shift for us…[P]arents are seeing, you know, they're having a lot less stress when they are not focusing on all the negative stuff. They can focus on some positive things, tell their kids that they are doing a good job. The kids feel like they are being loved and accepted by their parents. So they are less rebellious. Their acting out is a lot less, you know, because they are*	**1** Akin 2014	ML: No concerns C: No concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Study from outside of the UK.

more positive when practitioners got further into the PMTO curriculum.	*not trying to get any kind of attention from their parents. I mean they are getting positive attention from their parents because their parents are focusing on that; and, so, they don't have to act out and get that other kind of attention."*			
Barriers to effectiveness (practitioners) Family response depended on parents' cognitive skills, functioning level, and willingness to try PMTO strategies. Some families learned PMTO skills quickly, others took longer, and some did not get them. Practitioners reported that adapting PMTO was more challenging with families with single dads, with more children, and with children with complex needs, such as blind or non-verbal autistic children. Less than a third of the participants reported having challenges adapting PMTO to the unique needs of families, including grief, domestic violence, sexual abuse, parental mental health issues, and parental substance abuse. Delivering PMTO was difficult with parents with mental health and substance abuse issues, who were purportedly more likely to dropout from treatment. However, a couple of participants clarified that these issues are indirectly addressed by PMTO; families who faced multiple contextual factors required harder work.	*"…I've even had some families who really, kind of, were dragging their feet, I mean, like, with the role-plays and stuff; but, as it went on, they were able to see that it has worked pretty well within their family, so they've been able to follow through with it."*	**1** Akin 2014	ML: No concerns C: No concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Study from outside of the UK. Theme covered several different barriers to the effectiveness of PMTO.
Organisational Facilitators (practitioners) Important were supportive leadership and reasonable work expectations. Participants also expressed appreciation for collaborative processes, quick turnaround on questions, and work climates that were	*: "…they've been really good at working with us and making sure that we have the resources to be able to get there and that we have the time, and making sure that we are not overworked, but still able to meet what we are needing to do."*	**1** Akin 2014	ML: No concerns C: Minor concerns A: Serious concerns R: Minor concerns	Only 1 study contributed to this theme. Study from outside of the UK. Theme covered several different organisational

safe for "trial and learn. Key organizational supports included not rushing participants through training; sharing information quickly and continuously; making sure that staff were not overworked; carefully coordinating changes when there were staff shortages; and providing the structure, materials, and logistics for implementation. Advantages were also realized through effective communications and organizational structures that promoted peer support, teamwork, and collaboration. Some practitioners pointed to the helpfulness of fluid and effective communication throughout the implementation process; they felt their voices were heard by their agencies, describing how their agencies "listened" when participants had questions, frustrations, anxiety, or stress.	*"When you're adopting and implementing, I think it's all so new territory… I just feel like our agency leadership has done everything they possibly could to make this work…being supportive, being there, answering questions as they can and as fast as they can to get back with us."* *: "…I personally feel like my agency does a really good job, and specific people here do a really good job of making sure to keep us informed of what's going on. And, I think that that has really helped in our implementation of the model. For example, we hear your concerns, and then hearing that it's going up the chain."*		**Overall:** **Very Low**	facilitators to the effectiveness of PMTO.
Organisational Barriers (practitioners) Less than a third of the participants felt that they received inadequate support, resources, and encouragement from their agencies. A few of them described challenges associated with their agency's norms, policies, and centralization. Specific problems included lack of support from other staff, inability to use flexible work hours, transportation issues, heavy emphasis on paperwork, and indirect communication with trainers (e.g., not being allowed to directly ask questions to trainers). Indeed, a couple of participants felt as though the program was isolated in their agencies; they perceived resistance from other staff and had to advocate for clients within the agency due to conflicting practices or procedures (e.g., agency	*"I think there wasn't as much, there wasn't as much communication to the case managers what we were doing and what PMTO was. So there was some resistance from other agency staff members… I think better communication to them what was going on and the excitement that the upper management had could have been filtered all the way throughout the entire agency. It would've made things a little better for us."*	**1** Akin 2014	ML: No concerns C: Minor concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Study from outside of the UK. Theme covered several different organisational barriers to the effectiveness of PMTO.

practices regarding families affected by substance abuse). Others considered that the lack of support from the agency was associated with the lack of understanding of the intervention model. They felt that the agency administrators did not understand therapists' problems, such as the hassles and workload associated with uploading videos. Few respondents wondered whether their agencies knew what to do with the model; there was lack of agreement on how to use it within the agency and the organizational structures needed to reinforce it. These participants concluded that better internal communication from upper management would have helped to create a more accommodating climate and improved the implementation.				
Suggestions for organisations (practitioners) Do not be afraid of implementing new EBIs, select EBIs compatible with client needs, plan before implementing, have patience with the process, communicate excitement and information throughout the agency, share information timely, facilitate teamwork and collaboration among frontline staff, provide adequate working conditions, and listen to the struggles and suggestions of frontline practitioners.	No supportive quotes were reported for this theme	**1** Akin 2014	ML: No concerns C: Minor concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Study from outside of the UK. Theme covered several suggestions to organisations to facilitate the PMTO intervention
Stakeholder buy-in (practitioners) Participants recognized that stakeholder buy-in was a chief factor in successful implementation. In particular, the role of the court system was acknowledged: courts were supportive of the project because of the groundwork laid by agency administrators' efforts to reach out and educate them about PMTO. More	No supportive quotes were reported for this theme	**1** Akin 2014	ML: No concerns C: Minor concerns A: Serious concerns R: Minor concerns **Overall:**	Only 1 study contributed to this theme. Study from outside of the UK. Theme covered multiple important stakeholders.

frequent among participants' comments was an emphasis on the central role of case managers. They identified case managers as a major player whose backing and cooperation was essential.			**Very Low**	
Short timelines as a barrier to effectiveness of this intervention Timelines were pinpointed as major system-level challenges. The high demands placed on families by the child welfare system impacted their response to PMTO. First, when families started the program, parents were in shock because their children were in the system; they often felt angry and guilty, with a negative view of themselves as parents. Practitioners had to address those negative feelings that turned to displaced resentment Thus, practitioners recommended allowing families more time to get through the PMTO curriculum and learn the new parenting skills (i.e., longer than 6 months). Second, the mismatch between the time required by the child welfare system to attend to multiple case plan tasks and the time available for the family, creates frustrating barriers for families.	*"There's system time and then there is time in people's lives, and those times don't match up. And people get really frustrated with that understandably so."*	**1** Akin 2014	ML: No concerns C: No concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Study from outside of the UK.

1 ***Table 18: Summary CERQual table (Experience of foster care youth and conference facilitators undertaking Family Team Conferencing)***

Themes	illustrative quotes	Studies	CERQual concerns	CERQual explanation
The critical role of the facilitator A trained facilitator employed by the foster care agency facilitated the permanency planning family team conferences. Facilitators guided the team through each stage of Team Decision Making, including the introduction to the conference structure, ground rules and participants,	No supportive quotes were reported for this theme	**1** Ausberger 2014	ML: No concerns C: No concerns A: Serious concerns R: Minor concerns	Only 1 study contributed to this theme. Study from outside of the UK. Recruitment strategy and selection of participants was unclear. All

a discussion of youth strengths and concerns, brainstorming ideas to address the identified concerns, agreeing upon next steps, and developing an agreed upon service plan. The conferences followed a structured format however the facilitator played a critical role in positively engaging the young person in the decision-making process. The facilitation strategies employed to engage youth in decision making included: 1) creating a safe space, 2) encouraging the youth voice, 3) re-balancing power, and 4) establishing a personal connection. These strategies are described in depth with examples below.			**Overall:** **Very Low**	participants were over the age of 18 although family team conferencing happens at younger ages too.
Creating a safe space – addressing fears about breaking confidentiality A consistent theme identified throughout the youth interviews was the importance of adults respecting their privacy and confidentiality. In the context of the family team conference, it was important that the facilitator took time to thoroughly explain the parameters of privacy and the young person understood them. Since the information discussed in the conference was used for case planning purposes, the information was considered private but not confidential. One facilitator was observed telling the young person that the information in the conference would not come back and be detrimental to them afterwards. The facilitator explained that many youth in foster care are reluctant to open up and share information in the conference because they are afraid it will be used in negative or harmful manner. Her goal is to create a safe space where youth feel comfortable sharing information and engaging freely in the discussion. She explains the parameters of privacy, but also addresses their fears directly by emphasizing the collaborative nature of decision-making and informing them that no decisions will be made without their input and awareness.	No supportive quotes were reported for this theme	**1** Ausberger 2014	ML: Minor concerns C: No concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Study from outside of the UK. Recruitment strategy and selection of participants was unclear. All participants were over the age of 18 although family team conferencing happens at younger ages too.

Creating a safe and collaborative environment - trust building exercises - In addition to discussing the parameters of privacy, facilitators created a safe and collaborative environment by building trust among the conference participants. As illustrated in one conference the facilitator began by instructing each participant to write their name and relationship to the youth on a folded piece of cardboard, which she then placed on the table facing inward so everyone could view it. The facilitator then took the time to have each participant introduce themselves by their name and relationship to the youth. The note card visualization coupled with the verbal introduction highlighted the important role each participant played in supporting the youth in the decision-making process.	No supportive quotes were reported for this theme	**1** Ausberger 2014	ML: Minor concerns C: No concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Study from outside of the UK. Recruitment strategy and selection of participants was unclear. All participants were over the age of 18 although family team conferencing happens at younger ages too.
Encouraging the youth voice Another consistent theme in the youth interviews was the importance of having a voice in the family team conference. Youth wanted the opportunity to talk, be heard and have their perspective considered. The facilitator played an instrumental role in including youth in the conversation and making them feel like an equal member of the team. Facilitators used various engagement strategies including, verbal affirmations, non-verbal communication, everyday language, and humor. Facilitators used verbal affirmations to engage youth in the conference. For example, some facilitators used positive action words to describe the youth's behaviors such as successful, independent, consistent and diligent. The use of positive language when describing the youth's actions led youth to open up and engage in the discussion. They also encouraged other members of the group to focus on youth strengths, rather than deficits. Facilitators also used non-verbal communication to engage the youth in the discussion such as physical presence, maintaining eye contact, smiling, nodding, and stating, "uh hum" and "ok." Through the use of non-verbal communication, facilitators sent a message to the youth that they were physically present and interested in what	*one facilitator stated in the post-observation interview, when determining whether a youth has a permanent resource, rather than asking, "who are your permanent resources" she asks, "Who do you call when you get a really good grade or you got that job? Who do you call to share that with?" "So, every once in a while, I'll have to get into their world. So, they relate to things like, "Do you feel me?" You know, "Do you feel me? I'm tryin' to tell you somethin' very important." You know, we would say, "Do you understand," but the kids say, you know, "You feel me?" So, sometimes when I, when I can get there with him, you know, he smiles more. You know, he lets down a little bit more of a guard and, and it gets better. Two facilitators reported using humour to engage youth in the conference.*	**1** Ausberger 2014	ML: Minor concerns C: Minor concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Study from outside of the UK. Recruitment strategy and selection of participants was unclear. All participants were over the age of 18 although family team conferencing happens at younger ages too. Theme covered several aspects of practically encouraging the youth voice. Unclear the number of participants who agreed with each of these aspects.

the youth had to say. Facilitators used everyday language to communicate with the youth in the conference. Child welfare professionals often rely on professional jargon, which can create a divide between professionals and youth. Examples of such language include the use of codes, acronyms or technical language. In order to engage youth in the discussion, it was important to substitute professional jargon with more developmentally appropriate language.	*One facilitator noted that although it's not a topic addressed in training, humour makes a big difference in terms of working with and connecting to youth. ""I just try to make the conference like as, it's, for the teenagers, actually like as laid back as possible. Like I'll joke with them, tell jokes, whatever, to try to make it a little more laid back…"*			
Re-balancing power An important goal of the conference facilitator was to level the playing field so that all participants are provided the opportunity to speak, have their perspective heard, feel respected, and collaborate in the Team Decision Making process. Facilitators were responsible for managing power dynamics so youth and professionals were true collaborators, rather than the adults or professionals dominating the discussions. The idea of adults/professionals collaborating with youth in decision-making was novice and/or challenging for some participants. Therefore, it was the role of the facilitator to re-balance power when the adults were dominating the discussion. Facilitators accomplished this in multiple ways including keeping the focus on youth, seeking their perspective and advocating for their perspective. E.g. Several facilitators noted the importance of keeping the conference focused on the youth, including asking adults to remain quiet and/or re-directing the discussion when adults attempt to promote their views.	*The facilitator noted in the post-observation interview, "my role and my joy is to be able to turn it around and, as a facilitator, kind of quiet the rest down and say, 'Well, we know your opinion, you know, I know your opinion,' and keep redirecting it back to the youth." In the post-observation interview with the youth, she noted that the conference was "about me" and the facilitator "listened to me. That was good." Similarly, another youth praised her facilitator for shifting power dynamics to focus on her perspective. She said, "I feel like she's (facilitator) more concerned about what I have to say than anybody else in the room. Because, you know, plenty of times she stops the meeting and says, 'How come I only hear you all talk and I don't hear Monique? When we're here for her.'"*	**1** Ausberger 2014	ML: Minor concerns C: No concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Study from outside of the UK. Recruitment strategy and selection of participants was unclear. All participants were over the age of 18 although family team conferencing happens at younger ages too.

Brainstorming to support meeting goals Another re-balancing power strategy was to seek the youth perspective and brainstorm ways to assist them in meeting their planning goals. In one conference the youth reported an interest in obtaining employment in the medical field. The facilitator brainstormed the steps necessary to learn about educational and professional opportunities, and how other conference participants could support the young person in accomplishing this goal. Similarly, in another conference the youth reported that she wanted to graduate from high school. The facilitator responded positively by asking what she needed to do to graduate. The youth responded that she needed to go to class and said she was risking failing science. The facilitator probed further, asking about the specific steps the youth would take to pass science. The youth discussed steps she could take including, waking up on time and going to the makeup labs. The facilitator elaborated upon the discussion by focusing on concrete steps the youth can employ to pass her science class, including a discussion regarding how the foster parent and case planner could support the youth in getting up on time, getting on the bus and attending her science labs. These ideas were then documented in the action plan.	*the facilitator noted that foster care youth are often told what they can't do, but they need to be encouraged to accomplish their goals. She said, "So, he may have all these things he thinks but if somebody doesn't say, 'But you could do that. Of course, you can.' Then, I don't know if he even realizes that that's something I could even do." She went on to state, "It starts with a thought. "You hear what I said. Sit down and think about it. You got to think about it. Research it. Figure out how much it makes. Does it make enough for you? Do you want to go to school that long?" It starts with a thought."*	**1** Ausberger 2014	ML: Minor concerns C: No concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Study from outside of the UK. Recruitment strategy and selection of participants was unclear. All participants were over the age of 18 although family team conferencing happens at younger ages too.
Rebalancing power - advocacy Another important mechanism for re-balancing power was advocating for the youth perspective. At times this meant challenging the agency perspective and revealing potential agency missteps. For example, in a conference with a youth residing in a mother child residence, the youth complained that for the past two weekends when she came home from work the door to the facility was locked and she had to sit outside with her child for over an hour. The case planner attempted to place responsibility on the youth by saying that she needs to call the staff and notify them when she is coming home. In response, the youth reported she told the Assistant Manager of the residence that she will be home between 3:30 and 4 pm.	No supportive quote was reported for this theme	**1** Ausberger 2014	ML: Minor concerns C: No concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Study from outside of the UK. Recruitment strategy and selection of participants was unclear. All participants were over the age of 18 although family team conferencing happens at younger ages too.

The facilitator responded by advocating the youth perspective, stating to the agency, “we need to come up with a plan to deal with this.” The facilitator then focused on the agency's actions, asking the case planner a series of questions until it was acknowledged that the agency was indeed at fault because the Director had been on vacation and things had “fallen through the cracks.” The facilitator then brainstormed a plan to address the situation. The facilitator allowed the youth to voice their concerns, adopted their perspective and placed responsibility on the agency to address the concerns. The facilitator then brainstormed action steps to rectify the situation. The action steps became part of the written service plan, holding all parties accountable.				
Establishing a personal connection - remembering and celebrating goals A consistent theme in the youth interviews was the personal connection (or lack of connection) youth experienced with the facilitator. Youth felt positively engaged in the conference when they perceived the facilitator to take a genuine interest in them. One mechanism mentioned by youth to determine whether the facilitator took an interest in them was their knowledge about the case. For first time facilitators, it meant being familiar with the case history and permanency planning goals. For repeat facilitators, it meant remembering the case history, permanency planning goals and checking in with participants on the progress from the previous conference as illustrated in one conference when the facilitator began with a round of applause for the youth for meeting her goal of graduating from high school. In the post-observation interview, the youth reported feeling “like a star” because the facilitator remembered and publicly acknowledged her goal from the previous conference of finishing high school. The youth perceived the facilitator to be proud of her	No supportive quote was reported for this theme	**1** Ausberger 2014	ML: Minor concerns C: No concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Study from outside of the UK. Recruitment strategy and selection of participants was unclear. All participants were over the age of 18 although family team conferencing happens at younger ages too.

Establishing a personal connection - continuity of facilitators - not retelling story While the family team conference model does not call for continuity of facilitators several participants mentioned it as a factor in being able to establish a personal connection. From the facilitator perspective, it was helpful to be familiar with the individuals involved in the case, the case history and the case planning goals. By facilitating multiple conferences the facilitator became an "insider" to the case. Youth reported feeling more engaged in the conference when they had previous exposure to the facilitator. They discussed the importance of not having to re-tell their story. They also discussed the importance of already established trust and rapport.	*As illustrated through the words of one facilitator: ""I'm able to recall faces, and recall certain events, and incidents and situations, which make it, give it a personal touch. And they say, "Okay, you know, she recalls. So, it was important to her to some given extent what happened to me or what I expressed in the previous conference. That she is able to uh, bring it up now." So, you know, that has really uh, created some sort of rapport between myself and the youth."* *A youth observed to be very engaged in the conference, he reported, "It's just like when we have meetings, I am not nervous 'cause I feel like it's just me and her (facilitator) and I just, we just, connected." In contrast, youth who was not familiar with the facilitator felt more reluctant to open up. One such youth reported, "I won't talk to her (facilitator) like, about like anything, 'cause I don't really know her that much."*	**1** Ausberger 2014	ML: Minor concerns C: No concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Study from outside of the UK. Recruitment strategy and selection of participants was unclear. All participants were over the age of 18 although family team conferencing happens at younger ages too.
Limitations of a personal connection with the facilitator Although youth responded positively to facilitators who established personal connections, some facilitators did not perceive this to be their role. They saw their role as a neutral "outside" party to the case. One such facilitator discussed the importance of maintaining professional boundaries with the youth. She saw the case planner as the appropriate person to establish a connection with the	No supportive quote was reported for this theme	**1** Ausberger 2014	ML: Minor concerns C: Minor concerns A: Serious concerns R: Minor concerns **Overall:**	Only 1 study contributed to this theme. Study from outside of the UK. Recruitment strategy and selection of participants was unclear. All participants were over the age of 18 although

youth, since the case planner works closely with the youth. The perspective of the facilitator as the outside neutral party was contradictory to the preference of youth to have a personal connection with the facilitator. In fact, youth expressed reluctance to open up and share information with facilitator they did not know well. Given that youth are asked to share sensitive information and make important decisions that impact their life in the context of the conference, relational concerns were important to them.			**Very Low**	family team conferencing happens at younger ages too. Theme somewhat contradicted the previous theme but was coherent.

1 ***Table 19: Summary CERQual table (Experience of carers undertaking Treatment Foster Care)***

Themes	illustrative quotes	Studies	CERQual concerns	CERQual explanation
The need for information prior to placement. information gathering – feeling that information may be withheld. TFC parents used a variety of methods to gather information for making a decision about whether or not to accept a youth into their home. Some TFC parents reported asking the caseworker many questions about the youth or reading the youth's records, in addition to meeting and visiting. Other respondents seemed to require little information to make the decision to accept a youth. TFC parents also recognized the pitfalls of over-reliance on a youth's records or previous history. When TFC parents were asked what types of information they wanted about a youth they were considering accepting into their home, they mentioned characteristics related to the youth's behaviours, their background, and family experiences. Certain problem behaviours were frequently mentioned as important factors in assessing their	*"Oh, when I look at the chart. To me, the chart is everything…I don't accept [a child] without the chart because I don't want to be surprised." – TF Carer* *"I ask questions if I don't get enough information. I want to know more extensively about the child's behaviour. That way that will give me a general idea as to know whether I want to parent that child or if I'm competent enough to parent that child." – TF Carer* *"I just work with what I have. Because there's no way you can tell that by looking at a person or meeting them the first time and I don't think that's giving a person a real chance. Just to meet them and not really…you know, it takes time to get to know a person and they unfold themselves like an onion." - TF Carer* *"I try not to judge the child by the info they give you. Sometimes they just need a chance….You just have to let them come in and give them a*	**3** Castellanos-Brown 2010 Lee 2020 Tullberg 2019	ML: No concerns C: Minor concerns A: Minor R: Minor concerns **Overall:** **Very Low**	Only 3 studies contributed to this theme. Studies were from the USA. There was a distinction between the ideas that foster carers would have preferred more information and the suspicion that information was deliberately being withheld.

willingness to foster a youth. Several TFC parents specifically mentioned they wanted to know whether the child had been a "firesetter," was "violent," and if they acted out sexually. Other less commonly reported issues that were mentioned as important to consider included being pregnant, lying, stealing, running away, and anger management issues. At times, TFC parents reported not receiving information they wanted about the youth. For example, 1 TFC parent reported learning that a child had a bedwetting problem that was not disclosed prior to placement. Another TFC parent said of a youth with attention deficit issues: "I didn't know that he had it or anything about it." Other types of information not received were explanations of why previous placements had disrupted or a youth's involvement in sexual activities. TFC parents had different explanations for why information they wanted was not received. In some situations, the information may not have been available in a youth's record or may not have ever been reported previously. Other TFC parents suspected that the placement social worker purposely withheld information from them because they wanted the child placed.	*chance and find out for yourself. Is this child really all that's written on paper?"* – TF Carer *"A lot of things were not in her chart and I don't think [the agency] knew. She played with fire, she's having sex. That was not in her chart." – TF Carer* *"A lot of information, if [the state child welfare system] doesn't disclose to [the placement agency] right away, then we don't know about it." – TF Carer* *"I feel like most times, it's a 'don't ask, don't tell' situation." One TFC parent said, "It seems like they just kinda gave me fluff stuff." Another said, "I can understand, too, because sometimes they may want to place a child in an emergency and they don't want to disclose certain information because you look at this so-called innocent child and you want this child placed, but that's not the right way to do things."* *"Some percentage is that they don't have it; another percentage is that they don't want to share it; and another might be, what, I don't know, who knows." – TF Carer*			
Teamwork - Parent Expertise vs Worker Expertise As TFC parents are empowered to have larger roles as experts of the youth in their home, they may struggle to collaborate effectively with their TFC social worker. One of the workforce dynamics commonly found in TFC agencies is that TFC parents may have more life and parenting experience	*As one expert described, "Workers who have less experience than the foster parent is an issue because they are often young and they have no information and no history of the foster child." Expert* *"Staff don't have the skill or background, which is frustrating for the foster parents. TFC social workers really can't help them… and then TFC*	**2** **Lee 2020** **Tullberg 2019**	ML: No concerns C: No concerns A: Moderate concerns R: Minor concerns	Only 2 studies contributed to this theme. Study was from the USA.

while TFC social workers may have more formal training and education in treatment approaches. The different types of expertise is not just a problem for the TFC parents. For TFC social workers, playing a supervisory or coaching role with experienced TFC parents can be intimidating. This tension may inhibit the social worker from providing validation to the TFC parent's role as a treatment provider. To manage this tension, the experts offered several ideas. Operating from the perspective of a strengths-based partnership was one suggestion. Recognizing that each type of expertise can have value and contribute towards the family's success is key. TFC foster parents across groups repeatedly emphasized the importance of developing strong care teams founded on relationships built of mutual respect and characterized by consistent, clear communication. Participants who expressed satisfaction with their care team were positive about their roles. They felt included in decision-making around their child and were routinely kept abreast of important information. The importance of respect, engagement, and clear communication was also evident in TFC foster parents' relationships with clinicians, and their belief in the efficacy in mental health treatment overall.	*parents don't get the help they need." Expert* *"Sometimes the least experienced staff are doing the most challenging role: overseeing someone older with more life and parenting experience. There are a lot of barriers there." Expert* *"How can you look at strengths of a worker and strengths of the TFC family and how you can partner together?" Expert* *"If there is a good working relationship [between the TFC parent and their social worker], then they will work better…. If it is one of mutual respect, they will work well together. They need to be respectful of each other's experience and prior roles as we inch them closer to doing something different." Expert* *"The worker and the sociotherapist [work together] so I won't be bombarded with different people at my house every day. Try to come at the same time. We have a good relationship. They come, they laugh, sometimes they spend more time than they are supposed to, cause we're joking around. Then we get down to the point. We write down everything, makes sure everyone understands, including the child. [She] writes down everything that is expected of the child [and everyone gets a copy]." 'Good' caseworkers embraced TFC foster parents as part of the team and valued "work[ing] together." - Treatment Foster Carer*		**Overall:** **Very Low**	
Treatment foster carers need to know how to: • Be advocates – including in	*"TFC parents should be the voice for the youth." Expert* *""Foster parents need to be assertive when*	**2** **Lee 2020** **Tullberg 2019**	ML: No concerns C: No concerns	Only 2 studies contributed to this

education, medical, and behavioral health services. Bringing their unique perspectives. • Have systems knowledge – of both the child wefare system and behavioural health system so as to know how to navigate this care. • Managing challenging behaviours Parenting youth with emotional and behavioural issues requires specialized skills. The experts noted that TFC parents should have the capacity to identify when a youth may require clinical care	*working with professionals within various systems because they are the child's primary advocate; TFC parents know the child more than anyone. Because they know the child better than anyone else, they can talk about what that child needs and is experiencing." Expert* *"Understanding the system is really important…. It would be really helpful for caregivers to know the system in their state, how things are funded, and what each system's role is to the child." This includes knowing "how do you get access to services? What if you don't think the services are helping? What else is out there?" Expert* *"recognize mental health problems, especially if that child needs a referral. Foster children benefit if the TFC parent has a basic awareness of when a kid is having a behavioural or mental health problem." Expert* *"Knowing about adverse childhood experiences and how trauma can affect long-term health, but that you can intervene and that reinforces the need for mental health services. This helps parents better understand and cope with some of the behaviours." Expert* *"as a TFC parent, a common occurrence is getting your buttons pushed (foster parents reacting to kids instead of being proactive and stepping back, walking away and gaining control). … If foster parents can learn how to not react in the moment, how to take care of themselves and how to model that for our kids, that's huge."*		A: Moderate concerns R: Minor concerns **Overall:** **Very Low**	theme. Study was from the USA.

Preferences for training for TFC Experiential Training - Universally, the experts encouraged hands-on learning opportunities during training for TFC parents. One TFC expert recommended to "do a lot of experiential pieces in the training: practicing and role play. Keep it very behavioural." Another expert suggested, "giving them a skill, having them practice in class, and then work with the kids at home." As summarized by one expert: "the more interactive, the better." The experts seemed to agree that a single training event without follow-up would have little impact. This ongoing skill building could be in the form of a coach that could provide follow-up consultation and refining of skill development.	*"A lot of families are not oriented to academic learning. It's great to give foundational information, but it has to be operationalized." - Expert* *As one expert noted, "Follow-up to training is what is most important. Once a parent has a child in their home they utilize the training and tailor it to the child they are working with. Training is only as good as the follow-up and support." – Expert* *"Biggest support (to provide TFC parents) is coaching… This is more important than the training… Coaches who they can call in the moment could be really helpful." Another expert reinforced this sentiment by concluding that "ongoing coaching is what really changes practice." – Expert*	**2** **Lee 2020** **Tullberg 2019**	ML: No concerns C: No concerns A: Moderate concerns R: Minor concerns **Overall:** **Very Low**	Only 2 studies contributed to this theme. Study was from the USA.
Peer Support The experts emphasized the value of engaging other TFC parents in training and supporting TFC parents who are newer to the role or struggling. Learning from other parents was viewed as both credible and encouraging for TFC parents. The benefits were attributed to not just the recipient, but also for the experienced TFC parent who is able to exercise this leadership and service.	*"We used to have all training done by professionals. Now, we have parent trainers. This has been an incredible piece of our success. Parent voice to other parents is so important." - Expert and TFC provider noted* *"There is a lot of learning that happens in peer-to-peer interaction. It's important to know the things you are experiencing are similar for other people. Peer interaction offers support, normalization, and behavioural strategies to figure out how to be positive with the kid most of the time." – Expert* *"TFC parents are willing to be mentors and it's a real validation to them and a way they can share their competencies." – Expert*	**2** **Lee 2020** **Tullberg 2019**	ML: No concerns C: No concerns A: Moderate concerns R: Minor concerns **Overall:** **Very Low**	Only 2 studies contributed to this theme. Study was from the USA.

Trial period, importance of suitability of placements: Getting acquainted - visits to ensure suitability - Opportunities to become acquainted and begin building a relationship were often valued by TFC parents. The visits were helpful not just to assess the match between the youth and foster parents, but also to observe other family dynamics the youth would be joining. Some TFC parents had to consider how a new foster youth would adjust with other youth in the home. Incorporating the foster youth into the family was mentioned by various TFC parents as being an important consideration when deciding whether to accept a youth into their care.	*"I think it's important to have a day visit and a weekend visit before you make your final decision." – treatment foster carer* *Another TFC parent said that she knew from the visit that the placement would be successful "He came right in and blended right in with the family. It was like he was part of the family and I liked that."* *"When I do that one visit, I have my daughter around; she's very involved. She's in and out of here all the time. So if I'm going to have a [youth] visit, I make sure that she and her family will be here to see how they connect." – TF Carer* *"Me and another foster child that I had, the three of us went on an outing and I just wanted to get a general idea about their relationship….That's important, too, to include the other child if you have more than one child in the home." TF Carer*	**2** Castellanos-Brown 2010 Tullberg 2019	ML: No concerns C: No concerns A: Moderate concerns R: Minor concerns **Overall:** **Very Low**	Only 2 studies contributed to this theme. Study were from the USA.
Straightforward transition to new mental health, dental, and medical providers - mental health services transitions – In this TFC program, all youth were expected to receive weekly outpatient therapy. Transitioning youth to new mental health providers was made easier for most TFC parents because this agency's workers provide referrals to providers near the TFC home. The TFC parents also appreciated being able to choose the therapist they wanted to work with. Medical and dental services seemed equally straightforward. A TFC parent could have their caseworker transfer a youth's files to a provider of the parent's choice or the caseworker would	*"He had to go to a different therapist. I looked around in the neighborhood to find something that was close. So we go to [community mental health] center. As soon as he got here to the house, he started going to therapy." – TF Carer* *"Usually we transfer them. Like I transfer all my kids to where I usually take all my kids. It's the same therapist. We know each other and we have a good rapport." – TF Carer*	**2** Castellanos-Brown 2010 Tullberg 2019	ML: No concerns C: No concerns A: Moderate concerns R: Minor concerns **Overall:** **Very Low**	Only 2 studies contributed to this theme. Studies were from the USA.

help identify possible local providers. TFC parents reported few difficulties in logistics regarding securing services for youth in their home. TFC parents who were less experienced reported greater reliance on their caseworkers for help in navigating the process of getting settled, whereas more senior TFC parents knew the ropes well. Overall, TFC parents seemed satisfied with the quality of auxiliary services their youth received**.**				
Agency support in getting settled – good supportive relationships, training, respite, and referrals. The strengths of the program identified by TFC parents may have facilitated the getting acquainted stage of the transition process. These strengths highlighted various supports that were mentioned as being helpful to TFC parents. Eight TFC parents mentioned they had a good relationship with their TFC worker. Training was mentioned by 5 TFC parents as being a beneficial source of support. Respite was mentioned twice and referrals were mentioned by 1 TFC parent. Six mentioned the staff, counselors, or social workers at this agency were strengths.	*"I have an excellent worker, the intake lady was excellent," – TF Carer* *"Lately, I've been having some really great social workers." – TF Carer* *"good job in communication and in supporting the parents. I know they are constantly trying to develop more support for the foster parents to help them when they got children that is getting into some problems and they do have some things that they can work with." – TF Carer*	**2** Castellanos-Brown 2010 Tullberg 2019	ML: No concerns C: Minor concerns A: Moderate concerns R: Minor concerns **Overall:** **Very Low**	Only 2 studies contributed to this theme. Studies were from the USA. Several distinct aspects of the support that foster carers found to be helpful was outlined here.
Parent vs. Treatment Provider – Several experts commented on the challenges TFC parents face in balancing their role as a caregiver with the expectation to be a professional. In treatment foster care, the experts emphasized how the TFC parent is responsible for creating an environment that provides a therapeutic experience for youth. Although the TFC parent may not have a	*"TFC foster parents must be able to walk the line of being a treatment professional and being a caregiver: connect to kids in a positive way but also follow a treatment plan and implement good interventions." Expert* *"TFC foster parents as the therapeutic component should be seen as 'the key' action in the model. The therapists are important, but the foster parents are the key with their day-to-day*	**1** **Lee 2020**	ML: No concerns C: No concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Study was from the USA.

clinical education or license, several experts expressed that "TFC parents are the ones who create the change." Youth in a treatment foster care placement may also be receiving therapy outside the home, but "the foster family is the agent of treatment, not therapy from the outside." The home setting itself is intended to be transformative. Although many TFC parents have experience and competence with parenting, this is no guarantee that they will be effective as a TFC parent. This tension between being a caregiver and being a treatment provider is not just about different competencies but also about embracing this expanded role.	*interaction that is of optimal importance." Expert* *"It's a different relationship and different skill set than parenting your own children," expressed one expert. Because of the professional expectations, the TFC parenting role requires more than just parenting expertise. This includes being "…willing to take supervision– not just insist on doing things the way they did with their own kids." Expert*			
Destabilising staff turnover Consistent across all groups were reports of frequent and, sometimes, destabilizing transitions in the form of staff turnover or staff changing positions within their agency. As a result, participants widely agreed that strategies for managing transitions should be included as part of staff and foster parent training, and that additional resources— both for children and for treatment foster carers —were needed during periods of change. Concerns about staff transitions focused primarily on the impact of transitions on the mental health of children; "every time you turn around they are changing caseworkers on them … and then they feel like they just tired of them." Participants emphasized the toll repeated transitions could take their children, but most said agencies did not prepare them adequately for changes. More than one participant reported addressing transitions	"[Describing the child's questions:] "Why would they change my therapist, I love her … Are you and poppa going to leave me too?" "It bothered him. He was like; 'This is my third worker in six months.' So it really, really done something to him. He was really close with this worker and I don't think it's fair for the children. Kids have to get used to a new worker all over again … get adjusted … and that kind of angers them too … different foster home, new caseworker … no stability … because of what they been through." - TFC	**1** **Tullberg 2019**	ML: No concerns C: No concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Study was from the USA.

by telling their child to focus more on the stability of their (parent-child) relationship than the one with his/her caseworker. Participants agreed that more structured, consistent communication and support was needed around caseworker transitions—for everyone involved. At the very least, participants wanted to be informed in advance of impending departures, and, if possible, given the opportunity to meet with both workers, to facilitate transitions				
Need for emotional support in times of conflict In most of the groups, TFC foster parents described situations in which they felt staff members did not support them when there was conflict with a child in their care; at times staff were described as siding with the child during such conflicts, and at other times they were described as being absent and unsupportive. TFC foster parents who felt supported by their agency during periods of conflict described the things their agency did to make it easier for them to maintain difficult placements. One TFC foster parent said her agency did “everything” from setting up needed appointments with therapists “right away for the child” to picking up things at school. She reflected: “I feel like they are there for me … it's really important because sometimes you feel overwhelming … some kids, you feel like, ‘what am I going to do?’ – but you have phone numbers for everything.”	*"The worker gets to be friendly with the kids and they don't care about what you going through … cause they only see the kid for 10 minutes, 15 minutes, an hour at most … we have the kid all day … when they see the kid, the kid telling them this and that, that's not true – that is not true. [Another participant comments “There's two sides to the story.”]” - TFC* *"When I first came to the agency, I was new at foster care period… The older workers, the ones that been here for years … they know how to play, how to write the notes, to say that they've been to your house when they haven't been… so they was telling me they didn't have to come as long as [the behaviour specialist] was coming, they didn't have to come and we ran into a lot of friction because a lot of stuff was going wrong in the home and I didn't know what to do because I was new to it … I was talking to the behaviour specialist at the time, she really helped me and got me through it … really guided me through the process” TFC*	**1** **Tullberg 2019**	ML: No concerns C: No concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Study was from the USA.
Feeling rushed to make a decision, the transition process into the home - Timing.	*“Man, it was quick. It was very quick because his time at the diagnostic center was almost up, so they kind of moved kind of quickly on the*	1 Castellanos-Brown 2010	ML: No concerns C: Minor concerns	Only 1 study contributed to this theme. Study from

Some TFC parents expressed feeling rushed by the transition process of a youth being placed in their home. There seemed to be a push/pull between child welfare policies that emphasize youth living in family settings and the desire for TFC parents to feel adequately informed and prepared to receive the child. TFC parents recognize the pressures within the system even when there is some lead time for placements. Indeed, there was not a clear relationship between the amount of time involved in the transition and the experience of feeling rushed. Some TFC parents who received youth within hours of first being notified about the youth did not express any concerns about the timing, while other TFC parents who had a week or more to weigh the decision mentioned that the process seemed "real quick." This finding suggests that TFC parents differ on the amount of time they feel is needed to prepare for the transition.	*process because he didn't have no place to go. He was going to leave [the short-term center] and end up at a group home or some place like that." – TF Carer* *"We got a call that day, they wanted them placed that day, which we know is the nature of the beast. So you are trying to make a decision really quick and you are trying to ask questions and you are asking a team of people who may not know the information. I'm asking questions, I've got to call my husband, transfer all that, write all that down, and even talk to our kids here because it's a team here." - TF Carer* *""The agencies do the best that they can, but there's only so much they can do….The way they are set up, you can only have so many visits and you have to make a decision—am I gonna take the child or not? Because they have to get these children into a home. That's the thing, they have to try to get them in a normal home environment." – TF Carer*		A: Serious concerns R: Minor concerns **Overall:** **Very Low**	outside of the UK. There was not a clear relationship between the amount of time on the run up to the placement and how "rushed" the foster parent felt. Therefore, it was unclear what exactly led to the feeling of being rushed.
Resource needs of youngsters arriving for TFC. clothing and personal items TFC parents seemed prepared to provide personal care items for youth as needed, but often found that youth also needed new clothes. Suggestions for improving the adequacy of clothing included receiving a clothing grant when a child is placed (N = 5). Several TFC parents commented on how they took ownership of their youth's appearance. Providing for the youth's clothing needs seemed to make a positive impression on the youth. However, TFC parents were sometimes reluctant to invest so substantially in a youth newly-placed in	*"And what she came with was like rags," "Underwear too small, pants raggedy," "They usually have about 2 or 3 pair of underwear that's too small, the socks are really dirty if they have matching pairs, which is almost never. They have no hair supplies, no bath stuff. They usually don't have no haircut, no adequate shoes, no kind of toiletries. One child, she didn't have no jacket." – TF Carer* *"I'm really particular about what they wear and how they look. I took all the stuff she had and threw it in the trash pretty much because you are a representation of me….So if they come and their clothes are not adequate with me, then I*	**1** Castellanos-Brown 2010	ML: No concerns C: No concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Study from outside of the UK.

their home.	*don't let them wear that stuff." – TF Carer* *"The child was wearing small clothes and nobody could see it but me. So I went out to Marshalls and I spent $300. I'll never forget that. That night, before he went to school, I bought him all new clothes and automatically, that child loved me." – TF Carer* *"That was very unfair to me. I didn't think it was fair because what happens if this child doesn't work out well in my home….I had to go out and buy him an entire wardrobe—from inside to outside and a haircut. But everything turned out okay." – TF Carer*			
Issues transitioning youth to school Some TFC parents reported issues transitioning youth from their previous school to their new school e.g. difficulties getting registered. Others reported no problems in that transition.	*"It took me almost a month to get her registered in school. Seems like [the agency] should have gotten all that and passed that package with the child, but it seems like [the agency] and the city couldn't get their handshake together, so that was the hang-up there." – TF Carer* *"It was pretty smooth. They didn't miss any school at all." – TF Carer*	**1** Castellanos-Brown 2010	ML: No concerns C: Minor concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Study from outside of the UK. Unclear why some carers experienced problems while others did not.
Adjustment to the idea of family life. Youth transitioning from group care settings are adjusting not only to their foster family, but also sometimes to family life in general. Some youth seemed to lack experiences that are common in most families. For example, 1 TFC parent recalled having a youth in her home who admitted never before having a set bedtime. Another TFC parent was surprised by a youth's dietary habits. A TFC mother described her efforts to treat her foster youth similarly to how she	*"One girl I had, she was eating out of a can. I told her you're not supposed to eat out of a can and she got so ashamed." – TF Carer* *"If he stays on task and graduates and makes me proud of him, I will give him a party in the backyard….See, I did that for my kids, so it's like mainstreaming him." TF Carer*	**1** Castellanos-Brown 2010	ML: No concerns C: No concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Study from outside of the UK.

treated her biological children as a "mainstreaming" process.				
Reasons for breakdown. When youth coming from group care or other settings transition to TFC, struggles in the transition can lead to placement disruptions. More than half of the respondents had experienced at least one disruption of a child leaving their home. Reasons cited for disruptions included lying, running away, skipping school, stealing, and sexual behaviors. From the descriptions provided by TFC parents, disruptions often occurred after an increasing build-up of problems over time. For example, being thrown out of school, or stealing. As youth problems escalated or maintained at high levels of intensity, TFC parents seemed to reach a breaking point.	*"She was constantly being thrown out of school, so that was a constant. School started in August and by September she had been thrown out of school like 6 times. And I told her I couldn't keep going to the school like that…I have to work, too…so they found her another placement." – TF Carer* *"She steals everything that isn't nailed down and after a while I just got sick of it. Having to go get something or going to wear something and it not be there anymore. I just couldn't tolerate it anymore." – TF Carer*	**1** Castellanos-Brown 2010	ML: No concerns C: Minor concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Study from outside of the UK. Several aspects that could lead to placement breakdown were described here. Some of which may require very different responses.
Evidence of positive transition. Although not specifically asked about, many TFC parents shared evidence of a positive transition for youth they fostered, and they were proud and happy to share their success stories. E.g. success at school. Stakeholders perceived qualified clinical successes. One example is from a caseworker who thought that the youth's participation was beneficial even though her stay in an initial foster home placement lasted only a few months. Another qualified success was described by this foster parent, who saw substantial improvements in functioning in a youth she served.	*"She's doing quite well and they also gave her a voucher to get her driver's permit. She's doing well and that's what I would like to see all the children attain." A third said, "I just want that child to be successful so that child can say someone loved me enough to help me to be successful, so that's really my goal. Two of my children have done just that—graduated." – TF Carer* *"She graduated and she's going to school…she was able to get an apartment, she shared it with another young lady for the first year and now she has her own place through a program. She's working and going to college. She's one of my successes, a success story." – TF Carer*	**1** Castellanos-Brown 2010	ML: Minor concerns C: Minor concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Studies from outside of the UK. Multiple specific aspects of a positive transition were described here. For example, clinical improvement vs success at school. Multiple specific aspects of a positive transition were described here. For example, clinical improvement vs success at school.

	""I think what was most helpful for her out of the experience was just knowing that she could be in a home, and that she realized that she had more control over her behavior than she thought she did. She'd say, 'You know, I'm crazy, I can't live in a foster home.' That kind of stuff. And so I think her being in that foster home, even though it was four months, she was like no other time I've seen her." – Case worker *"She improved so much in her attitude toward others. It doesn't mean that she was without problems at the end, but it did mean that she seemed to start to get it. And that is the type of thing you feel really good about" – Foster Carer*			

1 ***Table 20: Summary CERQual table (Experience of carers, youth, and practitioners undertaking Multidimensional Treatment Foster Care)***

Themes	illustrative quotes	Studies	CERQual concerns	CERQual explanation
A common language and focus and the multidimentional treatment foster care team: One of the main strengths offered by the OSLC model was a degree of focus or 'common language' (seen as crucial in a multi-disciplinary team) and clarity of expectations for young people.	*"We're all very clear about what we're working towards and it helps in not splitting that group around the child." (Team member)*	**1** Kirton 2011	ML: Serious concerns C: No concerns A: Serious concerns R: Minor concerns **Overall: Very Low**	Only 1 study contributed to this theme. Data was likely collected prior to 2010. Unclear how participants were recruited and selected. No in-depth description of the analysis process. No apparent triangulation, respondent validation, or the use of more than one analyst.
Crucial emphasis on rewards and punishments: The emphasis on rewards and punishments was generally regarded as crucial, both for its transparency and potential for setting and maintaining boundaries	*"If they don't earn it, they can see it, there's something there that they can see, you can hold up in front of them and show them.*	**1** Kirton 2011	ML: Serious concerns C: No concerns	Only 1 study contributed to this theme. Data was likely collected prior to 2010. Unclear how

	(Foster carer)"		A: Serious concerns R: Minor concerns **Overall:** **Very Low**	participants were recruited and selected. No in-depth description of the analysis process. No apparent triangulation, respondent validation, or the use of more than one analyst.
The model takes the emotion out of the situation: A strength was the perceived capacity for the model, with its relatively neutral and technical language, to 'take the emotion out of the situation' and to avoid escalation in the face of anger and outbursts.	*"In a way it stops people really feeling too criticised because it's like ... if someone says to you 'off model'that's like, 'Oh well, I can get back on the model.' (Team member)"* *"You need to be quite calm and not easily fired up, to be able to just walk away when they're ranting and raving and they're in your face and they're shouting at you, and just walk away and let them calm down. (Foster carer)"*	**1** Kirton 2011	ML: Serious concerns C: No concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Data was likely collected prior to 2010. Unclear how participants were recruited and selected. No in-depth description of the analysis process. No apparent triangulation, respondent validation, or the use of more than one analyst.
Limitations of the MTFC model: Limitation 1) certain aspects of it needed to be 'Anglicised': Where they occurred, flexibilities tended to reflect either cultural differences or acquired practice wisdom. Within its UK context, some team members saw the programme being more holistic and less focused on 'breaking the cycle of offending', an emphasis sometimes couched in the language of 'leniency': "Helping that child develop ... in whatever way they need and meeting their needs to enable them to move to independence or whatever goes next to it. (Team member)". Limitation 2) it would work for some young people but not others; Limitation 3) the longer-term benefits of the programme were uncertain.	No supportive quote was reported for this theme	**1** Kirton 2011	ML: Serious concerns C: Minor concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Data was likely collected prior to 2010. Unclear how participants were recruited and selected. No in-depth description of the analysis process. No apparent triangulation, respondent validation, or the use of more than one analyst. Three distinct limitations were described.

Sticking to the model as a team – adaptions of MDTFC's logic and philosophy. Following the spirit rather than to the letter: A clear majority of interviewees saw themselves and the programme sticking closely to what they understood as 'the model', while often disclaiming any detailed knowledge of it. This partly reflected the routinisation of practice and perhaps the strength of team ethos. Broad adherence reflected a number of factors. First, the model appeared to 'make sense' to most of those involved, with several foster carers claiming (though with perhaps some oversimplification) that this had been the basis of their own childrearing: It's basically the way I brought my own children up, which is good children get lots of nice things and naughty children get nothing, but I do it with points. Second, the consensus was that, albeit with some flexibility (see below), the model 'worked' but that this required fairly strict adherence: A third factor was that of external monitoring and reporting mechanisms, whether from the NIT or OSLC itself. While this sometimes involved elements of 'presentation' to outside audiences that differed from day-to-day realities, it also served to reinforce the programme's logic and philosophy. Much of course, depended on how far the model and its weighty manuals were to be followed 'in spirit' or 'to the letter'. For example, one team member argued that expectations of young people in terms of healthy eating and eschewing of hip hop or rap music were unnecessarily restrictive and perhaps 'unrealistic'. While most foster carers came to find the award and deduction of points reasonably straightforward, the challenges, such as balancing consistency and individualisation and handling value judgements, should not be underestimated. Additional challenges included what constituted 'normal teenage behaviour' and how far the focus for change should rest with 'large' and 'small' behavioural problems respectively. These issues were, however, usually resolved fairly easily, with foster carers happy with their degree of discretion.	*"I know ... as a team we work towards the model and it's the Oregon model that we follow but it feels much more like we're working to our team model". (Team member)* *"We're very close to the model on most things and whenever we stray I have to say that it kicks us in the teeth." (Team member)* *"My lifestyle to somebody else's might be totally different and what I accept in my house is different to what somebody else accepts in theirs." (Foster carer)"*	**1** Kirton 2011	ML: Serious concerns C: Minor concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Data was likely collected prior to 2010. Unclear how participants were recruited and selected. No in-depth description of the analysis process. No apparent triangulation, respondent validation, or the use of more than one analyst. Three distinct limitations were described. Variability in how the model was applied could lead to inconsistent application and standards. However, there was the idea of the model as a philosophy rather than a detailed set of statutes, which could aid adaptability.

Usefulness of the parental daily report: Parental Daily Reports were sometimes seen as 'a chore' (Westermark et al, 2007), but almost universally valued for their capacity to concentrate minds on behaviours, to ensure daily contact between foster carers and the programme and help 'nip problems in the bud". The data yielded were seen as useful for identifying trends and one-off or recurrent 'spikes' that might reveal behavioural triggers, such as contact visits or school events and as having a potential 'predictive' value for disruptions and optimal transition timing. There were concerns that the prescribed list of behaviours was in places too 'Americanised' (eg 'mean talk') and that self-harm (not infrequent within the programme) was not listed separately but under destructiveness, requiring annotation to distinguish it from instances of 'kicking the door in'. Similarly, there was no reference to eating disorders other than 'skipping meals'. The question of whether behaviours were 'stressful' was clearly dependent to a degree on foster carers' tolerance and time of completion. Concern was also expressed that the Parental Daily Report's focus on negative behaviours was not entirely congruent with the programme's aims of accentuating the positives (see below), a situation that was seen as having a cultural dimension, with one team member commenting, albeit as a generalisation, on how US counterparts in MTFC tended to be 'more upbeat about things' and hence less likely to dwell on negative behaviours.	*"It makes me think about if things have happened, how I can do them better or how we can both do it better. So it's reflection for me." (Foster carer)* *"The next morning or the night time everything's died down and it probably isn't such a big deal ... [do] you give yourself that time just to calm down before you put it in the behaviour or should you do it when it happens?* (Foster carer)	**1** Kirton 2011	ML: Serious concerns C: Minor concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Data was likely collected prior to 2010. Unclear how participants were recruited and selected. No in-depth description of the analysis process. No apparent triangulation, respondent validation, or the use of more than one analyst. Theme covered several issues with the parental daily report including the burden on caregivers, the overly negative focus on behaviours, Americanisation of the language, and lack of distinction for medical or severe problems. However, spikes in behaviour could be tracked, which were helpful to identify triggers.
Engagement was crucial to outcomes but highly variable and prone to change over time: More generally, however, engagement levels were thought to be high, with some respondents indicating surprise at the apparent willingness to accept a restrictive regime with its initial 'boot camp' withdrawal of privileges.	*"She couldn't give a monkey's. It didn't matter what I'd say she was not gonna . . . And she stayed with me for three months and then she decided she'd had enough and went." (Foster carer)* *"I find it bizarre that they engage with it really quite well ... I kind of*	**1** Kirton 2011	ML: Serious concerns C: No concerns A: Serious concerns R: Minor concerns **Overall:**	Only 1 study contributed to this theme. Data was likely collected prior to 2010. Unclear how participants were recruited and selected. No in-depth description of the analysis process. No apparent

	think if I was a 13-year-old lad ... would I really want to be negotiating buying my free time, my time out with points? But they do ... and they stick to it." (Team member)		**Very Low**	triangulation, respondent validation, or the use of more than one analyst.
Need for persistence and finding and tailoring the right rewards: Situations were described where young people would rail against restrictions and thwarted demands but ultimately comply. While the motivational value of an identifiable goal (such as return home) was recognised, sustaining interest day-to-day was equally important and required delicate judgements from foster carers as the following contrasting approaches indicate. Equally important, however, was finding the right rewards and appropriate means of earning them (although one young person was said to 'just like getting points'), something that might entail individual tailoring. If this raises questions of 'inconsistency', it was justified in terms of motivation, individual pathways and progression through the programme. Similar logic had meant 'massaging' points to prevent a drop in levels, where this might provoke running away or placement breakdown.	*"My young man likes to look at his points on a daily basis so we go through them with him and then we sit down and work out how he's gonna use his rewards and what he's aiming for next. I have to say that I don't sit down and discuss points with [young person] every night because she will just rip it up and throw it at me and tell me what a load of bollocks it is" (Foster Carer)* *"She needs to score points really, really highly, so whereas one foster carer might give one of the lads ten points for doing what she did, she may need to earn 50 for it to mean something." (Team member)* *"I think with some young people they ... just wouldn't manage being on level one and therefore it is slightly adapted to sort of manage that. (Team member)"*	**1** Kirton 2011	ML: Serious concerns C: No concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Data was likely collected prior to 2010. Unclear how participants were recruited and selected. No in-depth description of the analysis process. No apparent triangulation, respondent validation, or the use of more than one analyst.
Are normal activities privileges? Transfer of placements into the programme also raised questions of how far previously 'normal' activities could be recast as privileges to be earned. Over time, this had reportedly given rise to some variations or changes of	No supportive quote was reported for this theme	**1** Kirton 2011	ML: Serious concerns C: No concerns A: Serious concerns	Only 1 study contributed to this theme. Data was likely collected prior to 2010. Unclear how

practice, for example, on televisions in bedrooms or consumption of fizzy drinks.			R: Minor concerns **Overall:** **Very Low**	participants were recruited and selected. No in-depth description of the analysis process. No apparent triangulation, respondent validation, or the use of more than one analyst.
Need for redemption and engagement with point and level system: A key element of the OSLC philosophy is 'turning it around', allowing loss of points to be redeemed by subsequent good behaviour or positive reaction to the deduction. Although (some) foster carers felt this approach potentially made light of misdemeanours, the overall working of the programme was supportive of it. One young person had reportedly asked his foster carer not to let him out in case he got into trouble and forfeited a much desired holiday, something that was seen as a significant shift in thinking and timescales.	*"Instead of giving her five points that she'd normally have I'll say, 'Well, you did that really well. I'll give you 15 for that today." (Foster carer)* *"You hear them talking about 'I really turned it around today' ... [or]'I'm working towards my points.' You actually hear the children saying, 'I know I need to be on this programme'. . . they ... have that insight." (Team member)"*	**1** Kirton 2011	ML: Serious concerns C: No concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Data was likely collected prior to 2010. Unclear how participants were recruited and selected. No in-depth description of the analysis process. No apparent triangulation, respondent validation, or the use of more than one analyst.
A behavioural model or an attachment model? Behavioural programmes are sometimes criticised for lacking depth or concentrating on 'symptoms rather than causes', a debate we explored in interviews. Foster carers tended to focus on their own specific role in dealing with behaviours and saw the addressing of any 'underlying' problems as being the responsibility of others, especially the individual therapist. Also emphasised strongly was the temporal focus on present and future, by comparison with attachment models 'looking backwards'. If in some senses, practice remained firmly within a behavioural framework, this was not seen as precluding consideration of attachment issues, whether at the level of understanding or in outcomes.	'I'm just trying to break a pattern but it's not actually solving why they do it.' (Foster Carer) 'I find it quite hard not to think about things in terms of attachment' (Team member) "I think what's been helpful is people have sort of said, 'Oh, it's not an attachment model' and I just have been able to say to them, 'What do you think actually putting a containing and caring environment around a child does?'	**1** Kirton 2011	ML: Serious concerns C: No concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Data was likely collected prior to 2010. Unclear how participants were recruited and selected. No in-depth description of the analysis process. No apparent triangulation, respondent validation, or the use of more than one analyst.

	... It's not the kind of ... Pavlov's dogs type thing that everyone thinks about when they think about behavioural models. (Team member)"			
Importance of appropriate matching: While in principle, behavioural approaches tend to de-emphasise the importance of relationship, the crucial importance of matching (which tended to involve consideration of several young people for one (or two) foster carer vacancies) was widely recognised and seen as a key area of learning within the programme.	*"I think we're getting it right more often than not and I think that's reflected in the ... reduction of disruptions. When we do get it wrong we get it wrong very spectacularly!" (Team member)*	**1** Kirton 2011	ML: Serious concerns C: No concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Data was likely collected prior to 2010. Unclear how participants were recruited and selected. No in-depth description of the analysis process. No apparent triangulation, respondent validation, or the use of more than one analyst.
Move on placements and step-down placements: Marrying MTFC's twin aims of providing time-limited 'move on' placements while effecting sustainable behavioural change required complex judgements as to the optimal timing of transitions. Opinion was divided on this (national guidance had suggested a shortening of placements from around 18 to nine months) between those emphasising the time needed to deal with 'long-term damage' or the dangers of 'relapse' and those worried about stagnation, disengagement or young people 'outgrowing the programme'. While practice wisdom and programme data were seen as aiding decision-making, follow-on placements remained a significant problem. In some instances, this had been resolved by the young person remaining with their MTFC (respite) carers, although this usually entailed the latter's loss to the programme. Consideration had also been given to the establishment of 'step-down' placements to provide a more gradual reduction in structure and support. However, such	No supportive quote was reported for this theme	**1** Kirton 2011	ML: Serious concerns C: Minor concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Data was likely collected prior to 2010. Unclear how participants were recruited and selected. No in-depth description of the analysis process. No apparent triangulation, respondent validation, or the use of more than one analyst. There was a lack of clarity regarding which approach had been most successful for move on or step-down placements.

provision is challenging in terms of recruitment. Several young people who had left MTFC had subsequently kept in contact, and interestingly this included some early and late leavers as well as graduates.				
Foster carers satisfaction with the level of support and out of hours service: Foster carers were extremely positive about levels of support in MTFC – 'Just absolutely amazing', 'I have to say brilliant. 100 per cent brilliant' – and some commented on how this had prevented disruptions that might otherwise have occurred. 'Enhanced' (relative to 'mainstream' fostering) features included higher levels of contact with supervising (and assistant) social workers and a structured pattern of short breaks or 'respite care'. In addition to their primary role of granting some relief from pressures, these arrangements sometimes evolved into follow-on placements after disruptions, helping to provide important elements of continuity. Another crucial 'enhanced' feature was a dedicated out-of-hours service staffed by members of the team, which, though used fairly modestly (typically one or two calls per day), was highly valued for its provision of a crucial safety net. Use of the out-of-hours service ranged from serious incidents involving offending, (alleged) sexual assaults, suicide concerns and violence or damage in the foster home, to reassurance on medical issues and dealing with difficult behaviours.	*"There's nothing more reassuring ... that you can ring someone up and actually hear that person on the end of the phone, it's not some call centre or someone you've never met before." (Foster carer)*	**1** Kirton 2011	ML: Serious concerns C: Minor concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Data was likely collected prior to 2010. Unclear how participants were recruited and selected. No in-depth description of the analysis process. No apparent triangulation, respondent validation, or the use of more than one analyst. Enhanced support covered several aspects that foster carers found to be helpful, particularly in comparison to usual fostering.
Value of therapists and skills workers While the roles of therapists and skills workers sometimes raised issues of co-ordination with foster carers, their capacity to ease pressures at times of difficulty was valued by carers.	No supportive quote was reported for this theme	**1** Kirton 2011	ML: Serious concerns C: Minor concerns A: Serious concerns R: Minor concerns **Overall:**	Only 1 study contributed to this theme. Data was likely collected prior to 2010. Unclear how participants were recruited and selected. No in-depth description of the analysis process. No apparent

			Very Low	triangulation, respondent validation, or the use of more than one analyst. It is unclear what was meant by "issues of co-ordination"
Usefulness of the foster carers' weekly meetings the foster carers' weekly meetings. These served both to ensure fairly prompt attention to issues, but also afforded the opportunity for mutual support and problem-solving	No supportive quote was reported for this theme	**1** Kirton 2011	ML: Serious concerns C: No concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Data was likely collected prior to 2010. Unclear how participants were recruited and selected. No in-depth description of the analysis process. No apparent triangulation, respondent validation, or the use of more than one analyst.
Success of co-ordinated working There has been little research on the operation of teamwork within MTFC or its external relations. Despite significant staff turnover and some reworking of roles, the programme had also benefited from continuity in some key positions and a capacity to fill vacancies relatively quickly. From interviews and observation, internal roles appeared to be fairly clear and well co-ordinated, although the team's relatively small size had inevitably given rise on occasion to questions of flexibility, with tensions between willingness to help out and the maintenance of role boundaries (eg on provision of transport or supervision of contact). The workings of MTFC both facilitate and require high levels of communication, combining multifarious opportunities for contact with a need to pass on information regarding 'eventful' lives and high levels of activity on the programme. With occasional, and usually fairly specific exceptions, team members regarded	*"On the whole, given that we have got a bunch of quite disparate professions ... we've got a conjoined CAMHS, education and social care team, there's a lot less conflict than I thought there might be." (Team member)* *"They do value your input and they value your knowledge and your sort of past experience." (Foster Carer)*	**1** Kirton 2011	ML: Serious concerns C: Minor concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Data was likely collected prior to 2010. Unclear how participants were recruited and selected. No in-depth description of the analysis process. No apparent triangulation, respondent validation, or the use of more than one analyst. Some sense of difficulty co-ordinating the team and role boundaries despite the overall positive findings.

communication as very effective, while foster carers were generally positive about their participation:				
Leadership of programme supervisors The role of Programme Supervisor (PS) as key decision-maker – variously referred to as 'Programme God' or 'the final word'– was crucial within the team. While some team members reported taking time to adapt to this, it was widely acknowledged that the PS and indeed 'the programme' could act as a lightning rod to defuse conflicts involving young people and their foster carers.	*"Always it's'[PS], says' ... in answer, so my [young person] wishes that [PS] would drop dead at any moment. But that takes a huge amount off of me because it's not me who's saying it. That's absolutely been brilliant." (Foster carer)*	**1** Kirton 2011	ML: Serious concerns C: No concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Data was likely collected prior to 2010. Unclear how participants were recruited and selected. No in-depth description of the analysis process. No apparent triangulation, respondent validation, or the use of more than one analyst.
Clash with the children's social worker Like any specialist programme, MTFC has faced challenges in its relationships with Children's Social Workers (often exacerbated by turnover among them) regarding the balance between a necessary transfer of responsibility on the part of Children's Social Workers while they continue to hold case accountability. Despite routinely sent information and discussions with the programme supervisors, almost all CSWs interviewed expressed some concerns, usually involving either not knowing of specific incidents (e.g. entry to hospital) or more ongoing matters, such as the content of counselling. For some, the concern was simply about being 'out of the loop', while for others it was the potential for exclusion from decision making and conflict with statutory duties. From a programme perspective, there were occasional references to Childrens Social Workers who 'found it hard to let go', or whose misunderstanding caused confusion. As one foster carer put it, 'they start telling these kids all sorts of things and you're thinking "no actually, they can't"', although it should be noted that some Social	*"It seemed to me that the treatment fostering team pretty much took on responsibility for the case, which is fine, but if anything goes wrong then don't make me accountable." Social Worker* *"[. . .] was the sort of child I used to literally wake up worrying about and I don't now because somebody else is doing that worrying."* Social Worker	**1** Kirton 2011	ML: Serious concerns C: No concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Data was likely collected prior to 2010. Unclear how participants were recruited and selected. No in-depth description of the analysis process. No apparent triangulation, respondent validation, or the use of more than one analyst.

Workers were viewed very positively. A more common concern, however, was that some Social workers 'opted out' once the young person entered MTFC, although this was often acknowledged (on both sides) as understandable given the workload pressures facing children's social workers. Encouragingly, CSWs also referred to improving communication, with some plaudits for MTFC being approachable and responsive. The programme had attempted to improve liaison by visiting teams and by inviting children's social workers to attend meetings, although these offers had not been taken up, with CSWs reporting diary clashes and imprecise timings to discuss 'their' charges. It was also noted that the very specific workings and language of MTFC were not always well-integrated into Looked After Children (LAC) review processes.				
Social workers were positive about the programme even where placements broke down This is not, of course, to say that time in MTFC represents any form of panacea, but recognition of its impact in often difficult circumstances. The idea that even 'failed' placements might nonetheless carry some residual benefit for young people – particularly those in 'multiple disruption mode' was also expressed by some.	*"He was a really, really difficult young man and they've really supported him and provided him with a stable home environment, really, really firm boundaries which he's really needed . . . I think the placement's been fantastic. She would have met the criteria [for secure accommodation] in terms of running off ... self-harming ... And now the self-harming is very ... very limited. It changed his life around to be perfectly honest. Yeah, I'd go that far."* *"He's only absconded three times in six months or so and it's only ever been running off from school and he's back by nine o'clock ... whereas before he was missing for days on end. (Team member)*	**1** Kirton 2011	ML: Serious concerns C: No concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Data was likely collected prior to 2010. Unclear how participants were recruited and selected. No in-depth description of the analysis process. No apparent triangulation, respondent validation, or the use of more than one analyst.

	There are obviously still concerns about her emotional welfare and there will be, but she was a very, very damaged girl for lots and lots of reasons, but there was a time where I thought she just might ... not survive. (CSW)"			
Creating relationships with birth families. The Circle Program was felt to be more likely to promote reunification with family or enter kinship care than among children in a generalist foster care placement. Factors contributing to the child's relationship with their family of origin included: valuing the unique knowledge brought by the parents, encouraging the attendance of family, and the usefulness of care team meetings.	*"The way the parents are treated and welcomed and their unique knowledge recognized contributes to the success of Circle" - Therapeutic specialist* *"Families generally don't come to every meeting but we encourage their attendance when they do come. In GFC, a carer has to be very assertive to create relationships with birth families, but it's a much more natural process in Circle because of care team meetings" FC worker*	**1** Frederico 2017	ML: Serious concerns C: No concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Study from outside of the UK. Researchers do not discuss how participants were selected for the study, and why these were the most appropriate or why some chose not to take part. Focus group and thematic analysis methods were not made explicit.
Support that was helpful for retaining foster carers - Focus group data highlighted factors deemed to be influential to carer retention such as support, training, ongoing education and access to flexible funds to obtain services. Comments highlighted the value of participation in regular care team meetings. Carers spoke of their commitment to their role as a Circle carer, highlighting the experience of support, training, and ongoing education.	No quote to support this theme was reported	**1** Frederico 2017	ML: Serious concerns C: Minor concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Study from outside of the UK. Researchers do not discuss how participants were selected for the study, and why these were the most appropriate or why some chose not to take part. Focus group and thematic analysis methods were not made

				explicit. Theme covered several distinct aspects of support that could help to retain foster carers.
Access to flexible brokerage funds These funds were described by carers as supporting children to participate in normative community activities, for example a dance class or organized sport. Where a child required a specialist assessment (e.g. speech therapy) that was not available through public funding within a reasonable time frame, brokerage funding could be used. A key message from carers was the importance of accessing such discretionary funds to meet a child's needs in a timely way.	No quote to support this theme was reported	**1** Frederico 2017	ML: Serious concerns C: No concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Study from outside of the UK. Researchers do not discuss how participants were selected for the study, and why these were the most appropriate or why some chose not to take part. Focus group and thematic analysis methods were not made explicit.
Carers valued and treated as professional equals. The Circle Program was described by some carers as elevating the role of the foster carer to one that is 'equal' to the other professionals on the care team. This, combined with the Circle Program training, professionalized the role of the foster carer, and some carers reported increased levels of confidence in their competence. Carers also commented that the success of the Circle Program was linked to the professional support provided: feeling 'listened to', having their opinions 'valued' and being 'supported' in their role as foster carer. In the focus groups, carers discussed their role and participation in the Circle Program with passion and enthusiasm. The wellbeing of the carer was also a focus of care team meetings with one carer commenting that someone always asked her how she was at care meetings and 'They really want to know how I am'!	No quote to support this theme was reported	**1** Frederico 2017	ML: Serious concerns C: No concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Study from outside of the UK. Researchers do not discuss how participants were selected for the study, and why these were the most appropriate or why some chose not to take part. Focus group and thematic analysis methods were not made explicit.

The common purpose of the care team with an equal system of carers – The egalitarian nature and common purpose of the care team were features mentioned by a number of focus group participants as having significance in their experience of TFC.	No quote to support this theme was reported	**1** Frederico 2017	ML: Serious concerns C: No concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Study from outside of the UK. Researchers do not discuss how participants were selected for the study, and why these were the most appropriate or why some chose not to take part. Focus group and thematic analysis methods were not made explicit.
Training essential particularly in trauma theory, attachment and self-knowledge. Contents of training - Training in trauma theory, attachment and selfknowledge were also identified as essential components by foster carers and foster care workers alike.	*"The education helps you not to take it personally and respond better and to keep the end in sight which is the relationship with the child'" - TF Carer*	**1** Frederico 2017	ML: Serious concerns C: No concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Study from outside of the UK. Researchers do not discuss how participants were selected for the study, and why these were the most appropriate or why some chose not to take part. Focus group and thematic analysis methods were not made explicit.
Key role of the therapeutic specialist (Circle programme). The key role of the therapeutic specialist - Therapeutic specialists were identified by all stakeholders as core to the Circle Program's success. Circle carers and foster care workers highlighted the value of this role in guiding assessment and the care of the child. The availability of the therapeutic specialist was	No quote to support this theme was reported	**1** Frederico 2017	ML: Serious concerns C: No concerns A: Serious concerns R: Minor concerns	Only 1 study contributed to this theme. Study from outside of the UK. Researchers do not discuss how participants were selected for the study, and why these

considered a particular strength given their knowledge; and ability to assist carers in understanding the child and their needs. Their role was active in guiding the foster carer in their day to day response to the child and this was experienced as very supportive and was seen to facilitate a more immediate and appropriate response in meeting the child's needs. The therapeutic specialist could also extend their focus to include the child's family of origin as from the commencement of placement the aim is for the child to reunify with their family if the family can meet their needs. As many of the families of origin had themselves experienced trauma, it is important that they be assisted to heal and change to be available for the care of their child/young person.			**Overall:** **Very Low**	were the most appropriate or why some chose not to take part. Focus group and thematic analysis methods were not made explicit.
Building a support network for the child. Feedback from focus groups and the survey highlighted the importance of building a support network for the child/young person. This network included teachers, extended family and others in addition to members of the care team.	*'The amazing camaraderie across the care team that is generated by the therapeutic specialist driving a continual focus on the child and the child's needs…. we really are a circle of friends around the child' – TF Carer*	**1** Frederico 2017	ML: Serious concerns C: No concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Study from outside of the UK. Researchers do not discuss how participants were selected for the study, and why these were the most appropriate or why some chose not to take part. Focus group and thematic analysis methods were not made explicit.
The hard and stressful work of fostering. How would foster parents and staff tolerate the intervention? a feasibility worry was that the TFC-OY intervention would be difficult for foster parents to tolerate. This was confirmed. In addition, some staff found the work stressful. In weekly meetings and in the qualitative research interviews, foster parents reported that the youth were extremely difficult to parent. Despite training that focused	*"It is challenging every day because I just have to pay attention to her moods more. The hardest thing is that I have to monitor her so closely and I have to watch what I say." – TF Carer* *"It seems like all at once, the kids*	**1** McMillen 2015	ML: Minor concerns C: No concerns A: Serious concerns R: Minor concerns **Overall:**	Only 1 study contributed to this theme. Study from outside of the UK. This study did not make its methods regarding coding and thematic analysis explicit.

on the needs of youth with psychiatric problems, the foster parents reported being surprised by the amount of emotional volatility in the young people they served, the low levels of what they perceived as emotional maturity, and high needs for monitoring and supervision. No parent or youth described an extended period of time when life settled into a comfortable routine. It always felt like stressful work to the foster parents. The experience was not easy for the TFC-OY staff either. One Life Coach was surprised by the low level of emotional functioning of youth in an office setting.	*started being very chaotic and disrupting things all over the place, and everyone was coming into my office, all in a row. Boom, boom, boom. And it was just chaos, chaos, chaos, chaos. Crisis. Running away from appointments. Breaking things. And it was for a month straight." – Life Coach*		**Very Low**	
Key role of the skills coach (Circle Programme) The skills coach component was uniformly appreciated by foster parents, the program supervisor and the youth. When asked about the skills coach component, the youth tended to report things the coach had done for and with them that were related to positive youth development. E.g. helping to find a job, getting a drivers liscence, going to find a place to eat. Multiple stakeholders commented on the positive relationships that youth developed with their skills coaches.	*"She took me outside and she helped me find a job. She took me out to eat. She helped me get my driver's license. She helped me get my permit. Helped me with my homework. She helped me learn how to make a grocery list, pay bills, audit. She helped me with a lot of things." – Foster care youth* *"They've been able to build a relationship with the kids that doesn't have any strings attached. The kids look at them as somebody who's on their side and doesn't want anything from them." – "Staff member" about relationship with skills coaches*	**1** McMillen 2015	ML: Minor concerns C: No concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Study from outside of the UK. This study did not make its methods regarding coding and thematic analysis explicit.
Key role of the psychiatric nurse (Circle programme). A second component that drew positive comments from stakeholders was that of the psychiatric nurse. Care managers appreciated the medication and diagnostic review provided by the nurse. They provided numerous examples of how they used this review and knowledge in their interactions with mental health providers. While some youth did not understand why they were receiving	No quote to support this theme was reported	**1** McMillen 2015	ML: Minor concerns C: No concerns A: Serious concerns R: Minor concerns	Only 1 study contributed to this theme. Study from outside of the UK. This study did not make its methods regarding coding and thematic analysis explicit.

psychoeducation about their mental health problems from a nurse, others greatly appreciated it, explaining that it changed how they monitored their symptoms and how they approached their psychiatric providers.			**Overall:** **Very Low**	
Role of the life coach (Circle programme). The role of the life coach was a difficult one to execute. Initially, the role was focused on interpersonal skills the youth needed to succeed in the foster home, but was later supposed to involve life planning and psychoeducation. Two life coaches worked in the program and both found their role frustrating in terms of completing what they felt they were being asked to do.	*"To talk with them about school and work and STDs and their grief issues and their placement issues and what they did in school and their upcoming court hearing….you can't do all that so it was…at times it was a little overwhelming to try to basically do what I thought I was being asked to do." – Life coach*	**1** McMillen 2015	ML: Minor concerns C: No concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Study from outside of the UK. This study did not make its methods regarding coding and thematic analysis explicit.
The family consultant role (Circle programme). The family consultant role was less well received. The family consultant made many unsuccessful efforts to re-engage biological relatives and other nominated individuals into the lives of youth in TFC-OY and executed one successful effort, involving an older sibling. The role was also expensive (using a master's level mental health professional). In the end, the principal investigator concluded that the family consultant role would be eliminated going forward and that needed family work would be conducted by the program supervisor.	No quote to support this theme was reported	**1** McMillen 2015	ML: Minor concerns C: No concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Study from outside of the UK. This study did not make its methods regarding coding and thematic analysis explicit.
Changes suggested for the circle programme. Program changes needed? Since it was decided that it was permissible to alter the intervention mid-pilot in order to have an intervention worthy of testing at the end of pilot period, two modifications to the protocols were made several months into the intervention: 1) redefined roles for team members; and 2) efforts to address emotional dysregulation. Some of the life coach's responsibilities were offloaded to other team members. The skills coaches became responsible for helping youth plan for more independent living and the	*"If they have Axis Two with Cluster B stuff going on, I don't think that the families are prepared for what kind of emotions that can bring up… So I don't know if there needs to be some sort of training for the foster parents, training to know how to handle that. Have the foster parents go through some sort of DBT training themselves? So that they're at least speaking*	**1** McMillen 2015	ML: Minor concerns C: Moderate concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Study from outside of the UK. This study did not make its methods regarding coding and thematic analysis explicit. Several changes to the intervention were described however it

psychiatric nurse became responsible for providing psychoeducation about mental health problems. These modifications were considered successful, as viewed by stakeholders in qualitative interviews at the end of the project. Most glaring was the need to develop intervention components to address youth emotion regulation problems. Six of the foster parents interviewed qualitatively reported that the young people served in their homes experienced severe emotional outbursts; typically youth were seen as quick to become emotional and remaining emotionally volatile for substantial periods of time. During the last six months of the pilot, TFC-OY staff explored the potential of using processes and materials from Dialectical Behaviour Therapy in TFC-OY to address youth emotion regulation problems. Staff received initial DBT training from a certified trainer and a DBT skills group was mounted with the foster youth to teach interpersonal effectiveness and mindfulness skills. The groups were well received by youth who attended them, but attendance was a problem, mostly due to logistics, such as distance from youth placements to the group site, work schedules, and transportation issues. By the end of the pilot, the intervention team concluded that any future trials or implementation of TFC-OY should be delayed until new intervention components were developed to address emotion regulation problems.	*the same language to remind them to use their skills."* – Life coach			was unclear where qualitative data were coming from for these changes and if participants were all in agreement.

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Economic evidence

Included studies

A systematic review was conducted to cover all questions within this guideline update. The study selection diagram is available in Appendix G. The search returned 3,197 publications since 2000. Additionally, 29 publications were identified through reference tracking. After screening titles and abstracts 3 publications were considered for full text inspection but did not meet the inclusion criteria and were excluded from the evidence report. An updated search was conducted in November 2020 to identify any newly published papers. The search returned 584 publications. After screening titles and abstracts five publications were considered for full text inspection but did not meet the inclusion criteria and were excluded from the evidence report. Reasons for exclusion are summarised in Appendix J – Excluded studies.

Economic model

Interventions to support care placement stability (review question 1.1), positive relationships (review question 2.1), and physical, mental, and emotional health and wellbeing of LACYP (review question 3.2) were initially prioritised for economic modelling, as the committee agreed that they were likely to have important downstream consequences on the health-related quality of life of LACYP and utilisation of public sector resources. Additionally, initial evidence mapping in the Economic Plan indicated an overlap in RCT evidence for review questions 1.1, 2.1 and 3.2, hence an overarching model was planned to address all three review questions. However, review question 1.1 was only to be considered for inclusion within the overarching model if sufficient evidence was available to support the efficacy of any intervention in improving placement stability. Two studies with effectiveness evidence for interventions improving placement stability showed a positive effect on outcomes for the intervention, but those effects were noted as potentially less than the MID. Therefore, review question 1.1 could not be included in the planned overarching model. Further details of the planned overarching model and a costing analysis undertaken to support recommendations for review questions 2.1 and 3.2 are provided in the respective evidence reviews.

The committee's discussion of the evidence

Interpreting the evidence

The outcomes that matter most

The committee considered the presented evidence on placement stability. The committee discussed the problematic follow-up times measured in some of the studies, for example, 6-months and 4- months was considered too short a length of time to adequately assess whether placement breakdown had or would occur. However, one of the significant differences observed was in a study which measured outcomes over a 6-month period (Akin 2015). Though a borderline (MD -0.30 95%CI -0.60 to -0.00) significant effect was observed in favour of the intervention group for this study, the committee expressed concern that observed effects could be due to a "honeymoon effect" whereby there is an initial positive response following the intervention, which drops off over time. Additionally, it was not clear in this study that outcomes and follow up time had been agreed *a priori* (e.g. no registered protocol was cited). While not unusual in the literature, this leaves open the possibility that results were selected for a certain timepoint that had significant differences between comparison groups.

The committee noted the difference between outcomes that measured the number of care placement moves vs those which measured the number of placement breakdowns (unplanned or for a negative reason such as foster carers being unable to cope). It was

considered that, particularly in short-term foster care, placement moves may happen in a manner that is planned and in the best interests of the child, and therefore not a true adverse event.

Otherwise, the outcomes of interest for this question were narrowly defined and all related to changes in care placement situation. It was noted that the majority of outcomes were derived straight from electronic administrative records or social care records which tend to be less subjective, and, depending on record keeping, may have greater accuracy than self-reported or carer-reported outcomes.

It was considered that certain results of interest (outlined in the protocol) had not been reported, for example, absconding. However, one study (Price 2008) included child runaways in its definition of a negative exit from care.

The quality of the evidence

The committee noted that the majority of the evidence presented had not shown a significant impact of the intervention studied upon placement stability outcomes. However, when the wideness of the confidence intervals in several studies was taken into account, this was not necessarily strong evidence of lack of effect. In numerous studies, the number of placement moves or placement breakdowns that had occurred across the follow-up period was less than had been anticipated, and therefore trials were underpowered to detect a significant effect.

The "very serious" GRADE-rated risk of bias that was determined for the majority of reported outcomes was noted. This was largely because of the imprecision described above; indirectness as a result of studies being from non-UK countries; and study-level quality leading to an increased risk of bias.

The committee considered, as with other review questions, that looked after children in other countries experience care systems that are considerably distinct from the UK's own. This particularly affects interpretation in studies that compared their intervention group to a "care as usual" group. In countries where the "usual" standard of care is considerably poorer than in the UK this could lead to the appearance of a considerable intervention effect that may not translate in the UK context. Additional areas of indirectness were apparent for a few selected studies which were in populations that may differ to the looked-after children in the UK. For example, certain studies considered youth offenders in the USA. In America, youth offenders may be mandated by a court to group home/residential care or multidimensional treatment foster care, often as a support to reunification with birth parents. It is unclear if this population are legally considered "ward of the state."

Study level quality was also problematic. Frequent problems with study quality included considerable differences between comparison groups at baseline, lack of clarity about how randomisation was performed, large loss to follow up, lack of clarity regarding how much missing data (or for what reason data was missing), and a lack of clarity regarding a priori approach to analysis or study methods (e.g. use of per protocol or intent to treat approach).

Benefits and harms

The committee considered the interventions presented and their possible benefits/harms. Multidimensional treatment foster care (MTFC) was found to have no meaningful impact for number of placement disruptions over 12 months in pre-schoolers in foster care between the ages of 3 – 6 years (Fisher 2011). Other evidence in MTFC for adolescents could not differentiate an effect for the intervention.

Interventions considering training for caregivers of looked after children were considered, studies investigating Promoting First Relationships, KEEP foster parent training, Middle School Success, CBT-informed foster parent training, Social Learning Theory-based training, were unable to differentiate an effect for placement stability. However, one study that considered Parent Management Training Oregon compared to care as usual, found an improvement in placement instability rate (defined as (number of placements/days in foster care)*365) over 6 months follow up. For the reasons described above (use of "number of

placements" and 6-month follow up) the committee did not consider this outcome to be a very convincing one. However, this intervention was discussed for its potential in UK practice. The committee thought that, broadly speaking, any training that provides skills in caregiver's "therapeutic parenting" is likely to be a good thing in looked after children. However, since Parent Management Training Oregon was an intensive behavioural training intervention for use among children with serious emotional disturbance, they were keen to review the evidence for the usefulness of training programmes in promoting positive relationships before recommending under this review question.

The committee also had further questions about the population in which Parent Management Training Oregon was applied. This study considered participants between the ages of 3 – 16 years, in foster care, with serious emotional disturbance, where the child had a case plan goal of reunification, and caregivers resided in the area. The intervention appeared to be delivered to both foster carers and the birth family. Therefore, was it an intervention with greater relevance for promoting reunification after short-term placement? If so, the committee were also keen to see evidence from review question 5.1 on supporting movement out of care before recommending this intervention.

The committee considered the potential negative effects of training interventions and were concerned that these interventions should be trauma-informed. For example, applying time-outs (often recommended in behavioural management training) can be harmful for children with history of trauma. The committee were concerned that any training offered to caregivers should include emotional support training and not just behaviour management.

Finally, the committee pointed out that while this intervention may reduce the number of placement moves prior to (possible) reunification with birth parents, it was difficult to tell from the outcomes provided if the intervention was successful in preventing placement breakdown following reunification with the birth parents.

Next the committee considered the Fostering Healthy Futures intervention which was found to be significantly associated with a lower odds of negative placement change over 18-months observation period (OR 0.29 95%CI 0.09 to 0.98) among preadolescents in foster care. This was an intervention to improve skills in small groups of looked after children such as emotional recognition, problem solving, anger management, and healthy relationships. In addition, this intervention included a one-to-one mentoring component with graduate students in social work. The committee considered that the intervention was promising however that there were resource implications involved with skills training and mentoring, and that the evidence for this particular intervention was insufficient to merit a recommendation for the entire population under study (preadolescent children in foster care). The committee were not aware of socioemotional skills building interventions currently being used for LACYP in the UK. Instead, the committee suggested such interventions should be considered in response to the needs of the particular child. The committee wanted to revisit relational interventions, such as mentoring, after considering the results from review question 2.1 (interventions to support positive relationships) and review question 3.2 (interventions to support health and wellbeing).

Following the presentation and discussion of evidence, the committee made recommendations that were primarily-consensus based in the response to the lack of clear evidence about interventions and approaches to support care placement stability.

Regarding training, the committee did not wish to make any recommendations about the specific curriculum or methods used in the training provided to caregivers until the other review questions had been completed. However, the committee considered that carers (for example, foster carers) are often unaware of the kinds of interventions that a looked after child placed with them has received or should be practicing. In order to support continuity of care in this regard the committee recommended that carers should be included and informed about the contents and aims of interventions used to support placement stability in looked after children.

The committee also discussed how any training should be delivered. They recognised that, in practice, training - such as behaviour management training - is often delivered reactively, in response to difficulties that a carer is currently experiencing. This threatens placement stability since the carer may feel underprepared and under-supported to continue the placement. Instead, the committee advocated a greater emphasis on forward planning support for carers (prior to placement) based on the recognised and documented needs of the individual child. As well as considering what kinds of training may be necessary, the plan should also identify any other agencies that might need to be involved (for example, mental health) and additionally where the source of funding is likely to come from.

As part of the above process, the committee wanted to suggest some specific aspects of training that should be considered for proactive and planned support. Given the high prevalence of trauma in children in care, the committee suggested that the need for trauma-informed care training should be considered for all caregivers. Examples of the kinds of topics that might be covered in trauma-informed care training include: information about trauma and looking after LACYP with a history of trauma, managing of own emotions, and promoting resilience and self-regulatory skills.

Alongside trauma, the committee considered training for other issues that may commonly affect substitute caregivers and impact placement stability. The committee considered behaviour to be more complex an issue than simply "behaviour management" in LACYP. Rather behaviour may stem from issues relating to disorganised attachment, leading to emotional and social consequences. Caregivers will often need to offer sensitive and responsive care in response to difficult behaviour. For some LACYP, further consolidation may be helpful to support placement stability. For example, coaching, mentoring, or skills training. Therefore, the committee recommended therapeutic parenting training for all carers (encompassing attachment-informed, high support and high nurturing relational care) and further consolidation based on the bespoke needs of the child.

The committee also considered that no evidence had been presented on the use of respite for substitute caregivers. This was felt to be something of vital importance to offer caregivers needed rest and to prevent burnout and subsequent placement breakdown. It was noted that some caregivers may feel that their caregiving duties prevent them from ever going on holiday or travelling. Once again, the committee considered that respite should be offered in a planned and proactive manner, if offered reactively in response to crisis it may already be too late to prevent placement breakdown. In addition, whoever is providing care while the primary caregiver is receiving respite will need to have the skill set required to cope with the individual needs of the child. The committee were also conscious that the term respite may be received very negatively by LACYP (e.g. "my carer needs a break from me"). Therefore, respite care should be framed in as positive a light as possible. The committee encouraged the use of an alternative term ("support care") for this reason. It is particularly helpful if respite is provided by a person with whom the LACYP is familiar to prevent the feeling that the child or young person is being "sent away". The committee therefore recommended that planned and proactive (not reactive) respite care be used to support care placements, as part of the care plan, and considering skill set required for the respite carer to meet the child's needs. Respite should be framed positively for the child and be in their best interest. Where possible, respite should be with a carer who is familiar to the child.

The committee considered that no evidence had been presented about interventions to support placement stability among looked after children and young people in residential care. Therefore, a research recommendation was drafted to encourage further research to fill this gap.

Cost effectiveness and resource use

No economic evidence was identified in relation to this review question, and overall, the committee felt that there was insufficient evidence of effectiveness in relation to costs to

recommend any specific interventions for placement stability. However, the committee noted that the interventions captured in the evidence review, especially those taking place in the home, were often intensive and likely to incur substantial costs, but that placement breakdown can also result in high costs to the system. In the short term, placement breakdown leads to increased social care case management work and the need for additional placement arrangements, some of which will be high-cost emergency placements. In addition, placement instability can contribute to further disruption of LACYP's social and emotional relationships, sense of belonging and educational outcomes, with long-term consequences that were not captured in randomised controlled trials.

The committee discussed that in current practice, behavioural management support is already offered for birth families by family support services in the UK but training for foster carers and other caregivers is more variable and the committee wished to make consensus-based recommendations about how training should be delivered to support placement stability. The committee discussed that in some local authorities, trauma-informed training and therapeutic parenting training for all foster carers is already part of current practice and that it would be desirable to reduce variation in practice across the country. While this is likely to incur additional costs in some areas, the committee felt that the costs would be partially offset by preventing placement breakdown. The committee also agreed that there are freely available training resources on trauma-informed care, and that making these accessible and/or integrating them into existing training for carers would not have additional resource implications.

The committee also discussed the importance of support, including respite for carers. These recommendations are about how respite care should be done if it is going to be done (i.e. in a planned manner with better communication and a support carer who the looked after person is familiar with). Therefore, there shouldn't be a significant additional cost beyond taking a more proactive approach to respite support arrangements.

The committee recognised that there was an additional set of recommendations for carers in the NICE guideline on supporting adult carers, and that these recommendations may be relevant for some carers of older looked-after children.

Recommendations

1.3.8 Inform the looked-after child or young person's carers about any interventions used to support the looked-after person, including the purpose of these interventions.

1.3.9 For further guidance on support for adult carers, follow the NICE guideline on supporting adult carers.

1.3.10 Plan training for carers so that it is delivered before it is needed. Think about the need for multiagency involvement in training programmes and ensure that the organisations involved agree the source of funding between them. Consider the need for trauma-informed care training for all carers.

1.3.11 Supervising social workers should work with carers to assess the needs of the looked-after person to inform and tailor training and development needs for the carers.

1.3.12 Provide a schedule of mandatory training for all carers. This should cover:

- Therapeutic, trauma-informed, parenting (covering attachment-informed, highly supportive and responsive relational care).

1.3.4 As part of the care plan, think about the need for planned respite care (or 'support care') for carers.

1.3.5 Ensure that respite care is used in the looked-after person's best interests and explain this to the looked-after person.

1.3.6 Use a respite carer who the child or young person is familiar with if possible, and take into account the skills or training needed to meet the looked-after person's assessed need.

Research recommendations

What is the effectiveness of interventions to promote placement stability among looked-after children and young people in residential care?

This evidence review supports recommendations 1.3.4 to 1.3.6 and 1.3.8 to 1.3.12 and the research recommendation on placement stability in residential care. Other evidence supporting these recommendations can be found in the evidence review on barriers to, and facilitators for, supporting care placement stability among looked-after children and young people [review B]

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Qualitative evidence

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Cost effectiveness

No cost-effectiveness evidence identified for this review question

1 # Appendices

2 ## Appendix A – Review protocols

3 **Review protocol for interventions to support placement stability for looked-after children and young people**
4

ID	Field	Content
0.	PROSPERO registration number	[Complete this section with the PROSPERO registration number once allocated]
1.	Review title	Interventions and approaches to support care placement stability in looked-after children and young people
2.	Review question	1.1a: What is the effectiveness of health and social care interventions and approaches to support care placement stability? 1.1b: Are interventions to support placement stability acceptable and accessible to looked-after children and young people and their care providers? What are the barriers to, and facilitators for the effectiveness of these interventions to support placement stability in looked-after children and young people?
3.	Objective	<u>Quantitative</u> To determine the effectiveness and harms of health and social care interventions and approaches to support care placement stability in looked after children and young people. <u>Qualitative</u> To determine if interventions to support placement stability are acceptable and accessible to looked after children, their carers, and providers who

		would deliver them. To determine other barriers and facilitators to the effectiveness of these interventions.
4.	Searches	**Sources to be searched** • PsycINFO (Ovid) • Embase (Ovid) • MEDLINE (Ovid) • MEDLINE In-Process (Ovid) • MEDLINE Epubs Ahead of Print • PsycINFO (Ovid) • Social policy and practice (Ovid) • Cochrane Central Register of Controlled Trials (CENTRAL) • Cochrane Database of Systematic Reviews (CDSR) • Database of Abstracts of Reviews of Effect (DARE) • EconLit (Ovid) – economic searches only • NHSEED (CRD) - economic searches only **Supplementary search techniques** • Studies published from 1st January 1990 to present day. **Limits** • Studies reported in English • No study design filters will be applied • Animal studies will be excluded • Conference abstracts/proceedings will be excluded. • For economic searches, the Cost Utility, Economic Evaluations and Quality of Life filters will be applied. The full search strategies for MEDLINE database will be published in the final review.

		For each search the Information Services team at NICE will quality assure the principal database search strategy and peer review the strategies for the other databases using an adaptation of the PRESS 2015 Guideline Evidence-Based Checklist
5.	Condition or domain being studied	This review is for part of an updated NICE guideline for looked-after children and young people and concerns the support of placement stability in their current care placement.
6.	Population	Looked after children and young people, wherever they are looked after, from birth until age 18 and their families and carers (including birth parents, connected carers, and prospective adoptive parents). Also including: • Children and young people living at home with birth parents but under a full or interim local authority care order and are subject to looked-after children and young people processes and statutory duties. • Children and young people in a prospective adoptive placement. • Looked-after children and young people on remand, detained in secure youth custody and those serving community orders.
7.	Intervention	Health and social care interventions and approaches to support care placement stability. Including support for: children and young people themselves; birth families (with children and young people under a full care order); foster carers; key workers in residential care units; connected carers; prospective adopters; special guardians; and social care workers. Example interventions and approaches of interest, include: • Interventions to support care planning (e.g. to support transition between care placements; to support continuity of health and social care in new care placements; to prevent crisis situations)

		• Interventions for preparing a child or young person before entering care or changing placement (not including leaving care) • Approaches and interventions to improve education, information giving, advice, and signposting for carers or LACYP prior to, and during, care placement • Models of multi-agency care placement panel • Interventions to support kinship placements and connected care • Interventions to support keeping siblings together (e.g. supporting sibling relationships and considering the individual needs of siblings) • Interventions to support continuity of significant relationships (e.g. direct and indirect contact with trusted adults) • Interventions and approaches to support positive relationships between LACYP and carer (as relates to placement stability and excluding interventions for attachment disorders) • Mentoring interventions • Day visits and activity-based holidays
8.	Comparator	Quantitative evidence Comparator may include standard care, waiting list, or another approach to support care placement stability Qualitative evidence Not applicable
9.	Types of study to be included	Quantitative evidence • Systematic reviews of included study designs • Randomised controlled trials If insufficient evidence, progress to non-randomised prospective controlled study designs

		If insufficient evidence, progress to non-randomised, non-prospective, controlled study designs (for example, retrospective cohort studies, case control studies, uncontrolled before and after studies, and interrupted time series) <u>Qualitative evidence</u> • Including focus groups and interview-based studies (mixed-methods studies will also be included provided they contain relevant qualitative data). Evidence must be related to acceptability, accessibility of interventions or other barriers to and facilitators for their effectiveness to support care placement stability.
10.	Other exclusion criteria	• Studies including mixed populations (i.e. looked after and non-looked after children) without reporting results separately for LACYP • Strategies, policies, system structure and the delivery of care that is covered in statutory guidance about looked after children and young people • Studies relating to transition from children's to adult health or social care services • Studies of interventions for specific clinical conditions covered in existing NICE guidelines • Interventions for mental health and emotional wellbeing covered in existing NICE guidelines • Health promotion interventions covered in existing NICE guidelines • Interventions focussed on improving permanency of placements out of care (covered in review question 5.1 and 5.2) • Studies and interventions relating to attachment in children and young people who are in care (excluding evidence that is primarily among LACYP with attachment disorders or attachment difficulties, using the definitions outlined in the NICE guideline on attachment difficulties)

		Quantitative evidence exclusion • Countries outside of the UK (unless not enough evidence, then progress to OECD countries) • Studies older than the year 2000 (unless not enough evidence, then progress to include studies between 1990 to current) Qualitative evidence exclusion • Mixed-methods studies reporting qualitative data that cannot be distinguished from quantitative data. • Countries outside of the UK (unless evidence concerns an intervention which has been shown to be effective in reviewed quantitative evidence) • Studies older than the year 2010 (unless not enough evidence, then progress to include studies between 1990 to current)
11.	Context	This review will consider interventions to support placement stability in children and young people who are looked after. In March 2018, 75,420 children and young people in England were looked after. Care placements for looked after children and young people may include: foster placement (73%), residential accommodation (including secure units, children's homes, and semi-independent living arrangements) (11%), placement with birth parents (6%), placement for prospective adoption (3%), another placement in the community (4%), or placement in residential schools or other residential settings (3%). For looked after children and young people only 29% of placements are long term and 50% of long-term teenage placements have been found to break down. Placement break-down is associated with poor outcomes for looked-after children and young people.
12.	Primary outcomes (critical outcomes)	Quantitative outcomes • Completion of care placement • Number of placements

		• Adverse events such as prematurely dropping out of a care placement, transitioning from one care situation to another, absconding, or re-entering previous care situation Qualitative outcomes Qualitative evidence related to interventions to support placement stability will be examined. Evidence should relate to the views of looked after children, their carers, and providers, who would deliver eligible interventions, on: • The accessibility and acceptability of the intervention, including information about the source and type of intervention used. • Barriers to and facilitators for intervention effectiveness in supporting placement stability.
13.	Secondary outcomes (important outcomes)	None
14.	Data extraction (selection and coding)	All references identified by the searches and from other sources will be uploaded into EPPI reviewer and de-duplicated. 10% of the abstracts will be reviewed by two reviewers, with any disagreements resolved by discussion or, if necessary, a third independent reviewer. The full text of potentially eligible studies will be retrieved and will be assessed in line with the criteria outlined above. A standardised form will be used to extract data from studies (see Developing NICE guidelines: the manual section 6.4). Study investigators may be contacted for missing data where time and resources allow.
15.	Risk of bias (quality) assessment	Risk of bias and/or methodological quality will be assessed using the preferred checklist for each study type as described in Developing NICE guidelines: the manual.

		The risk of bias across all available evidence will be evaluated for each outcome using an adaptation of the 'Grading of Recommendations Assessment, Development and Evaluation (GRADE) toolbox' developed by the international GRADE working group http://www.gradeworkinggroup.org/ GRADE and GRADE CERQual will be used to assess confidence in the findings from quantitative and qualitative evidence synthesis respectively.
16.	Strategy for data synthesis	Quantitative data Meta-analyses of interventional data will be conducted with reference to the Cochrane Handbook for Systematic Reviews of Interventions (Higgins et al. 2011). Fixed- and random-effects models (der Simonian and Laird) will be fitted for all syntheses, with the presented analysis dependent on the degree of heterogeneity in the assembled evidence. Fixed-effects models will be the preferred choice to report, but in situations where the assumption of a shared mean for fixed-effects model is clearly not met, even after appropriate pre-specified subgroup analyses is conducted, random-effects results are presented. Fixed-effects models are deemed to be inappropriate if one or both of the following conditions was met: • Significant between study heterogeneity in methodology, population, intervention or comparator was identified by the reviewer in advance of data analysis. • The presence of significant statistical heterogeneity in the meta-analysis, defined as $I^2 \geq 50\%$.

		• Meta-analyses will be performed in Cochrane Review Manager V5.3 If the studies are found to be too heterogeneous to be pooled statistically, a simple recounting and description of findings (a narrative synthesis) will be conducted. Qualitative data Information from qualitative studies will be combined using a thematic synthesis. By examining the findings of each included study, descriptive themes will be independently identified and coded in NVivo v.11. The qualitative synthesis will interrogate these 'descriptive themes' to develop 'analytical themes', using the theoretical framework derived from overarching qualitative review questions. Themes will also be organised at the level of recipients of care and providers of care. Evidence integration A segregated and contingent approach will be undertaken, with sequential synthesis. Quantitative and qualitative data will be analysed and presented separately. For non-UK evidence, the data collection and analysis of qualitative data will occur after and be informed by the collection and analysis of quantitative effectiveness data. Following this, all qualitative and quantitative data will be integrated using tables and matrices. By intervention, qualitative analytical themes will be presented next to quantitative effectiveness data. Data will be compared for similarities and incongruence with supporting explanatory quotes where possible.

17.	Analysis of sub-groups	Results will be stratified by the following subgroups where possible. In addition, for quantitative synthesis where there is heterogeneity, subgroup analysis will be undertaken using the following subgroups. Age of LACYP: • LACYP in early years • LACYP in primary education • LACYP in secondary education and further education until age 18 Subgroups, of specific consideration, will include: • Looked-after children on remand • Looked-after children in secure settings • Looked-after children and young people with mental health and emotional wellbeing needs • Looked-after children and young people who are babies and young children • Looked-after children and young people who are unaccompanied children seeking asylum, or refugees • Looked-after children and young people who are at risk or victims of exploitation (including female genital mutilation) and trafficking • Looked-after children and young people who are teenage and young parents in care • Looked-after children and young people with disabilities; speech, language and communication needs; special education needs or behaviour that challenges. • Looked-after children and young people who are placed out of area • Looked-after children and young people who are LGBTQ

18.	Type and method of review	☒ Intervention ☐ Diagnostic ☐ Prognostic ☐ Qualitative ☐ Epidemiologic ☐ Service Delivery ☐ Other (please specify)
19.	Language	English
20.	Country	England
21.	Anticipated or actual start date	[For the purposes of PROSPERO, the date of commencement for the systematic review can be defined as any point after completion of a protocol but before formal screening of the identified studies against the eligibility criteria begins. A protocol can be deemed complete after sign-off by the NICE team with responsibility for quality assurance.]
22.	Anticipated completion date	[Give the date by which the guideline is expected to be published. This field may be edited at any time. All edits will appear in the record audit trail. A brief explanation of the reason for changes should be given in the Revision Notes facility.]
23.	Stage of review at time of this submission	**Review stage** / **Started** / **Completed** Preliminary searches ☐ ☐ Piloting of the study selection process ☐ ☐ Formal screening of search results against eligibility criteria ☐ ☐ Data extraction ☐ ☐

		Risk of bias (quality) assessment	☐	☐
		Data analysis	☐	☐
24.	Named contact	**5a. Named contact** [Give development centre name] **5b Named contact e-mail** [Guideline email]@nice.org.uk [Developer to check with Guideline Coordinator for email address] **5e Organisational affiliation of the review** National Institute for Health and Care Excellence (NICE)		
25.	Review team members	From the Guideline Updates Team: • Caroline Mulvihill • Stephen Duffield • Bernadette Li • Rui Martins		
26.	Funding sources/sponsor	This systematic review is being completed by the Guideline Updates Team, which is part of NICE.		
27.	Conflicts of interest	All guideline committee members and anyone who has direct input into NICE guidelines (including the evidence review team and expert witnesses) must declare any potential conflicts of interest in line with NICE's code of practice for declaring and dealing with conflicts of interest. Any relevant interests, or changes to interests, will also be declared publicly at the start of each guideline committee meeting. Before each meeting, any potential conflicts of interest will be considered by the guideline committee Chair and a senior member of the development team. Any decisions to exclude a person from all or part of a meeting will be documented. Any changes to a member's		

		declaration of interests will be recorded in the minutes of the meeting. Declarations of interests will be published with the final guideline.
28.	Collaborators	Development of this systematic review will be overseen by an advisory committee who will use the review to inform the development of evidence-based recommendations in line with section 3 of Developing NICE guidelines: the manual. Members of the guideline committee are available on the NICE website: [NICE guideline webpage].
29.	Other registration details	[Give the name of any organisation where the systematic review title or protocol is registered (such as with The Campbell Collaboration, or The Joanna Briggs Institute) together with any unique identification number assigned. If extracted data will be stored and made available through a repository such as the Systematic Review Data Repository (SRDR), details and a link should be included here. If none, leave blank.]
30.	Reference/URL for published protocol	[Give the citation and link for the published protocol, if there is one.]
31.	Dissemination plans	NICE may use a range of different methods to raise awareness of the guideline. These include standard approaches such as: • notifying registered stakeholders of publication • publicising the guideline through NICE's newsletter and alerts • issuing a press release or briefing as appropriate, posting news articles on the NICE website, using social media channels, and publicising the guideline within NICE. [Add in any additional agree dissemination plans.]
32.	Keywords	Looked after children, looked after young people, children in care, placement stability, interventions, systematic review, quantitative,
33.	Details of existing review of same topic by same authors	[Give details of earlier versions of the systematic review if an update of an existing review is being registered, including full bibliographic reference if possible. NOTE: most NICE reviews will not constitute an update in PROSPERO language. To be an update it needs to be the same review question/search/methodology. If anything has changed it is a new review]

34.	Current review status	☐ Ongoing ☐ Completed but not published ☐ Completed and published ☐ Completed, published and being updated ☐ Discontinued
35..	Additional information	[Provide any other information the review team feel is relevant to the registration of the review.]
36.	Details of final publication	www.nice.org.uk

1

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Appendix B – Literature search strategies

Effectiveness searches

Bibliographic databases searched for the guideline:

- Cochrane Database of Systematic Reviews – CDSR (Wiley)
- Cochrane Central Register of Controlled Trials – CENTRAL (Wiley)
- Database of Abstracts of Reviews of Effects – DARE (CDSR)
- PsycINFO (Ovid)
- EMBASE (Ovid)
- MEDLINE (Ovid)
- MEDLINE Epub Ahead of Print (Ovid)
- MEDLINE In-Process (Ovid)
- Social policy and practice (Ovid)
- ERIC (ProQuest)

A NICE information specialist conducted the literature searches for the evidence review. The searches were originally run in June 2019 with an additional search of the ERIC database in October 2019.

Searches were run on population only and the results were sifted for each review question (RQ). The searches were rerun on all databases reported above in July 2020 and again in October 2020.

The principal search strategy was developed in MEDLINE (Ovid interface) and adapted, as appropriate, for use in the other sources listed in the protocol, taking into account their size, search functionality and subject coverage.

The MEDLINE strategy below was quality assured (QA) by trained NICE information specialist. All translated search strategies were peer reviewed to ensure their accuracy. Both procedures were adapted from the 2016 PRESS Checklist. The translated search strategies are available in the evidence reviews for the guideline.

The search results were managed in EPPI-Reviewer v5. Duplicates were removed in EPPI-R5 using a two-step process. First, automated deduplication is performed using a high-value algorithm. Second, manual deduplication is used to assess 'low-probability' matches. All decisions made for the review can be accessed via the deduplication history.

English language limits were applied in adherence to standard NICE practice and the review protocol.

A date limit of 1990 was applied to align with the approximate advent of the Children Act 1989.

The limit to remove animal studies in the searches was the standard NICE practice, which has been adapted from: Dickersin, K., Scherer, R., & Lefebvre, C. (1994). Systematic Reviews: Identifying relevant studies for systematic reviews. *BMJ*, 309(6964), 1286.

No study design filters were applied, in adherence to the review protocol.

Table 1: search strategy

Medline Strategy, searched 10th June 2019 **Database: Ovid MEDLINE(R) 1946 to June 10, 2019** **Search Strategy:**
1 child, orphaned/ (659)
2 child, foster/ (71)
3 child, adopted/ (46)
4 adolescent, institutionalized/ (126)
5 ("looked after" adj2 (juvenile* or child* or adolescen* or toddler* or infant* or infancy* or teen* or tween* or young* or baby* or babies* or twin* or sibling* or youth*)).tw. (123)
6 ("care leaver*" or "leaving care").tw. (31)

Medline Strategy, searched 10th June 2019 Database: Ovid MEDLINE(R) 1946 to June 10, 2019 Search Strategy:
7 (("in care" or "care experience*") adj1 (juvenile* or child* or adolescen* or toddler* or infant* or infancy* or teen* or tween* or young* or baby* or babies* or twin* or sibling* or youth*)).tw. (236) 8 ((nonparent* or non-parent* or parentless* or parent-less) adj3 (juvenile* or child* or adolescen* or toddler* or infant* or infancy* or teen* or tween* or young* or baby* or babies* or twin* or sibling* or youth*)).tw. (111) 9 ((relinquish* or estrange*) adj2 (juvenile* or child* or adolescen* or toddler* or infant* or infancy* or teen* or tween* or young* or baby* or babies* or twin* or sibling* or youth*)).tw. (74) 10 ((child* or infancy or adolescen* or juvenile* or toddler* or infant* or teen* or tween* or young* or baby or babies or twin* or sibling* or youth*) adj2 (orphan* or foster* or adopt* or abandon* or unwanted or unaccompanied or homeless or asylum* or refugee*)).ti. (2973) 11 "ward of court*".tw. (12) 12 or/1-11 (4225) 13 residential facilities/ (5286) 14 group homes/ (948) 15 halfway houses/ (1051) 16 (("out of home" or " out-of-home" or placement* or "semi independent" or "semi-independent") adj2 care*).tw. (1131) 17 ((residential or supported or remand* or secure or correctional) adj1 (accommodation* or institut* or care or lodging or home* or centre* or center* or facilit*)).tw. (6595)

Medline Strategy, searched 10th June 2019 **Database: Ovid MEDLINE(R) 1946 to June 10, 2019** **Search Strategy:**
18 or/13-17 (13612) 19 orphanages/ (435) 20 adoption/ (4727) 21 foster home care/ (3503) 22 (special adj1 guardian*).tw. (7) 23 ((placement* or foster*) adj2 (care* or family or families)).tw. (3144) 24 ((kinship or nonkinship or non kinship or connected or substitute*) adj1 care*).tw. (279) 25 or/19-24 (9589) 26 exp Infant/ or Infant Health/ or Infant Welfare/ (1098738) 27 (prematur* or pre-matur* or preterm* or pre-term* or infan* or newborn* or new-born* or perinat* or peri-nat* or neonat* or neo-nat* or baby* or babies or toddler*).ti,ab,in,jn. (811620) 28 exp Child/ or exp Child Behavior/ or Child Health/ or Child Welfare/ (1838706) 29 Minors/ (2505) 30 (child* or minor or minors or boy* or girl* or kid or kids or young*).ti,ab,in,jn. (2212038)

Medline Strategy, searched 10th June 2019 Database: Ovid MEDLINE(R) 1946 to June 10, 2019 Search Strategy:
31 exp pediatrics/ (55350) 32 (pediatric* or paediatric* or peadiatric*).ti,ab,in,jn. (768069) 33 Adolescent/ or Adolescent Behavior/ or Adolescent Health/ (1937435) 34 Puberty/ (12990) 35 (adolescen* or pubescen* or prepubescen* or pre-pubescen* or pubert* or prepubert* or pre-pubert* or teen* or preteen* or pre-teen* or juvenil* or youth* or under*age*).ti,ab,in,jn. (393509) 36 Schools/ (35128) 37 Child Day Care Centers/ or exp Nurseries/ or Schools, Nursery/ (8591) 38 (pre-school* or preschool* or kindergar* or daycare or day-care or nurser* or school* or pupil* or student*).ti,ab,jn. (440583) 39 ("under 18*" or "under eighteen*" or "under 25*" or "under twenty five*").ti,ab. (3651) 40 or/26-39 (4935665) 41 18 and 40 (4519) 42 12 or 25 or 41 (15912) 43 animals/ not humans/ (4554892)

Medline Strategy, searched 10th June 2019 **Database: Ovid MEDLINE(R) 1946 to June 10, 2019** **Search Strategy:**
44 42 not 43 (15801) 45 limit 44 to english language (14199) 46 limit 45 to ed=19900101-20190606 (11059) No study design filters were used for the search strategy

Cost-effectiveness searches

Sources searched:

- Econlit (Ovid)
- Embase (Ovid)
- MEDLINE (Ovid)
- MEDLINE In-Process (Ovid)
- PsycINFO (Ovid)
- NHS EED (Wiley)

Search filters to retrieve cost utility, economic evaluations and quality of life papers were appended to the MEDLINE, Embase and PsycINFO searches reported above. The searches were conducted in July 2019. The searches were re-run in October 2020.

Databases	Date searched	Version/files	No. retrieved with CU filter	No retrieved with Econ Eval and QoL filters	No. retrieved with Econ Eval and QoL filters and NOT out CU results
EconLit (Ovid)	09/07/2019	1886 to June 27, 2019	176 (no filter)	Not run again	Not run again
NHS Economic Evaluation Database (NHS EED) (legacy database)	09/07/2019	09/07/2019	105 (no filter)	Not run again	Not run again
Embase (Ovid)	09/07/2019 15/07/2019	1946 to July 08, 2019 1988 to 2019 Week 28	307	2228	1908
MEDLINE (Ovid)	09/07/2019 15/07/2019	1946 to July 08, 2019 1946 to July 12, 2019	269	1136	1135
MEDLINE In-Process (Ovid)	09/07/2019 15/07/2019	1946 to July 08, 2019 1946 to July 12, 2019	6	122	93
MEDLINE Epub Ahead of Print	09/07/2019 15/07/2019	July 08, 2019 July 12, 2019	12	38	29
PsycINFO (Ovid)	09/07/2019 15/07/2019	1987 to July Week 1 2019 1987 to July Week 2 2019	265	Not searched for econ eval and QoL results	Not searched for econ eval and QoL results

Search strategies: Cost Utility filter
Database: PsycINFO <1987 to July Week 1 2019> Search Strategy:

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1 Foster children/ (1566)

2 Adopted children/ (1578)

3 ("looked after" adj2 (juvenile* or child* or adolescen* or toddler* or infant* or infancy* or teen* or tween* or young* or baby* or babies* or twin* or sibling* or youth*)).tw. (433)

4 ("care leaver*" or "leaving care").tw. (282)

5 (("in care" or "care experience*") adj1 (juvenile* or child* or adolescen* or toddler* or infant* or infancy* or teen* or tween* or young* or baby* or babies* or twin* or sibling* or youth*)).tw. (772)

6 ((nonparent* or non-parent* or parentless* or parent-less) adj3 (juvenile* or child* or adolescen* or toddler* or infant* or infancy* or teen* or tween* or young* or baby* or babies* or twin* or sibling* or youth*)).tw. (309)

7 ((relinquish* or estrange*) adj2 (juvenile* or child* or adolescen* or toddler* or infant* or infancy* or teen* or tween* or young* or baby* or babies* or twin* or sibling* or youth*)).tw. (142)

8 "ward of court*".tw. (0)

9 ((child* or infancy or adolescen* or juvenile* or toddler* or infant* or teen* or tween* or young* or baby or babies or twin* or sibling* or youth*) adj2 (abandon* or unwanted or unaccompanied or homeless or asylum* or refugee*)).ti. (1638)

10 or/1-9 (6348)

11 group homes/ (884)

12 halfway houses/ (114)

13 (("out of home" or " out-of-home" or placement* or "semi independent" or "semi-independent") adj2 care*).tw. (1917)

14 ((residential or supported or remand* or secure or correctional) adj1 (accommodation* or institut* or care or lodging or home* or centre* or center* or facilit*)).tw. (8380)

15 or/11-14 (10954)

16 orphanages/ (301)

17 adoption/ (2693)

18 foster home care/ (0)

19 (special adj1 guardian*).tw. (5)

20 ((placement* or foster*) adj2 (care* or family or families)).tw. (7275)

21 ((kinship or nonkinship or non kinship or connected or substitute*) adj1 care*).tw. (790)

22 or/16-21 (10189)

23 exp Infant/ or Infant Health/ or Infant Welfare/ (0)

24 (prematur* or pre-matur* or preterm* or pre-term* or infan* or newborn* or new-born* or perinat* or peri-nat* or neonat* or neo-nat* or baby* or babies or toddler*).ti,ab,in,jn. (119577)

25 exp Child/ or exp Child Behavior/ or Child Health/ or Child Welfare/ (8166)

26 Minors/ (0)

27 (child* or minor or minors or boy* or girl* or kid or kids or young*).ti,ab,in,jn. (762095)

28 exp pediatrics/ (26284)

29 (pediatric* or paediatric* or peadiatric*).ti,ab,in,jn. (71640)

30 Adolescent/ or Adolescent Behavior/ or Adolescent Health/ (1874)

31 Puberty/ (2287)

32 (adolescen* or pubescen* or prepubescen* or pre-pubescen* or pubert* or prepubert* or pre-pubert* or teen* or preteen* or pre-teen* or juvenil* or youth* or under*age*).ti,ab,in,jn. (291098)

33 Schools/ (25726)

34 Child Day Care Centers/ or exp Nurseries/ or Schools, Nursery/ (0)

35 (pre-school* or preschool* or kindergar* or daycare or day-care or nurser* or school* or pupil* or student*).ti,ab,jn. (578348)

36 ("under 18*" or "under eighteen*" or "under 25*" or "under twenty five*").ti,ab. (811)

37 or/23-36 (1281612)

38 15 and 37 (5647)

39 10 or 22 or 38 (18267)

40 animals/ not humans/ (4267)

41 39 not 40 (18266)

42 limit 41 to english language (17063)

43 (1990* or 1991* or 1992* or 1993* or 1994* 1995* or 1996* or 1997* or 1998* or 1999* or 2000* or 2001* or 2002* or 2003* or 2004* or 2005* or 2006* or 2007* or 2008* or 2009* or 2010* or 2011* or 2012* or 2013* or 2014* or 2015* or 2016* or 2017* or 2018* or 2019*).up. (3398945)

44 42 and 43 (16072)

45 Markov chains/ (1336)

46 ((qualit* adj2 adjust* adj2 life*) or qaly*).tw. (1638)

47 (EQ5D* or EQ-5D* or ((euroqol or euro-qol or euroquol or euro-quol or eurocol or euro-col) adj3 ("5" or five)) or (european* adj2 quality adj3 ("5" or five))).tw. (1711)

48 "Costs and Cost Analysis"/ (14750)

49 cost.ti. (7067)

50 (cost* adj2 utilit*).tw. (745)

51 (cost* adj2 (effective* or assess* or evaluat* or analys* or model* or benefit* or threshold* or quality or expens* or saving* or reduc*)).tw. (29345)

52 (economic* adj2 (evaluat* or assess* or analys* or model* or outcome* or benefit* or threshold* or expens* or saving* or reduc*)).tw. (7025)

53 ((incremental* adj2 cost*) or ICER).tw. (1058)

54 utilities.tw. (1742)

55 markov*.tw. (3797)

56 (dollar* or USD or cents or pound or pounds or GBP or sterling* or pence or euro or euros or yen or JPY).tw. (8371)

57 ((utility or effective*) adj2 analys*).tw. (2844)

58 (willing* adj2 pay*).tw. (2253)

59 45 or 46 or 47 or 48 or 49 or 50 or 51 or 52 or 53 or 54 or 55 or 56 or 57 or 58 (60767)

60 44 and 59 (265)

Database: Ovid MEDLINE(R) <1946 to July 08, 2019>

(line 65)

Search Strategy:

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1 child, orphaned/ (661)

2 child, foster/ (74)

3 child, adopted/ (48)

4 adolescent, institutionalized/ (126)

5 ("looked after" adj2 (juvenile* or child* or adolescen* or toddler* or infant* or infancy* or teen* or tween* or young* or baby* or babies* or twin* or sibling* or youth*)).tw. (123)

6 ("care leaver*" or "leaving care").tw. (32)

7 (("in care" or "care experience*") adj1 (juvenile* or child* or adolescen* or toddler* or infant* or infancy* or teen* or tween* or young* or baby* or babies* or twin* or sibling* or youth*)).tw. (240)

8 ((nonparent* or non-parent* or parentless* or parent-less) adj3 (juvenile* or child* or adolescen* or toddler* or infant* or infancy* or teen* or tween* or young* or baby* or babies* or twin* or sibling* or youth*)).tw. (111)

9 ((relinquish* or estrange*) adj2 (juvenile* or child* or adolescen* or toddler* or infant* or infancy* or teen* or tween* or young* or baby* or babies* or twin* or sibling* or youth*)).tw. (74)

10 ((child* or infancy or adolescen* or juvenile* or toddler* or infant* or teen* or tween* or young* or baby or babies or twin* or sibling* or youth*) adj2 (orphan* or foster* or adopt* or abandon* or unwanted or unaccompanied or homeless or asylum* or refugee*)).ti. (2986)

11 "ward of court*".tw. (12)

12 or/1-11 (4244)

13 residential facilities/ (5299)

14 group homes/ (950)

15 halfway houses/ (1052)

16 (("out of home" or " out-of-home" or placement* or "semi independent" or "semi-independent") adj2 care*).tw. (1136)

17 ((residential or supported or remand* or secure or correctional) adj1 (accommodation* or institut* or care or lodging or home* or centre* or center* or facilit*)).tw. (6631)

18 or/13-17 (13661)

19 orphanages/ (436)

20 adoption/ (4728)

21 foster home care/ (3508)

22 (special adj1 guardian*).tw. (7)

23 ((placement* or foster*) adj2 (care* or family or families)).tw. (3156)

24 ((kinship or nonkinship or non kinship or connected or substitute*) adj1 care*).tw. (282)

25 or/19-24 (9605)

26 exp Infant/ or Infant Health/ or Infant Welfare/ (1101046)

27 (prematur* or pre-matur* or preterm* or pre-term* or infan* or newborn* or new-born* or perinat* or peri-nat* or neonat* or neo-nat* or baby* or babies or toddler*).ti,ab,in,jn. (813997)

28 exp Child/ or exp Child Behavior/ or Child Health/ or Child Welfare/ (1843400)

29 Minors/ (2509)

30 (child* or minor or minors or boy* or girl* or kid or kids or young*).ti,ab,in,jn. (2221342)

31 exp pediatrics/ (55492)

32 (pediatric* or paediatric* or peadiatric*).ti,ab,in,jn. (771944)

33 Adolescent/ or Adolescent Behavior/ or Adolescent Health/ (1942946)

34 Puberty/ (13005)

35 (adolescen* or pubescen* or prepubescen* or pre-pubescen* or pubert* or prepubert* or pre-pubert* or teen* or preteen* or pre-teen* or juvenil* or youth* or under*age*).ti,ab,in,jn. (395382)

36 Schools/ (35299)

37 Child Day Care Centers/ or exp Nurseries/ or Schools, Nursery/ (8611)

38 (pre-school* or preschool* or kindergar* or daycare or day-care or nurser* or school* or pupil* or student*).ti,ab,jn. (442260)

39 ("under 18*" or "under eighteen*" or "under 25*" or "under twenty five*").ti,ab. (3665)

40 or/26-39 (4951548)

41 18 and 40 (4537)

42 12 or 25 or 41 (15959)

43 animals/ not humans/ (4563292)

44 42 not 43 (15848)

45 limit 44 to english language (14243)

46 limit 45 to ed=19900101-20190606 (11059)

47 limit 45 to dt=19900101-20190611 (10685)

48 Markov Chains/ (13500)

49 Quality-Adjusted Life Years/ or (qualit* adj2 adjust* adj2 life*).tw. or qaly*.tw. (15718)

50 (EQ5D* or EQ-5D* or ((euroqol or euro-qol or euroquol or euro-quol or eurocol or euro-col) adj3 ("5" or five)) or (european* adj2 quality adj3 ("5" or five))).tw. (6545)

51 Cost-Benefit Analysis/ (77012)

52 exp Models, Economic/ (14227)

53 cost.ti. (60952)

54 (cost* adj2 utilit*).tw. (4392)

55 (cost* adj2 (effective* or assess* or evaluat* or analys* or model* or benefit* or threshold* or quality or expens* or saving* or reduc*)).tw. (162969)

56 (economic* adj2 (evaluat* or assess* or analys* or model* or outcome* or benefit* or threshold* or expens* or saving* or reduc*)).tw. (26515)

57 ((incremental* adj2 cost*) or ICER).tw. (10100)

58 utilities.tw. (5428)

59 markov*.tw. (16739)

60 (dollar* or USD or cents or pound or pounds or GBP or sterling* or pence or euro or euros or yen or JPY).tw. (36613)

61 ((utility or effective*) adj2 analys*).tw. (14480)

62 (willing* adj2 pay*).tw. (4632)

63 or/48-62 (287270)

64 45 and 63 (311)

65 46 and 63 (269)

Database: Ovid MEDLINE(R) In-Process & Other Non-Indexed Citations <1946 to July 08, 2019>

(Line 66)

Search Strategy:

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1 child, orphaned/ (0)

2 child, foster/ (0)

3 child, adopted/ (0)

4 adolescent, institutionalized/ (0)

5 ("looked after" adj2 (juvenile* or child* or adolescen* or toddler* or infant* or infancy* or teen* or tween* or young* or baby* or babies* or twin* or sibling* or youth*)).tw. (17)

6 ("care leaver*" or "leaving care").tw. (6)

7 (("in care" or "care experience*") adj1 (juvenile* or child* or adolescen* or toddler* or infant* or infancy* or teen* or tween* or young* or baby* or babies* or twin* or sibling* or youth*)).tw. (45)

8 ((nonparent* or non-parent* or parentless* or parent-less) adj3 (juvenile* or child* or adolescen* or toddler* or infant* or infancy* or teen* or tween* or young* or baby* or babies* or twin* or sibling* or youth*)).tw. (18)

9 ((relinquish* or estrange*) adj2 (juvenile* or child* or adolescen* or toddler* or infant* or infancy* or teen* or tween* or young* or baby* or babies* or twin* or sibling* or youth*)).tw. (4)

10 ((child* or infancy or adolescen* or juvenile* or toddler* or infant* or teen* or tween* or young* or baby or babies or twin* or sibling* or youth*) adj2 (orphan* or foster* or adopt* or abandon* or unwanted or unaccompanied or homeless or asylum* or refugee*)).ti. (361)

11 "ward of court*".tw. (0)

12 or/1-11 (443)

13 residential facilities/ (0)

14 group homes/ (0)

15 halfway houses/ (0)

16 (("out of home" or " out-of-home" or placement* or "semi independent" or "semi-independent") adj2 care*).tw. (122)

17 ((residential or supported or remand* or secure or correctional) adj1 (accommodation* or institut* or care or lodging or home* or centre* or center* or facilit*)).tw. (785)

18 or/13-17 (897)

19 orphanages/ (0)

20 adoption/ (0)

21 foster home care/ (0)

22 (special adj1 guardian*).tw. (0)

23 ((placement* or foster*) adj2 (care* or family or families)).tw. (367)

24 ((kinship or nonkinship or non kinship or connected or substitute*) adj1 care*).tw. (31)

25 or/20-24 (391)

26 exp Infant/ or Infant Health/ or Infant Welfare/ (0)

27 (prematur* or pre-matur* or preterm* or pre-term* or infan* or newborn* or new-born* or perinat* or peri-nat* or neonat* or neo-nat* or baby* or babies or toddler*).ti,ab,in,jn. (71122)

28 exp Child/ or exp Child Behavior/ or Child Health/ or Child Welfare/ (0)

29 Minors/ (0)

30 (child* or minor or minors or boy* or girl* or kid or kids or young*).ti,ab,in,jn. (282655)

31 exp pediatrics/ (0)

32 (pediatric* or paediatric* or peadiatric*).ti,ab,in,jn. (105594)

33 Adolescent/ or Adolescent Behavior/ or Adolescent Health/ (0)

34 Puberty/ (0)

35 (adolescen* or pubescen* or prepubescen* or pre-pubescen* or pubert* or prepubert* or pre-pubert* or teen* or preteen* or pre-teen* or juvenil* or youth* or under*age*).ti,ab,in,jn. (52576)

36 Schools/ (0)

37 Child Day Care Centers/ or exp Nurseries/ or Schools, Nursery/ (0)

38 (pre-school* or preschool* or kindergar* or daycare or day-care or nurser* or school* or pupil* or student*).ti,ab,jn. (61256)

39 ("under 18*" or "under eighteen*" or "under 25*" or "under twenty five*").ti,ab. (516)

40 or/26-39 (410151)

41 18 and 40 (260)

42 12 or 25 or 41 (962)

43 animals/ not humans/ (0)

44 42 not 43 (962)

45 limit 44 to english language (945)

46 limit 45 to ed=19900101-20190606 (256)

47 limit 45 to dt=19900101-20190611 (916)

48 Markov Chains/ (0)

49 Quality-Adjusted Life Years/ or (qualit* adj2 adjust* adj2 life*).tw. or qaly*.tw. (1713)

50 (EQ5D* or EQ-5D* or ((euroqol or euro-qol or euroquol or euro-quol or eurocol or euro-col) adj3 ("5" or five)) or (european* adj2 quality adj3 ("5" or five))).tw. (1364)

51 Cost-Benefit Analysis/ (0)

52 exp Models, Economic/ (0)

53 cost.ti. (9867)

54 (cost* adj2 utilit*).tw. (767)

55 (cost* adj2 (effective* or assess* or evaluat* or analys* or model* or benefit* or threshold* or quality or expens* or saving* or reduc*)).tw. (29070)

56 (economic* adj2 (evaluat* or assess* or analys* or model* or outcome* or benefit* or threshold* or expens* or saving* or reduc*)).tw. (4431)

57 ((incremental* adj2 cost*) or ICER).tw. (1607)

58 utilities.tw. (947)

59 markov*.tw. (4984)

60 (dollar* or USD or cents or pound or pounds or GBP or sterling* or pence or euro or euros or yen or JPY).tw. (4280)

61 ((utility or effective*) adj2 analys*).tw. (2504)

62 (willing* adj2 pay*).tw. (911)

63 or/48-62 (45705)

64 45 and 63 (28)

65 46 and 63 (6)

66 47 and 63 (27)

Database: Ovid MEDLINE(R) Epub Ahead of Print <July 08, 2019>

(Line 64)

Search Strategy:

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1 child, orphaned/ (0)

2 child, foster/ (0)

3 child, adopted/ (0)

4 adolescent, institutionalized/ (0)

5 ("looked after" adj2 (juvenile* or child* or adolescen* or toddler* or infant* or infancy* or teen* or tween* or young* or baby* or babies* or twin* or sibling* or youth*)).tw. (8)

6 ("care leaver*" or "leaving care").tw. (5)

7 (("in care" or "care experience*") adj1 (juvenile* or child* or adolescen* or toddler* or infant* or infancy* or teen* or tween* or young* or baby* or babies* or twin* or sibling* or youth*)).tw. (13)

8 ((nonparent* or non-parent* or parentless* or parent-less) adj3 (juvenile* or child* or adolescen* or toddler* or infant* or infancy* or teen* or tween* or young* or baby* or babies* or twin* or sibling* or youth*)).tw. (8)

9 ((relinquish* or estrange*) adj2 (juvenile* or child* or adolescen* or toddler* or infant* or infancy* or teen* or tween* or young* or baby* or babies* or twin* or sibling* or youth*)).tw. (3)

10 ((child* or infancy or adolescen* or juvenile* or toddler* or infant* or teen* or tween* or young* or baby or babies or twin* or sibling* or youth*) adj2 (orphan* or foster* or adopt* or abandon* or unwanted or unaccompanied or homeless or asylum* or refugee*)).ti. (170)

11 "ward of court*".tw. (0)

12 or/1-11 (198)

13 residential facilities/ (0)

14 group homes/ (0)

15 halfway houses/ (0)

16 (("out of home" or " out-of-home" or placement* or "semi independent" or "semi-independent") adj2 care*).tw. (60)

17 ((residential or supported or remand* or secure or correctional) adj1 (accommodation* or institut* or care or lodging or home* or centre* or center* or facilit*)).tw. (232)

18 or/13-17 (288)

19 orphanages/ (0)

20 adoption/ (0)

21 foster home care/ (0)

22 (special adj1 guardian*).tw. (0)

23 ((placement* or foster*) adj2 (care* or family or families)).tw. (185)

24 ((kinship or nonkinship or non kinship or connected or substitute*) adj1 care*).tw. (11)

25 or/20-24 (191)

26 exp Infant/ or Infant Health/ or Infant Welfare/ (0)

27 (prematur* or pre-matur* or preterm* or pre-term* or infan* or newborn* or new-born* or perinat* or peri-nat* or neonat* or neo-nat* or baby* or babies or toddler*).ti,ab,in,jn. (14304)

28 exp Child/ or exp Child Behavior/ or Child Health/ or Child Welfare/ (0)

29 Minors/ (0)

30 (child* or minor or minors or boy* or girl* or kid or kids or young*).ti,ab,in,jn. (49388)

31 exp pediatrics/ (0)

32 (pediatric* or paediatric* or peadiatric*).ti,ab,in,jn. (19442)

33 Adolescent/ or Adolescent Behavior/ or Adolescent Health/ (0)

34 Puberty/ (0)

35 (adolescen* or pubescen* or prepubescen* or pre-pubescen* or pubert* or prepubert* or pre-pubert* or teen* or preteen* or pre-teen* or juvenil* or youth* or under*age*).ti,ab,in,jn. (12671)

36 Schools/ (0)

37 Child Day Care Centers/ or exp Nurseries/ or Schools, Nursery/ (0)

38 (pre-school* or preschool* or kindergar* or daycare or day-care or nurser* or school* or pupil* or student*).ti,ab,jn. (11661)

39 ("under 18*" or "under eighteen*" or "under 25*" or "under twenty five*").ti,ab. (95)

40 or/26-39 (72744)

41 18 and 40 (102)

42 12 or 25 or 41 (409)

43 animals/ not humans/ (0)

44 42 not 43 (409)

45 limit 44 to english language (407)

46 limit 45 to ed=19900101-20190606 (0)

47 limit 45 to dt=19900101-20190611 (382)

48 Markov Chains/ (0)

49 Quality-Adjusted Life Years/ or (qualit* adj2 adjust* adj2 life*).tw. or qaly*.tw. (419)

50 (EQ5D* or EQ-5D* or ((euroqol or euro-qol or euroquol or euro-quol or eurocol or euro-col) adj3 ("5" or five)) or (european* adj2 quality adj3 ("5" or five))).tw. (316)

51 Cost-Benefit Analysis/ (0)

52 exp Models, Economic/ (0)

53 cost.ti. (1350)

54 (cost* adj2 utilit*).tw. (162)

55 (cost* adj2 (effective* or assess* or evaluat* or analys* or model* or benefit* or threshold* or quality or expens* or saving* or reduc*)).tw. (4696)

56 (economic* adj2 (evaluat* or assess* or analys* or model* or outcome* or benefit* or threshold* or expens* or saving* or reduc*)).tw. (838)

57 ((incremental* adj2 cost*) or ICER).tw. (342)

58 utilities.tw. (155)

59 markov*.tw. (807)

60 (dollar* or USD or cents or pound or pounds or GBP or sterling* or pence or euro or euros or yen or JPY).tw. (712)

61 ((utility or effective*) adj2 analys*).tw. (482)

62 (willing* adj2 pay*).tw. (178)

63 or/48-62 (7346)

64 45 and 63 (12)

Database: Embase <1988 to 2019 Week 27>

Search Strategy:

----

1 orphaned child/ (606)

2 foster child/ (72)

3 adopted child/ (507)

4 institutionalized adolescent/ (16)

5 ("looked after" adj2 (juvenile* or child* or adolescen* or toddler* or infant* or infancy* or teen* or tween* or young* or baby* or babies* or twin* or sibling* or youth*)).tw. (239)

6 ("care leaver*" or "leaving care").tw. (60)

7 (("in care" or "care experience*") adj1 (juvenile* or child* or adolescen* or toddler* or infant* or infancy* or teen* or tween* or young* or baby* or babies* or twin* or sibling* or youth*)).tw. (328)

8 ((nonparent* or non-parent* or parentless* or parent-less) adj3 (juvenile* or child* or adolescen* or toddler* or infant* or infancy* or teen* or tween* or young* or baby* or babies* or twin* or sibling* or youth*)).tw. (137)

9 ((relinquish* or estrange*) adj2 (juvenile* or child* or adolescen* or toddler* or infant* or infancy* or teen* or tween* or young* or baby* or babies* or twin* or sibling* or youth*)).tw. (66)

10 ((child* or infancy or adolescen* or juvenile* or toddler* or infant* or teen* or tween* or young* or baby or babies or twin* or sibling* or youth*) adj2 (orphan* or foster* or adopt* or abandon* or unwanted or unaccompanied or homeless or asylum* or refugee*)).ti. (3301)

11 "ward of court*".tw. (13)

12 or/1-11 (4918)

13 residential home/ (5797)

14 halfway house/ (616)

15 (("out of home" or " out-of-home" or placement* or "semi independent" or "semi-independent") adj2 care*).tw. (1546)

16 ((residential or supported or remand* or secure or correctional) adj1 (accommodation* or institut* or care or lodging or home* or centre* or center* or facilit*)).tw. (8776)

17 or/13-16 (15272)

18 orphanage/ (851)

19 foster care/ (3851)

20 (special adj1 guardian*).tw. (7)

21 ((placement* or foster*) adj2 (care* or family or families)).tw. (4024)

22 ((kinship or nonkinship or non kinship or connected or substitute*) adj1 care*).tw. (359)

23 *adoption/ (2710)

24 or/18-23 (6865)

25 exp juvenile/ or Child Behavior/ or Child Welfare/ or Child Health/ or infant welfare/ or "minor (person)"/ or elementary student/ (2784798)

26 (prematur* or pre-matur* or preterm* or pre-term* or infan* or newborn* or new-born* or perinat* or peri-nat* or neonat* or neo-nat* or baby* or babies or toddler*).ti,ab,in,ad,jw. (990094)

27 (child* or minor or minors or boy* or girl* or kid or kids or young*).ti,ab,in,ad,jw. (3070275)

28 exp pediatrics/ (89360)

29 (pediatric* or paediatric* or peadiatric*).ti,ab,in,ad,jw. (1438284)

30 exp adolescence/ or exp adolescent behavior/ or adolescent health/ or high school student/ or middle school student/ (88098)

31 (adolescen* or pubescen* or prepubescen* or pre-pubescen* or pubert* or prepubert* or pre-pubert* or teen* or preteen* or pre-teen* or juvenil* or youth* or under*age*).ti,ab,in,ad,jw. (568613)

32 school/ or high school/ or kindergarten/ or middle school/ or primary school/ or nursery school/ or day care/ (91653)

33 (pre-school* or preschool* or kindergar* or daycare or day-care or nurser* or school* or pupil* or student*).ti,ab,jw. (588621)

34 ("under 18*" or "under eighteen*" or "under 25*" or "under twenty five*").ti,ab. (6349)

35 or/25-34 (5334085)

36 17 and 35 (5115)

37 24 and 35 (5358)

38 12 or 24 or 36 or 37 (14911)

39 nonhuman/ not human/ (3937063)

40 38 not 39 (14760)

41 (letter or editorial).pt. (1540594)

42 (conference abstract or conference paper or conference proceeding or "conference review").pt. (4222564)

43 41 or 42 (5763158)

44 40 not 43 (12196)

45 limit 44 to dc=19900101-20190606 (11884)

46 limit 45 to english language (11023)

47 Markov chain/ (4090)

48 quality adjusted life year/ or (qualit* adj2 adjust* adj2 life*).tw. or qaly*.tw. (30409)

49 (EQ5D* or EQ-5D* or ((euroqol or euro-qol or euroquol or euro-quol or eurocol or euro-col) adj3 ("5" or five)) or (european* adj2 quality adj3 ("5" or five))).tw. (15875)

50 "cost benefit analysis"/ (76518)

51 exp economic model/ (1504)

52 cost.ti. (88995)

53 (cost* adj2 utilit*).tw. (8688)

54 (cost* adj2 (effective* or assess* or evaluat* or analys* or model* or benefit* or threshold* or quality or expens* or saving* or reduc*)).tw. (264435)

55 (economic* adj2 (evaluat* or assess* or analys* or model* or outcome* or benefit* or threshold* or expens* or saving* or reduc*)).tw. (44462)

56 ((incremental* adj2 cost*) or ICER).tw. (20797)

57 utilities.tw. (10291)

58 markov*.tw. (26990)

59 (dollar* or USD or cents or pound or pounds or GBP or sterling* or pence or euro or euros or yen or JPY).tw. (49359)

60 ((utility or effective*) adj2 analys*).tw. (25580)

61 (willing* adj2 pay*).tw. (8767)

62 47 or 48 or 49 or 50 or 51 or 52 or 53 or 54 or 55 or 56 or 57 or 58 or 59 or 60 or 61 (437018)

63 46 and 62 (307)

64 (conference abstract or conference paper or conference proceeding or "conference review" or letter or editorial).pt. (5763158)

65 63 not 64 (307)

Database: Econlit <1886 to June 27, 2019>

Search Strategy:

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1 [child, orphaned/] (0)

2 [child, foster/] (0)

3 [child, adopted/] (0)

4 [adolescent, institutionalized/] (0)

5 ("looked after" adj2 (juvenile* or child* or adolescen* or toddler* or infant* or infancy* or teen* or tween* or young* or baby* or babies* or twin* or sibling* or youth*)).tw. (3)

6 ("care leaver*" or "leaving care").tw. (2)

7 (("in care" or "care experience*") adj1 (juvenile* or child* or adolescen* or toddler* or infant* or infancy* or teen* or tween* or young* or baby* or babies* or twin* or sibling* or youth*)).tw. (15)

8 ((nonparent* or non-parent* or parentless* or parent-less) adj3 (juvenile* or child* or adolescen* or toddler* or infant* or infancy* or teen* or tween* or young* or baby* or babies* or twin* or sibling* or youth*)).tw. (34)

9 ((relinquish* or estrange*) adj2 (juvenile* or child* or adolescen* or toddler* or infant* or infancy* or teen* or tween* or young* or baby* or babies* or twin* or sibling* or youth*)).tw. (6)

10 ((child* or infancy or adolescen* or juvenile* or toddler* or infant* or teen* or tween* or young* or baby or babies or twin* or sibling* or youth*) adj2 (orphan* or foster* or adopt* or abandon* or unwanted or unaccompanied or homeless or asylum* or refugee*)).ti. (111)

11 "ward of court*".tw. (0)

12 or/1-11 (163)

13 [residential facilities/] (0)

14 [group homes/] (0)

15 [halfway houses/] (0)

16 (("out of home" or " out-of-home" or placement* or "semi independent" or "semi-independent") adj2 care*).tw. (42)

17 ((residential or supported or remand* or secure or correctional) adj1 (accommodation* or institut* or care or lodging or home* or centre* or center* or facilit*)).tw. (208)

18 or/13-17 (250)

19 [orphanages/] (0)

20 [adoption/] (0)

21 [foster home care/] (0)

22 (special adj1 guardian*).tw. (0)

23 ((placement* or foster*) adj2 (care* or family or families)).tw. (154)

24 ((kinship or nonkinship or non kinship or connected or substitute*) adj1 care*).tw. (23)

25 or/20-24 (172)

26 [exp Infant/ or Infant Health/ or Infant Welfare/] (0)

27 (prematur* or pre-matur* or preterm* or pre-term* or infan* or newborn* or new-born* or perinat* or peri-nat* or neonat* or neo-nat* or baby* or babies or toddler*).ti,ab,in,jn. (5404)

28 [exp Child/ or exp Child Behavior/ or Child Health/ or Child Welfare/] (0)

29 [Minors/] (0)

30 (child* or minor or minors or boy* or girl* or kid or kids or young*).ti,ab,in,jn. (45263)

31 [exp pediatrics/] (0)

32 (pediatric* or paediatric* or peadiatric*).ti,ab,in,jn. (168)

33 [Adolescent/ or Adolescent Behavior/ or Adolescent Health/] (0)

34 [Puberty/] (0)

35 (adolescen* or pubescen* or prepubescen* or pre-pubescen* or pubert* or prepubert* or pre-pubert* or teen* or preteen* or pre-teen* or juvenil* or youth* or under*age*).ti,ab,in,jn. (8812)

36 [Schools/] (0)

37 [Child Day Care Centers/ or exp Nurseries/ or Schools, Nursery/] (0)

38 (pre-school* or preschool* or kindergar* or daycare or day-care or nurser* or school* or pupil* or student*).ti,ab,jn. (47608)

39 ("under 18*" or "under eighteen*" or "under 25*" or "under twenty five*").ti,ab. (56)

40 or/26-39 (91121)

41 18 and 40 (71)

42 12 or 25 or 41 (359)

43 limit 42 to yr="2009 -Current" (176)

Database: NHSEED (CRD)

1 MeSH DESCRIPTOR Child, Orphaned EXPLODE ALL TREES IN NHSEED 0

2 MeSH DESCRIPTOR Adoption EXPLODE ALL TREES IN NHSEED 3

3 (("looked after" NEAR2 (juvenile* or child* or adolescen* or toddler* or infant* or infancy* or teen* or tween* or young* or baby* or babies* or twin* or sibling* or youth*))) IN NHSEED 0

4 ("care leaver*" or "leaving care") IN NHSEED 0

5 ("in care") IN NHSEED 40

6 ("care experience") IN NHSEED 1

7 (nonparent* or non-parent* or parentless* or parent-less) IN NHSEED 0

8 (relinquish* or estrange*) IN NHSEED 0

9 (orphan* or foster* or adopt* or abandon* or unwanted or unaccompanied or homeless or asylum* or refugee*):TI IN NHSEED 22

10 ("ward of court*") IN NHSEED 0

11 #1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 64

12 (((residential or supported or remand* or secure or correctional) NEAR1 (accommodation* or institut* or care or lodging or home* or centre* or center* or facilit*))) IN NHSEED 88

13 MeSH DESCRIPTOR orphanages EXPLODE ALL TREES IN NHSEED 0

14 (guardian) IN NHSEED 13

15 (((placement* or foster*) NEAR2 (care* or family or families))) IN NHSEED 7

16 (((kinship or nonkinship or non kinship or connected or substitute*) NEAR1 care*)) IN NHSEED 1

17 #13 OR #14 OR #15 OR #16 21

18 (infan* or newborn* or new-born* or perinat* or peri-nat* or neonat* or neo-nat* or baby* or babies or toddler* or child* or minor or minors or boy* or girl* or kid or kids or young* or adolescen* or pubescen* or prepubescen* or pre-pubescen* or pubert* or prepubert* or pre-pubert* or teen* or preteen* or pre-teen* or juvenil* or youth* or under*age*) IN NHSEED 5275

19 #12 AND #18 23

20 #11 OR #17 OR #19 105

Search strategies: Economic Evaluation and Quality of Life filters
Database: Ovid MEDLINE(R) <1946 to July 12, 2019> Search Strategy: -- 1 child, orphaned/ (664) 2 child, foster/ (74) 3 child, adopted/ (48) 4 adolescent, institutionalized/ (126) 5 ("looked after" adj2 (juvenile* or child* or adolescen* or toddler* or infant* or infancy* or teen* or tween* or young* or baby* or babies* or twin* or sibling* or youth*)).tw. (123) 6 ("care leaver*" or "leaving care").tw. (32) 7 (("in care" or "care experience*") adj1 (juvenile* or child* or adolescen* or toddler* or infant* or infancy* or teen* or tween* or young* or baby* or babies* or twin* or sibling* or youth*)).tw. (240) 8 ((nonparent* or non-parent* or parentless* or parent-less) adj3 (juvenile* or child* or adolescen* or toddler* or infant* or infancy* or teen* or tween* or young* or baby* or babies* or twin* or sibling* or youth*)).tw. (111) 9 ((relinquish* or estrange*) adj2 (juvenile* or child* or adolescen* or toddler* or infant* or infancy* or teen* or tween* or young* or baby* or babies* or twin* or sibling* or youth*)).tw. (74) 10 ((child* or infancy or adolescen* or juvenile* or toddler* or infant* or teen* or tween* or young* or baby or babies or twin* or sibling* or youth*) adj2 (orphan* or foster* or adopt* or abandon* or unwanted or unaccompanied or homeless or asylum* or refugee*)).ti. (2989) 11 "ward of court*".tw. (12) 12 or/1-11 (4249) 13 residential facilities/ (5301)

14 group homes/ (951)

15 halfway houses/ (1052)

16 (("out of home" or " out-of-home" or placement* or "semi independent" or "semi-independent") adj2 care*).tw. (1136)

17 ((residential or supported or remand* or secure or correctional) adj1 (accommodation* or institut* or care or lodging or home* or centre* or center* or facilit*)).tw. (6640)

18 or/13-17 (13672)

19 orphanages/ (438)

20 adoption/ (4729)

21 foster home care/ (3508)

22 (special adj1 guardian*).tw. (7)

23 ((placement* or foster*) adj2 (care* or family or families)).tw. (3156)

24 ((kinship or nonkinship or non kinship or connected or substitute*) adj1 care*).tw. (282)

25 or/19-24 (9924)

26 exp Infant/ or Infant Health/ or Infant Welfare/ (1101512)

27 (prematur* or pre-matur* or preterm* or pre-term* or infan* or newborn* or new-born* or perinat* or peri-nat* or neonat* or neo-nat* or baby* or babies or toddler*).ti,ab,in,jn. (814530)

28 exp Child/ or exp Child Behavior/ or Child Health/ or Child Welfare/ (1844269)

29 Minors/ (2509)

30 (child* or minor or minors or boy* or girl* or kid or kids or young*).ti,ab,in,jn. (2223285)

31 exp pediatrics/ (55515)

32 (pediatric* or paediatric* or peadiatric*).ti,ab,in,jn. (772838)

33 Adolescent/ or Adolescent Behavior/ or Adolescent Health/ (1944098)

34 Puberty/ (13005)

35 (adolescen* or pubescen* or prepubescen* or pre-pubescen* or pubert* or prepubert* or pre-pubert* or teen* or preteen* or pre-teen* or juvenil* or youth* or under*age*).ti,ab,in,jn. (395763)

36 Schools/ (35334)

37 Child Day Care Centers/ or exp Nurseries/ or Schools, Nursery/ (8611)

38 (pre-school* or preschool* or kindergar* or daycare or day-care or nurser* or school* or pupil* or student*).ti,ab,jn. (442578)

39 ("under 18*" or "under eighteen*" or "under 25*" or "under twenty five*").ti,ab. (3674)

40 or/26-39 (4954893)

41 18 and 40 (4538)

42 12 or 25 or 41 (16193)

43 animals/ not humans/ (4565244)

44 42 not 43 (16082)

45 limit 44 to english language (14416)

46 limit 45 to ed=19900101-20190714 (11278)

47 limit 45 to dt=19900101-20190715 (10852)

48 Markov Chains/ (13507)

49 Quality-Adjusted Life Years/ or (qualit* adj2 adjust* adj2 life*).tw. or qaly*.tw. (15740)

50 (EQ5D* or EQ-5D* or ((euroqol or euro-qol or euroquol or euro-quol or eurocol or euro-col) adj3 ("5" or five)) or (european* adj2 quality adj3 ("5" or five))).tw. (6562)

51 Cost-Benefit Analysis/ (77068)

52 exp Models, Economic/ (14240)

53 cost.ti. (61003)

54	(cost* adj2 utilit*).tw. (4395)
55	(cost* adj2 (effective* or assess* or evaluat* or analys* or model* or benefit* or threshold* or quality or expens* or saving* or reduc*)).tw. (163128)
56	(economic* adj2 (evaluat* or assess* or analys* or model* or outcome* or benefit* or threshold* or expens* or saving* or reduc*)).tw. (26542)
57	((incremental* adj2 cost*) or ICER).tw. (10113)
58	utilities.tw. (5434)
59	markov*.tw. (16747)
60	(dollar* or USD or cents or pound or pounds or GBP or sterling* or pence or euro or euros or yen or JPY).tw. (36633)
61	((utility or effective*) adj2 analys*).tw. (14500)
62	(willing* adj2 pay*).tw. (4638)
63	or/48-62 (287514)
64	45 and 63 (314)
65	46 and 63 (272)
66	47 and 63 (267)
67	Economics/ (27059)
68	exp "Costs and Cost Analysis"/ (226218)
69	Economics, Dental/ (1906)
70	exp Economics, Hospital/ (23683)
71	exp Economics, Medical/ (14107)
72	Economics, Nursing/ (3986)
73	Economics, Pharmaceutical/ (2868)
74	Budgets/ (11138)

75	exp Models, Economic/ (14240)
76	Markov Chains/ (13507)
77	Monte Carlo Method/ (26889)
78	Decision Trees/ (10615)
79	econom$.tw. (220798)
80	cba.tw. (9569)
81	cea.tw. (19685)
82	cua.tw. (941)
83	markov$.tw. (16747)
84	(monte adj carlo).tw. (28270)
85	(decision adj3 (tree$ or analys$)).tw. (12136)
86	(cost or costs or costing$ or costly or costed).tw. (428019)
87	(price$ or pricing$).tw. (31251)
88	budget$.tw. (22462)
89	expenditure$.tw. (46305)
90	(value adj3 (money or monetary)).tw. (1946)
91	(pharmacoeconomic$ or (pharmaco adj economic$)).tw. (3350)
92	or/67-91 (869079)
93	"Quality of Life"/ (178315)
94	quality of life.tw. (210147)
95	"Value of Life"/ (5653)

96 Quality-Adjusted Life Years/ (11173)

97 quality adjusted life.tw. (9768)

98 (qaly$ or qald$ or qale$ or qtime$).tw. (8028)

99 disability adjusted life.tw. (2374)

100 daly$.tw. (2184)

101 Health Status Indicators/ (22927)

102 (sf36 or sf 36 or short form 36 or shortform 36 or sf thirtysix or sf thirty six or shortform thirtysix or shortform thirty six or short form thirtysix or short form thirty six).tw. (21132)

103 (sf6 or sf 6 or short form 6 or shortform 6 or sf six or sfsix or shortform six or short form six).tw. (1258)

104 (sf12 or sf 12 or short form 12 or shortform 12 or sf twelve or sftwelve or shortform twelve or short form twelve).tw. (4470)

105 (sf16 or sf 16 or short form 16 or shortform 16 or sf sixteen or sfsixteen or shortform sixteen or short form sixteen).tw. (28)

106 (sf20 or sf 20 or short form 20 or shortform 20 or sf twenty or sftwenty or shortform twenty or short form twenty).tw. (370)

107 (euroqol or euro qol or eq5d or eq 5d).tw. (7790)

108 (qol or hql or hqol or hrqol).tw. (39934)

109 (hye or hyes).tw. (58)

110 health$ year$ equivalent$.tw. (38)

111 utilit$.tw. (158839)

112 (hui or hui1 or hui2 or hui3).tw. (1208)

113 disutili$.tw. (351)

114 rosser.tw. (82)

115 quality of wellbeing.tw. (11)

116 quality of well-being.tw. (367)

117 qwb.tw. (186)

118 willingness to pay.tw. (3952)

119 standard gamble$.tw. (763)

120 time trade off.tw. (981)

121 time tradeoff.tw. (223)

122 tto.tw. (848)

123 or/93-122 (455927)

124 92 or 123 (1261859)

125 45 and 124 (1599)

126 46 and 124 (1395)

127 47 and 124 (1345)

128 125 not 64 (1300)

129 126 not 65 (1136)

130 127 not 66 (1090)

Database: Embase <1988 to 2019 Week 28>

Search Strategy:

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1 orphaned child/ (608)

2 foster child/ (73)

3 adopted child/ (510)

4 institutionalized adolescent/ (16)

5 ("looked after" adj2 (juvenile* or child* or adolescen* or toddler* or infant* or infancy* or teen* or tween* or young* or baby* or babies* or twin* or sibling* or youth*)).tw. (239)

6 ("care leaver*" or "leaving care").tw. (60)

7 (("in care" or "care experience*") adj1 (juvenile* or child* or adolescen* or toddler* or infant* or infancy* or teen* or tween* or young* or baby* or babies* or twin* or sibling* or youth*)).tw. (328)

8 ((nonparent* or non-parent* or parentless* or parent-less) adj3 (juvenile* or child* or adolescen* or toddler* or infant* or infancy* or teen* or tween* or young* or baby* or babies* or twin* or sibling* or youth*)).tw. (137)

9 ((relinquish* or estrange*) adj2 (juvenile* or child* or adolescen* or toddler* or infant* or infancy* or teen* or tween* or young* or baby* or babies* or twin* or sibling* or youth*)).tw. (66)

10 ((child* or infancy or adolescen* or juvenile* or toddler* or infant* or teen* or tween* or young* or baby or babies or twin* or sibling* or youth*) adj2 (orphan* or foster* or adopt* or abandon* or unwanted or unaccompanied or homeless or asylum* or refugee*)).ti. (3308)

11 "ward of court*".tw. (13)

12 or/1-11 (4928)

13 residential home/ (5806)

14 halfway house/ (618)

15 (("out of home" or " out-of-home" or placement* or "semi independent" or "semi-independent") adj2 care*).tw. (1548)

16 ((residential or supported or remand* or secure or correctional) adj1 (accommodation* or institut* or care or lodging or home* or centre* or center* or facilit*)).tw. (8794)

17 or/13-16 (15298)

18 orphanage/ (851)

19 foster care/ (3854)

20 (special adj1 guardian*).tw. (7)

21 ((placement* or foster*) adj2 (care* or family or families)).tw. (4029)

22 ((kinship or nonkinship or non kinship or connected or substitute*) adj1 care*).tw. (360)

23 *adoption/ (2704)

24 or/18-23 (9315)

25 exp juvenile/ or Child Behavior/ or Child Welfare/ or Child Health/ or infant welfare/ or "minor (person)"/ or elementary student/ (2788952)

26 (prematur* or pre-matur* or preterm* or pre-term* or infan* or newborn* or new-born* or perinat* or peri-nat* or neonat* or neo-nat* or baby* or babies or toddler*).ti,ab,in,ad,jw. (991635)

27 (child* or minor or minors or boy* or girl* or kid or kids or young*).ti,ab,in,ad,jw. (3075545)

28 exp pediatrics/ (89475)

29 (pediatric* or paediatric* or peadiatric*).ti,ab,in,ad,jw. (1440596)

30 exp adolescence/ or exp adolescent behavior/ or adolescent health/ or high school student/ or middle school student/ (88253)

31 (adolescen* or pubescen* or prepubescen* or pre-pubescen* or pubert* or prepubert* or pre-pubert* or teen* or preteen* or pre-teen* or juvenil* or youth* or under*age*).ti,ab,in,ad,jw. (569652)

32 school/ or high school/ or kindergarten/ or middle school/ or primary school/ or nursery school/ or day care/ (91782)

33 (pre-school* or preschool* or kindergar* or daycare or day-care or nurser* or school* or pupil* or student*).ti,ab,jw. (589614)

34 ("under 18*" or "under eighteen*" or "under 25*" or "under twenty five*").ti,ab. (6369)

35 or/25-34 (5342804)

36 17 and 35 (5123)

37 24 and 35 (6834)

38 12 or 24 or 36 or 37 (16935)

39 nonhuman/ not human/ (3943285)

40 38 not 39 (16745)

41 (letter or editorial).pt. (1542836)

42 (conference abstract or conference paper or conference proceeding or "conference review").pt. (4231963)

43 41 or 42 (5774799)

44 40 not 43 (13711)

45 limit 44 to dc=19900101-20190606 (13274)

46 limit 45 to english language (12254)

47 Markov chain/ (4122)

48 quality adjusted life year/ or (qualit* adj2 adjust* adj2 life*).tw. or qaly*.tw. (30497)

49 (EQ5D* or EQ-5D* or ((euroqol or euro-qol or euroquol or euro-quol or eurocol or euro-col) adj3 ("5" or five)) or (european* adj2 quality adj3 ("5" or five))).tw. (15926)

50 "cost benefit analysis"/ (76622)

51 exp economic model/ (1511)

52 cost.ti. (89185)

53 (cost* adj2 utilit*).tw. (8710)

54 (cost* adj2 (effective* or assess* or evaluat* or analys* or model* or benefit* or threshold* or quality or expens* or saving* or reduc*)).tw. (264961)

55 (economic* adj2 (evaluat* or assess* or analys* or model* or outcome* or benefit* or threshold* or expens* or saving* or reduc*)).tw. (44536)

56 ((incremental* adj2 cost*) or ICER).tw. (20854)

57 utilities.tw. (10311)

58 markov*.tw. (27064)

59 (dollar* or USD or cents or pound or pounds or GBP or sterling* or pence or euro or euros or yen or JPY).tw. (49454)

60 ((utility or effective*) adj2 analys*).tw. (25652)

61 (willing* adj2 pay*).tw. (8797)

62 47 or 48 or 49 or 50 or 51 or 52 or 53 or 54 or 55 or 56 or 57 or 58 or 59 or 60 or 61 (437885)

63	46 and 62 (336)
64	exp Health Economics/ (754904)
65	exp "Health Care Cost"/ (271264)
66	exp Pharmacoeconomics/ (183070)
67	Monte Carlo Method/ (36411)
68	Decision Tree/ (11234)
69	econom$.tw. (313756)
70	cba.tw. (8890)
71	cea.tw. (29221)
72	cua.tw. (1304)
73	markov$.tw. (27064)
74	(monte adj carlo).tw. (42778)
75	(decision adj3 (tree$ or analys$)).tw. (20246)
76	(cost or costs or costing$ or costly or costed).tw. (667335)
77	(price$ or pricing$).tw. (48966)
78	budget$.tw. (32761)
79	expenditure$.tw. (65082)
80	(value adj3 (money or monetary)).tw. (3103)
81	(pharmacoeconomic$ or (pharmaco adj economic$)).tw. (8274)
82	or/64-81 (1524839)
83	"Quality of Life"/ (429148)

84 Quality Adjusted Life Year/ (24150)

85 Quality of Life Index/ (2640)

86 Short Form 36/ (26202)

87 Health Status/ (117486)

88 quality of life.tw. (394895)

89 quality adjusted life.tw. (17693)

90 (qaly$ or qald$ or qale$ or qtime$).tw. (18129)

91 disability adjusted life.tw. (3574)

92 daly$.tw. (3505)

93 (sf36 or sf 36 or short form 36 or shortform 36 or sf thirtysix or sf thirty six or shortform thirtysix or shortform thirty six or short form thirtysix or short form thirty six).tw. (38927)

94 (sf6 or sf 6 or short form 6 or shortform 6 or sf six or sfsix or shortform six or short form six).tw. (1902)

95 (sf12 or sf 12 or short form 12 or shortform 12 or sf twelve or sftwelve or shortform twelve or short form twelve).tw. (8636)

96 (sf16 or sf 16 or short form 16 or shortform 16 or sf sixteen or sfsixteen or shortform sixteen or short form sixteen).tw. (51)

97 (sf20 or sf 20 or short form 20 or shortform 20 or sf twenty or sftwenty or shortform twenty or short form twenty).tw. (403)

98 (euroqol or euro qol or eq5d or eq 5d).tw. (18036)

99 (qol or hql or hqol or hrqol).tw. (87193)

100 (hye or hyes).tw. (123)

101 health$ year$ equivalent$.tw. (41)

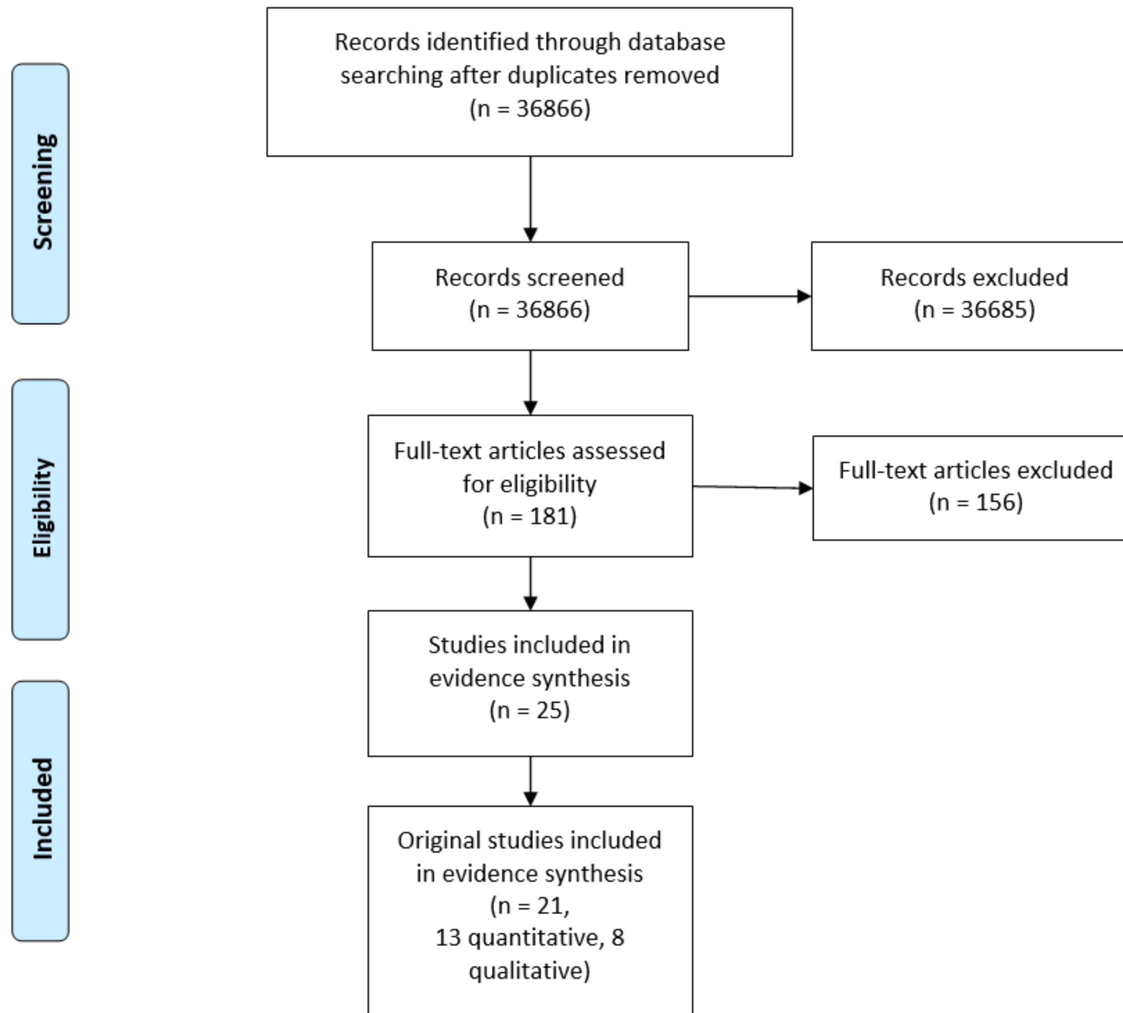
102 utilit$.tw. (256882)

103 (hui or hui1 or hui2 or hui3).tw. (2074)

104 disutili$.tw. (837)

105	rosser.tw. (116)
106	quality of wellbeing.tw. (38)
107	quality of well-being.tw. (464)
108	qwb.tw. (234)
109	willingness to pay.tw. (7664)
110	standard gamble$.tw. (1054)
111	time trade off.tw. (1611)
112	time tradeoff.tw. (279)
113	tto.tw. (1529)
114	or/83-113 (891635)
115	82 or 114 (2273922)
116	46 and 115 (2228)
117	116 not 63 (1908)

Appendix C – Evidence study selection



Appendix D – Evidence tables

Quantitative studies

Akin 2015

Study type	Randomised controlled trial (RCT)
Study location	USA
Study setting	Children in foster care with serious emotional disturbance
Study dates	Not reported (published 2015)
Duration of follow-up	Participants were tested pre and post intervention. Post-test was at 6-months.
Sources of funding	developed under the Kansas Intensive Permanency Project, which was funded by the Children's Bureau, Administration on Children, Youth and Families, Administration for Children and Families, U.S. Department of Health and Human Services
Inclusion criteria	Age aged between 3 and 16 years Care situation in foster care; participating families also: 1) had a case plan goal of reunification; 2) had caregivers who resided in the service area and had not been incarcerated for more than three months at the time of study enrollment; Emotional or mental health needs identified as having an SED within six months of entering foster care
Exclusion criteria	Caregiver characteristics an order of “no contact” from the court.
Sample size	121

Split between study groups	PMTO: 78 CAU: 43
Loss to follow-up	Not reported
% Female	56.2
Mean age (SD)	11.7 ± 4.2 years
Condition specific characteristics	Non-white 21.5%
Outcome measures	Social-emotional outcomes 1 Social-emotional functioning: he Child and Adolescent Functioning Assessment Scale (CAFAS) and the Preschool and Early Childhood Functional Scale (PECFAS); The CAFAS provides an overall functioning score and eight subscales (School, Home, Community, Behavior Toward Others, Moods/ Emotions, Thinking Problems, Self-Harm, and Substance Use). Social outcome 1 Social Skills: Social Skills Improvement System (SSIS): used to assess child problem behaviors and social skills by administering it to the primary caregiver seeking to reunify with the child (i.e., usually the birth parent). Data collection protocols required that the caregiver had had visits with the child within the last 60 days. The SSIS measures problem behaviors with a total score that is based on five subscales: externalizing, bullying, hyperactivity/inattention, internalizing, and Autism Spectrum. Higher problem behavior scores indicate more problem behaviors. The SSIS measures social skills with a total score that comprises seven subscales: communication, cooperation, assertion, responsibility, empathy, engagement, and self-control. Higher social skills scores indicate stronger social skills. Placement stability 1 Placement instability: erived from administrative data and was calculated as an annualized rate of placement settings: ðAnnualized Placement Rate = ((number of placement/days in foster care)*365)
Study arms	**Parent Management Training-Oregon (N = 78)** PMTO is a behavioral parent training program based on social interaction learning theory, which posits that parents are the agents of change for affecting improvements in their children's problematic behaviors. It was developed for children with externalizing behavior problems and is one of a family of parent training programs that were developed at the Oregon Social Learning Center (OSLC), specifically by its affiliate the Implementation Sciences International, Incorporated. PMTO was delivered in-home to individual families, focusing on parents as the agents of change, and delivered for up to

six months. Core components include: 1) appropriate discipline; 2) skill building; 3) supervision and monitoring; 4) problem-solving; and 5) positive involvement.

% Female	51.3
Mean age (SD)	11.2 ± 4.22 years
Condition specific characteristics	Non-white 23.1%
Outcome measures	Social-emotional outcomes 1 Social-emotional functioning postintervention (CAFAS): 34.9 ± 38.4 Behavioural outcome 1 Problem behaviours postintervention: 20.2 ± 11.7 Social outcome 1 Social Skills postintervention (SSIS): 96.5 ± 19.6 Placement stability 1 Placement instability rate postintervention: 0.9 ± 0.8

Care-as-usual (N = 43)
Participants received services as usual

Study type	Randomised controlled trial (RCT)
Study location	USA
Study setting	Children in foster care with serious emotional disturbance
Study dates	Not reported (published 2015)

Duration of follow-up	Participants were tested pre and post intervention. Post-test was at 6-months.
Sources of funding	developed under the Kansas Intensive Permanency Project, which was funded by the Children's Bureau, Administration on Children, Youth and Families, Administration for Children and Families, U.S. Department of Health and Human Services
Inclusion criteria	Age aged between 3 and 16 years Care situation in foster care; participating families also: 1) had a case plan goal of reunification; 2) had caregivers who resided in the service area and had not been incarcerated for more than three months at the time of study enrollment; Emotional or mental health needs identified as having an SED within six months of entering foster care
Sample size	121
Split between study groups	PMTO: 78 CAU: 43
Loss to follow-up	Not reported
% Female	56.2
Mean age (SD)	11.7 ± 4.2 years
Outcome measures	Social-emotional outcomes 1 Social-emotional functioning postintervention (CAFAS): 64.1 ± 53.3 Behavioural outcome 1 Problem behaviours score postintervention (SSIS): 29.6 ± 16.6

	Social outcome 1 Social Skills score postintervention (SSIS): 81.4 ± 21.5 **Placement stability 1** Placement instability rate postintervention: 1.2 ± 0.8
Risk of Bias	**Domain 1: Bias arising from the randomisation process** **High** (Subjects were aware of their assignment group prior to agreeing to study participation. Few baseline characteristics reported. Some differences but unclear if significant. 1:1 Randomisation resulted in considerably more in the intervention group.) **Domain 2a: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention)** **High** (Unclear if there were deviations from assigned intervention, this is likely since more participants were assigned to the intervention group than control group despite 1:1 randomisation (in order to fill PMTO case load)) **Domain 3. Bias due to missing outcome data** **High** (Though missing data did occur, this study is not clear how much data was missing and proportion between groups) **Domain 4. Bias in measurement of the outcome** **Some concerns** (Low risk for placement stability that was determined using administration data) **Domain 5. Bias in selection of the reported result** **Some concerns** (Information on conduct of trial was insufficient and there was no protocol cited.) **Overall bias and Directness**

	High **Overall Directness** **Partially applicable** (USA based)

Bergstrom 2016

Study type	Randomised controlled trial (RCT)
Study location	Sweden
Study setting	Juveniles entering into out of home care
Study dates	Not reported
Duration of follow-up	3 year follow up
Sources of funding	Not reported
Inclusion criteria	Age between 12 and 17 years old Care situation at risk for immediate out-of-home placement (all but one participants were in out of home care during the course of the study Behavioural needs eet the diagnostic criteria for a conduct disorder according to DSM-IV-TR (Diagnostic and Statistical Manual of Mental Disorders, American Psychiatric Association)
Sample size	46

Split between study groups	MTFC: 19 CAU: 27
Loss to follow-up	None reported
% Female	Not reported
Mean age (SD)	Not reported
Condition specific characteristics	Behaviour that challenges 100%
Outcome measures	Placement stability 1 Number of out-of-home placements: indicates whether the juvenile has been in an out-of-home placement (e.g., foster home or residential care). Excerpted data from social case record. Criminal outcomes Locked settings: describes whether the juvenile was in an out-of-home care setting and in a locked ward. Excerpted data from social case record. Homelessness Homeless: describes whether the juvenile had a notation of not having a place to live or did not currently have a registered place to live. Excerpted data from social case record. Negative placement change Negative treatment exit describes whether the juvenile experienced a breakdown or had exited a minor treatment facility to enter a more secure one (e.g., the juvenile exited foster care and entered institutional care). Excerpted data from social case record. Criminal outcomes 2 Criminality is described using only confirmed reports from the police or convictions reported in the case record. Violent crime describes whether the crime involved a crime towards a person (e.g., assault, rape or robbery) from confirmed police reports or convictions. Excerpted data from social case record. Health outcome 1 Substance Abuse is described using a combination of records, such as urine samples, to test for drugs, treatment (e.g., out-of-home placement in group care directed towards drug problems) or conviction (use or dealing). Excerpted data from social case record.
Study arms	**Multidimensional Treatment Foster Care (N = 19)**

	MTFC is designed to decrease deviant behaviour and to increase pro-social behaviour (e.g., co-operativeness, acting within boundaries of the law, attending school, engaging in socially acceptable communication). A juvenile is placed with a professionally trained foster family, and a clinical team is formed around the juvenile and his or her birth family. The clinical team consists of a case manager (who supervises and coordinates the treatment), a family therapist (who conducts weekly therapy sessions with the juvenile and her or his family), an individual therapist (who supports the juvenile to achieve daily progress), a skills trainer (who practises new skills in the juvenile's daily activities and everyday life), a parent daily report (PDR) caller (who telephones the foster family every day to monitor progress) and the foster family (which provides the juvenile with a structured, therapeutic living environment). Members of the foster family help the juvenile to develop pro-social skills by being role models and providing clear sets of rules with predictable privileges and consequences for specified target behaviours. They also make sure the juvenile has a high level of structure for daily activities and tasks, and they closely monitor their adolescent. The programme provides juveniles with tight supervision but also focuses on helping youths develop positive relationships with the adults around them. Efforts are made by the MTFC team to strengthen the juvenile's relations to peers or friends not associated with antisocial behaviour, for example, to re-establish contacts with friends from the youth's social past. The individual therapist has sessions with the juvenile to discuss what constitutes a good friend and a positive relationship. The skills trainer can role-play with the juvenile to prepare the latter to re-establish contact with former friends. Interventions for the birth family through family therapy and carefully planned home visits are essential parts of the programme. The home visits start after about three weeks and increase in frequency and length in an ongoing manner. Interventions to reduce the juvenile's contact with antisocial peers are also an important focus, as is developing a functional school situation (e.g., greater participation, less truancy and improved pupil skills). Efforts within the MTFC team are meant to ensure school attendance. For example, the case manager has worked out a plan of action with the head teacher that is applied if minor or major problems occur. The school personnel are instructed to inform the case manager of any problems. If a major problem arises (e.g., the juvenile is involved in physical fighting), the day after the incident, at the latest, the case manager personally visits the school to provide support. Daily school activities with troublesome juveniles are often challenging. Much effort is expended to assure the school personnel that all their efforts with the juvenile in MTFC are taken seriously. The MTFC programme has five parts, one for each treatment role, outlined in a manual description (Chamberlain, 1998). Several aspects must be individually adjusted,according to the manual—for instance, which specific need (individual, family or skills) should first be addressed and the length of the initial home visits. Adherence to the manual was considered important throughout the programme processes. For example, the foster parents had to complete the PDR checklist and report every day on the

juvenile's performance on the point and level systems. Further, the team discussions and foster parents' supervision sessions were videotaped and sent to the Oregon Social Learning Center for analysis of adherence.

Outcome measures	Placement stability 1 Number of out-of-home placements over 1 year/3 years follow up: 1.4 ± 0.5/3.1 ± 2.2 Criminal outcomes Juveniles with experience of a locked setting over 1 year/3 years follow up: 1 (5%)/5 (26%) Homelessness Homeless over 1 year/3 years follow up: 0 (0%)/ 0 (0%) Negative placement change Negative treatment exit over 1 year/3 years: 2 (11%)/8 (42%) Criminal outcomes 2 Criminal activity over 1 years/3 years: 1 (5%)/3 (15%); Violent crime over 1 years/3 years: 0 (0%)/ 0 (0%) Health outcome 1 Substance Abuse over 1 year/3 years follow up: 4 (21%)/5 (26%)

Care as Usual (N = 27)

The juveniles in the TAU group received several different treatment alternatives. Most of them (n = 21, 78%) received more than one intervention during the first year after assessment. Out-of-home care was the most-used option (n = 26); this alternative could include residential care, private group care and foster care. Fifteen juveniles received in-home care, an alternative that could involve family therapy, individual counselling, mentorship with non-professional volunteers and drug testing. Only one juvenile was sent home, stayed home the whole first year and later received in-home care. Another two juveniles were sent home first but received out-of-home care during parts of the first year. The TAU alternative seldom included manual-based treatment, behaviour modification or evidence-based programmes. Some of the juveniles in out-of-home care may have received some form of manual-based treatment, at least in the residential care; at most, 12 juveniles experienced this. only one recording was found for one adolescent who received a manual-based treatment during the first year at in-home care.

Outcome measures	Placement stability 1 Number of out-of-home placements over 1 year/3 year follow up: 1.5 ± 1.0/3.4 ± 2.4

	Criminal outcomes Experience of a locked settings over 1 year/3 years follow up: 12 (44%)/12 (44%) **Homelessness** Homeless over 1 year/3 years follow up: 0 (0%)/ 2 (7%) **Negative placement change** Negative treatment exit over 1 year/3 years follow up: 9 (33%)/13 (48%) **Criminal outcomes 2** Criminal activity over 1 year/3 year follow up: 6 (22%)/11 (41%); Violent crime over 1 year/3 year follow up: 7 (26%)/11 (41%) **Health outcome 1** Substance Abuse over 1 year/3 year follow up: 10 (27%)/12 (44%)
Risk of Bias	**Domain 1: Bias arising from the randomisation process** **High** (unclear if allocation concealment. the MTFC group had significantly more families with an immigrant background. Few baseline characteristics reported other than those on which randomisation was performed.) **Domain 2a: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention)** **High** (No information provided about whether there were deviations from treatment, or whether intent-to-treat analysis was used) **Domain 3. Bias due to missing outcome data** **High** (Unclear if missing outcome data, approach to missing outcome data and whether missing data varied between comparison groups) **Domain 4. Bias in measurement of the outcome** **Low** **Domain 5. Bias in selection of the reported result**

	Some concerns (Unclear information about the conduct of trial and no protocol cited) **Overall bias and Directness** **High** **Overall Directness** **Partially applicable** (Participants were juveniles at risk for immediate out-of-home placement (awaiting placement in out of home care). However, all but one participants (treatment/control group) were in out of home care during the course of the study.)

Berzin 2008

Study type	Randomised controlled trial (RCT)
Study location	USA
Study setting	Foster family or relative care and were at risk of placement moves or placement in a higher level of care.
Study dates	April 2000 to December 2002
Duration of follow-up	Outcomes assessed over a 5 year period
Sources of funding	Not reported
Inclusion criteria	Age ages 2 to 12 years Care situation at risk of placement moves or placement in a higher level of care.

Sample size	50
Split between study groups	FGDM=31 Comparison = 19
Loss to follow-up	missing data in 4 from the intervention group and 2 from the comparison group for permanency outcomes
% Female	44%
Mean age (SD)	5.5 ± 3.3 years
Condition specific characteristics	Exploitation or trafficking Caregiver absence of incapacity: 44.2%; physical abuse: 7.7%; severe neglect: 7.7%; Sexual abuse: 3.9%; exploitation: 0% Non-white 54% Care situation foster family home: 22%; relative home: 74%; guardian home: 2.0%
Outcome measures	Placement stability 1 number of placement moves, placement moves as a dichotomous measure (0 moves or 1 or more moves), and steps up in placement (from a foster home or foster family agency to a group home). Administrative data were extracted from the California Children's Services Archive. The archive is administered by the Child Welfare Research Center (CWRC) at the University of California at Berkeley. The primary data in the archive are from the Child Welfare Services/Case Management System (CWS/CMS), the information system administered by the CDSS and used by county child welfare workers to manage information related to a child's involvement with the child welfare system. Permanency 1 case closure during the study period, exit type, and time from case opening to case closure. Administrative data were extracted from the California Children's Services Archive. The archive is administered by the Child Welfare Research Center (CWRC) at the University of California at Berkeley. The primary data in the archive are from the Child Welfare Services/Case Management System (CWS/CMS), the information system administered by the CDSS and used by county child welfare workers to manage information related to a child's involvement with the child welfare system.
Study arms	**Family Group Decision Making (FGDM) (N = 31)** FGDM is a child welfare decision-making process in which efforts are made to bring together all parties with an interest in the well-being of the child and his/her family. At the FGDM meeting, the group works to discuss the concerns that bring the child to the attention of protective services, the strengths that exist in the family system, and the changes necessary to

	keep the child safe. Parallel to the rise of family group conferencing in New Zealand, the family unity meeting model arose out of a casework audit conducted by the Oregon State Office for Children and Families. Like family group conferencing, this model seeks to include extended family members in child welfare decisions. Variations on the family group conferencing and family unity meeting models proliferate. Despite their differences, the majority of FGDM models share several basic tenets: • collaboration between families and community and agency supports in child welfare decision making and service provision • respect for the family's community and culture • children's rights to a voice in decision making and to safety • empowerment of families to formulate their own workable family plans • mobilization of increased family support, including extended family and community resources. In addition to these philosophies and goals, the FGDM model relies on a structure of four main components: (1) referral, (2) preparation and planning, (3) the FGDM meeting, and (4) follow-up planning and events. In the referral stage, the social worker assigned to investigate the initial report of child abuse or neglect refers a family to a FGDM meeting coordinator, who determines whether a FGDM meeting will be held. The preparation and planning stage includes several premeeting activities including (1) ensuring safety for the child or adolescent (2) inviting family members and other participants, (3) defining and communicating participants' roles, (4) managing unresolved family conflicts, and (5) coordinating meeting logistics.The FGDM meeting itself consists of an introduction, an information sharing phase, a plan-deliberation phase, and finalization of a family plan. Family plans are formulated in the family deliberation phase of the FGDM meeting, which may involve a private family meeting or a joint meeting between family members, agency professionals, and community members. Family plans comprise specific provisions for child safety, child physical and mental health, material assistance, recreational activities, and other services, as well as detailed plans regarding how and by whom each provision will be completed. Family plans are presented to the full group for discussion and the meeting concludes with the final approval of the plan. The follow-up phase, the plan is monitored to ensure that the requested services are accessible and that all participants honor agreements made toward ensuring the care and protection of the child. Monitoring may include collateral contacts with professionals and family members, as well as additional FGDM meetings. Failure to comply with the provisions set forth in the family plan may result in referral to family court.

Loss to follow-up	Not reported
% Female	Not reported
Mean age (SD)	Not reported

Outcome measures	Placement stability 1 mean number of placement moves: 0.94 ± 1.36 Permanency 1 case closure for a positive reason during the study period: 11/27 (40.7%) Permanency 2 For children who's case was closed the average time to permanency was 20.81 ± 5.82 months

Comparison group (N = 19)

Care of comparison group not described. Riverside County's program was aimed at children ages 2 to 12 years who were placed in foster family or relative care and were at risk of placement moves or placement in a higher level of care.

Loss to follow-up	Not reported
% Female	Not reported
Mean age (SD)	Not reported
Outcome measures	Placement stability 1 mean number of placement moves: 0.95 ± 1.51 Permanency 1 case closure for a positive reason during the study period: 6/18 (33.3%) Permanency 2 For children who's case was closed the average time to permanency was 17.25 ± 9.34 months

Risk of Bias	**Domain 1: Bias arising from the randomisation process** High **Domain 2a: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention)** Low

	Domain 3. Bias due to missing outcome data Low **Domain 4. Bias in measurement of the outcome** Low **Domain 5. Bias in selection of the reported result** Low **Overall bias and Directness** High (No information with regards to the randomization method. No information with regards to the baseline characteristics comparisons for each arm of the 2 studies. Allocation concealment was not possible.) **Overall Directness** Partially applicable (USA study)

Fisher 2011/Lynch 2014

Study type	Randomised controlled trial (RCT)
Study location	USA
Study setting	Preschool foster children
Study dates	Not reported

Duration of follow-up	12 months post baseline
Sources of funding	National Institute of Mental Health, U.S. Public Health Service; National Institute on Drug Abuse, U.S. Public Health Service; and National Institute of Mental Health and Office of Research on Minority Health (ORMH), U.S. Public Health Service.
Inclusion criteria	Age 3-6 years Care situation entering care for the first time, reentering care, or moving between foster homes
Sample size	137
Split between study groups	MDTFC = 64 Regular foster care = 73
Loss to follow-up	26 participants (19 participants in regular foster care/7 participants in MTFC)
% Female	Not reported for total sample
Mean age (SD)	Not reported for total sample
Outcome measures	Placement stability 1 Time to placement disruption in months: Authors defined a placement disruption as exiting the current placement for a negative reason (i.e., removal deemed in the best interest of the child or requested by the caregiver). Authors did not include nonnegative reasons for placement disruptions (i.e., changing circumstances in the home unrelated to child behavior, clinical transitions, permanent foster placements, adoptions, and biological family reunifications). The duration of each foster placement was recorded as the dependent variable. Placement stability 2 Children who experienced a placement disruption: Authors defined a placement disruption as exiting the current placement for a negative reason (i.e., removal deemed in the best interest of the child or requested by the caregiver). Authors did not include nonnegative reasons for placement disruptions (i.e., changing circumstances in the home unrelated to child behavior, clinical transitions, permanent foster placements, adoptions, and biological family reunifications). Placement stability 3

	Number of placement disruptions over 12 months follow up: Authors defined a placement disruption as exiting the current placement for a negative reason (i.e., removal deemed in the best interest of the child or requested by the caregiver). Authors did not include nonnegative reasons for placement disruptions (i.e., changing circumstances in the home unrelated to child behavior, clinical transitions, permanent foster placements, adoptions, and biological family reunifications).
Study arms	**Multidimensional Treatment Foster Care for Preschoolers (N = 57)** The MTFC-P intervention addresses key developmental and social-emotional needs for foster preschoolers. The intervention is delivered via a team approach to the children, foster parents, and permanent placement resources (birthparent and adoptive relative/nonrelative). Before receiving a foster child, each foster parent completes 12 hr of intensive training. After placement, the foster parents work with a foster parent consultant and receive support and supervision through daily telephone contacts, weekly foster parent support group meetings, and 24-hour on-call staff. The foster parent consultant works with the foster parent to maintain a positive, responsive, and consistent environment through the use of concrete encouragement for positive behavior and clear limit setting for problem behavior. The children also receive services from a behavior specialist working in preschool/daycare and home-based settings. Additionally, the children attend weekly socialization playgroup sessions. The program staff is largely composed of clinicians with bachelor's and master's degrees, with a licensed psychologist as the clinical supervisor. Group supervision occurs weekly, with consultation provided as needed. Whenever possible, a family therapist works with birth parents or adoptive parents to familiarize them with the parenting skills used by the foster parents in the program. This helps to facilitate consistency between settings. Children typically receive services for 9–12 months, including the period of transition to a permanent placement (or, if the child is remaining in long-term foster care, until his/her behavior has stabilized and the risk of placement disruption appears to have been mitigated). Treatment fidelity for all MTFC-P components is monitored via progress notes and checklists completed by the clinical staff.

Study type	Randomised controlled trial (RCT)
Study location	USA
Study setting	Preschool foster children
Study dates	Not reported
Duration of follow-up	12 months post baseline

Sources of funding	National Institute of Mental Health, U.S. Public Health Service; National Institute on Drug Abuse, U.S. Public Health Service; and National Institute of Mental Health and Office of Research on Minority Health (ORMH), U.S. Public Health Service.
Sample size	137
Split between study groups	MDTFC = 64 Regular foster care = 73
Loss to follow-up	26 participants (19 participants in regular foster care/7 participants in MTFC)
% Female	50.9%
Mean age (SD)	4.54 ± 0.86
Condition specific characteristics	Behaviour that challenges Parent Daily Report Score, mean: 22.31 ± 13.50 Non-white 17.5%
Outcome measures	Placement stability 1 Time to placement disruption in months: 3.82 ± 3.93 Placement stability 2 Children who experienced a placement disruption: 7 (12.3%) Placement stability 3 Number of placement disruptions over 12 months follow up, mean: 1.08 ± 0.29

Usual Foster Care (N = 60)

	The routine foster care families received routine services, which commonly involve individual psychotherapy, developmental screening, and referrals for services for the children and social service support, substance abuse treatment, mental health treatment, and parent training (not through our center) for the birth families and adoptive families.

Study type	Randomised controlled trial (RCT)
Study location	USA
Study setting	Preschool foster children
Study dates	Not reported
Duration of follow-up	12 months post baseline
Sources of funding	National Institute of Mental Health, U.S. Public Health Service; National Institute on Drug Abuse, U.S. Public Health Service; and National Institute of Mental Health and Office of Research on Minority Health (ORMH), U.S. Public Health Service.
Sample size	137
Split between study groups	MDTFC = 64 Regular foster care = 73
Loss to follow-up	26 participants (19 participants in regular foster care/7 participants in MTFC)
% Female	41.7%
Mean age (SD)	4.34 ± 0.83 years

	<table><tr><td>Condition specific characteristics</td><td>Behaviour that challenges Parent Daily Report score, mean: 18.41 ± 12.85 Non-white 6.6%</td></tr><tr><td>Outcome measures</td><td>Placement stability 1 Time to placement disruption in months: 4.45 ± 2.64 months Placement stability 2 Children who experienced a placement disruption: 12 (20%) Placement stability 3 Number of placement disruptions over 12 months follow up, mean: 1.08 ± 0.29</td></tr></table>
Risk of Bias	**Domain 1: Bias arising from the randomisation process** Low **Domain 2a: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention)** Low **Domain 3. Bias due to missing outcome data** Low **Domain 4. Bias in measurement of the outcome** Low **Domain 5. Bias in selection of the reported result** Low **Overall bias and Directness** Low **Overall Directness**

	Partially applicable (USA study)

Kim 2011/2013

Study type	Randomised controlled trial (RCT)
Study location	USA
Study setting	Summer programme for girls in foster care
Study dates	Not reported (study published 2011)
Duration of follow-up	36 months
Sources of funding	National Institute of Mental Health US Public Health Service National Institute on Drug Abuse
Inclusion criteria	Age In final year of elementary school Gender Girls Care setting Relative or non-relative foster care Geography

	Living in one of two counties in the Pacific Northwest
Sample size	100
Split between study groups	48 randomised to intervention group; 52 randomised to control group
Loss to follow-up	3 lost to follow up in intervention group, 7 lost to follow up in control group
% Female	100%
Mean age (SD)	Not reported for total sample
Outcome measures	Number of placement changes Number of care placement changes from baseline to 12 months follow up. Behavioural outcomes Internalising and externalising symptoms defined by caregiver report using the Achenbach System of Empirically Based Assessment (ASEBA). Mean results across 12 and 24 month follow up were reported. Behavioural outcomes 2 At 6 months (Smith 2011) internalising problems. An internalizing problems composite was computed based on five Parent Daily Report items that reflected internalizing behavior (e.g., irritable and nervous/jittery). Behavioural outcomes 2 At 6 months (Smith 2011) externalising problems. An externalising problems composite was computed based on 18 PDR items that reflected externalizing behavior (e.g., argue and defiant). Social outcomes Prosocial behaviour defined by a subscale from the Parent Daily Report Checklist. A prosocial behavior composite was computed based on 11 PDR items that reflected prosocial behavior (e.g., clean up after herself and do a favor for someone). Delinquency Delinquent behaviour and was measured using the Self-Report Delinquency Scale (SRD). Girls association with delinquent peers was defined using a modified version of the general delinquency scale from the SRD. Delinquency was measured at 36 months. Substance use girls were asked how many times in the past year they had (a) smoked cigarettes or chewed tobacco, (b) drank alcohol (beer, wine, or hard liquor), and (c) used marijuana. The response scale ranged from 1 (never) through 9 (daily). Substance use was assessed at 36 months.

<table>
<tr><td rowspan="3">Study arms</td><td colspan="2">Middle School Success intervention (N = 48)

The MSS intervention was delivered during the summer prior to middle school entry with the goal of preventing delinquency, substance use, and related problems for girls in foster care. The intervention consisted of two primary components: (a) six sessions of group-based caregiver management training for the foster parents and (b) six sessions of group-based skill-building sessions for the girls. The groups met twice a week for 3 weeks, with approximately seven participants in each group. In addition to the summer group sessions, follow-up intervention services (i.e., ongoing training and support) were provided to the caregivers and girls in the intervention group once a week for two hr (foster parent meeting; one-on-one session for girls) during the first year of middle school. The interventionists were supervised weekly, where videotaped sessions were reviewed and feedback was provided to maintain the fidelity of the clinical model. The summer group sessions for the caregivers emphasized establishing and maintaining stability in the foster home, preparing girls for the start of middle school, and preventing early adjustment problems during the transition to middle school. The summer group sessions for the girls were designed to prepare the girls for the middle school transition by increasing their social skills for establishing and maintaining positive relationships with peers, increasing their self-confidence, and decreasing their receptivity to initiation from deviant peers. Specifically, the girls' curriculum targeted strengthening pro-social skills; practicing sharing/cooperating with peers; increasing the accuracy of perceptions about peer norms for abstinence from substance use, sexual activity, and violence; and practicing strategies for meeting new people, dealing with feelings of exclusion, and talking to friends and teachers about life in foster care.</td></tr>
<tr><td>Condition specific characteristics</td><td>% with disabilities; speech, language and communication needs; or special education needs
History of special services: 46.2%

% with behaviour that challenges
Arrest record 2.1%; history of runaway 4.2%</td></tr>
<tr><td>Outcome measures</td><td>Number of placement changes
Mean 0.33 changes ± 1.05

Behavioural outcomes
Internalising and externalising behaviour score: mean 12.77 ± 8.53

Behavioural outcomes 2
Association between being in the intervention group and foster parent and girl reported internalising problems at 6 months: β -0.28 P<0.01 (adjusted for age, maltreatment history, pubertal development, internalising behaviours at baseline)

Behavioural outcomes 3
Association between being in the intervention group and foster parent and girl reported externalising problems at 6 months: β -0.21 P<0.01 (adjusted for age, maltreatment history, pubertal development, externalising behaviours at baseline)

Social outcomes
Prosocial behaviour score: mean 0.80 ± 0.12. Association between being in the intervention group and foster parent and girl reported prosocial behaviour at 6 months: β 0.15 P>0.05</td></tr>
</table>

	Delinquency Self-Report Delinquency Scale (SRD): mean 0.30 ± 0.92; Girls association with delinquent peers score: mean -0.17 ± 0.86; Composite delinquency score: mean -0.17 ± 0.57 **Substance use** Tobacco use score: mean 1.49 ± 1.63; Alcohol use score: mean 1.49 ± 0.90; Marijuana use score: mean 1.29 ± 0.82; composite substance use score: mean 1.42 ± 0.93

Control group (N = 52)

The girls and caregivers in the control condition received the usual services provided by the child welfare system, including services such as referrals to individual or family therapy, parenting classes for biological parents, and case monitoring.

Condition specific characteristics	**% with disabilities; speech, language and communication needs; or special education needs** History of special services: 36.6% **% with behaviour that challenges** Arrest record: 3.8%; History of runaway: 7.7%
Interventions	**Control 1** 62% percent of girls in the control condition received individual counseling, 20% received family counseling, 22% received group counseling, 30% received mentoring, 37% received psychiatric support, and 40% received other counseling or therapy services (e.g., school counseling, academic support) during the 1st year of middle school
Outcome measures	**Number of placement changes** mean 0.76 ± 1.19 **Behavioural outcomes** internalising/externalising behaviour score: mean 12.50 ± 8.29 **Social outcomes** Prosocial behaviour score: mean 0.74 ±0.14 **Delinquency** Delinquent behaviour score: mean 0.95 ± 2.69; association with delinquent peers score: mean 0.17 ± 1.02; composite delinquency score: mean 0.17 ± 1.06 **Substance use** Tobacco use score: mean 2.36 ± 2.49; Alcohol use score: mean 1.80 ± 1.46; Marijuana use score: mean 2.33 ± 2.43; Composite substance use score: mean 2.16 ± 1.93

Risk of Bias	Domain 1: Bias arising from the randomisation process Some concerns Domain 2a: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention) Low Domain 3. Bias due to missing outcome data Low Domain 4. Bias in measurement of the outcome Low Domain 5. Bias in selection of the reported result High Overall bias and Directness Risk of bias judgement High (High for placement change, prosocial behaviour, and internalising and externalising symptoms outcomes. Some concerns for delinquency and substance use outcomes.)

Landsman 2014/Boel-Studt 2017

Study type	Randomised controlled trial (RCT)
Study location	USA
Study setting	Children in foster care

Study dates	May 2009 to Feb 2012.
Duration of follow-up	3 year observation period
Sources of funding	U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau,
Inclusion criteria	Age children ages 0–17 Care situation eferred to the state's centralized foster care placement matching program managed by Four Oaks
Sample size	243
Split between study groups	FIC = 139 Control = 123
Loss to follow-up	FIC = 10 Control = 5
% Female	47%
Mean age (SD)	9.81 ± 5.48
Condition specific characteristics	Non-white 29.9%
Outcome measures	Outcome 1 Data for this study were extracted from case records and a database that was specifically developed for this project to monitor random assignment procedures and model implementation. In addition, for children assigned to FIC the database served as the primary data source for documenting case progress and outcomes. DHS case files served as the primary data source for children in the control group. To extract data fromcase files of children in the control group the research team traveled to county DHS offices that were within the service area included in the project. Case file reading took place at two time points over the course of the three-year study period. We created a data collection instrument to ensure that the information extracted from the DHS case records was comparable to the data that was extracted from the project database. This instrument was piloted in one county

	office and revised. Case file reading was completed by two of the authors and two research assistants who were trained in the data collection procedures. In addition, inter-rater coding was used at each site, representing 15.25% of cases. Any discrepancies were discussed between the two raters and resolved. Placement stability 1 Placement changes over 3 year observation period: authors calculated the number of placement disruptions from the date of random assignment through case closure or the end of the study. Permanency 1 Type of permanent placement over 3 year observation period: Physical permanency was determined based on the type of placement to which the child was discharged or where the child was living at the final observation period. To compare differences in the time it took for children to achieve permanency, the number of days that elapsed between the date of random assignment and placement in a setting that was planned to be the child's permanent home was recorded. Permanency 2 Maltreatment report over 3 year observation period: child maltreatment data provided by DHS to identify whether each child had a confirmed maltreatment report following the date of random assignment. Relational outcome 1 Relational permanency over 3 year observation period: Relational permanency wasmeasured as a 1/0 variable and was based on qualitative data extracted from case records. A child was coded “1” if therewas evidence in the case record of continued contact and emotional support from at least one adult. A child was coded “0” if there was no evidence that the child had ongoing contact and emotional support from at least one adult consistently. Authors recognized the inherent subjectivity of this measure, but there was sufficient detail in the case records—including case notes, permanency plans, family team meeting minutes, and court reports—to make this assessment. To ensure reliability, two researchers examined the coding of this measure, with nearly complete agreement.
Study arms	**Family Finding Intervention (N = 130)** The theory of change underlying family finding and engagement asserts that by focusing efforts on identifying and nurturing a natural support network for each child in care, meeting frequently to sustain a sense of urgency around permanency, providing opportunities for relationship-building, and providing post-placement support, this expanded support network will result in shorter time to permanency, a greater likelihood of permanent placement with family, and improved child safety. FIC was conceptualized in five key components: Referral; Information Gathering, Documentation and Search and Identification; Contact, Assessment and Engagement; Family Ties: Transition to Family; and Documentation. The goal of the Referral stage is to expedite family finding through a seamless randomization process, with quick turnaround times for approving and assigning cases. At the Information Gathering stage, the focus is on identifying and searching for all potential relatives and kin and creating an individualized team and a process for facilitating permanency. The Contact, Assessment and Engagement stage seeks to work with family and supports on relationship building and to prepare the child and family for successful visits with family. By the Family Ties stage, the emphasis is on transitioning decision-making to the family and strengthening plans for sustained family connection after case closure. Documentation represents the provision of ongoing feedback and continuous assessment of process and outcomes. Although these stages are presented as discrete and sequentially related, they occurred simultaneously and in an

	interrelated way. Children were assigned a DHS worker and each received standard child welfare services. As well as Children in FIC were additionally assigned a Search and Engagement Specialist (S&E specialist) who provided intensive family finding and engagement services.
% Female	53.6%
Mean age (SD)	9.41 ± 5.24
Condition specific characteristics	Exploitation or trafficking Physical abuse: 16.7%; Psychological abuse 1.8%; Sexual abuse 6.1%; neglect 67.5% Placement changes prior placements: 2.40 ± 3.13 Non-white 30.4%
Outcome measures	Placement stability 1 Placement changes over 3 year observation period: 2.20 ± 2.25 placement changes. Controlling for gender FFI was not significantly associated with reduced placement changes: beta -0.13 ± 0.61 Permanency 1 Type of placement over 3 year observation period n(%): birth home 36 (28.8%); relative 22 (17.6%); relative adoption 16 (12.8%); nonrelative adoption 16 (12.8%); foster home 28 (22.4%); group care 16 (12.8%); aged out 6 (4.8%). Controlling for gender family finding intervention, beta coefficient: birth home -0.19 ± 0.55; relative 0.77 ± 0.80; relative adoption ; nonrelative adoption 2.16 ± 1.51; foster home 0.32 ± 0.67; group care 0.45 ± 0.82; aged out -1.06 ± 1.00 Permanency 2 In a placement planned for permanency by the last observation: 59.2%; Analysis of the survival curves showed that for both groups the probability of not entering a permanent placement decreased as days of service increased. Difference between groups was not significant. limited to participants with history of congregate care, intensive family finding was not significantly associated with physical permanency over follow up: beta 0.73 ± 0.78 for being in the control group with congregate care Relational outcome 1 Relational permanency over 3 year observation period: beta 0.87 ± 0.61. Limited to participants with history of congregate care, intensive family finding was significantly associated with relational permanency over follow up: beta -0.87 ± 0.78 for being in the control group with congregate care adverse event Maltreatment report over 3 year observation period: 26 (22.8%): beta 0.26 ± 0.67

	Standard Child Welfare Services (N = 123) Children were assigned a DHS worker and each received standard child welfare services. because all children in the study were active child welfare cases, both the experimental and control groups received DHS casework services and other therapeutic and supportive services based on individual needs. FIC services were viewed as an enhancement, not a substitute for other child welfare services. <table><tr><td>% Female</td><td>53.6%</td></tr><tr><td>Mean age (SD)</td><td>9.41 ± 5.24</td></tr><tr><td>Condition specific characteristics</td><td>Exploitation or trafficking Physical abuse: 16.7%; Psychological abuse 1.8%; Sexual abuse 6.1%; neglect 67.5% Placement changes prior placements: 2.40 ± 3.13 Non-white 30.4%</td></tr><tr><td>Outcome measures</td><td>Placement stability 1 Placement changes over 3 year observation period: 2.28 ± 2.54 placement changes Permanency 1 Type of permanent placement over 3 year observation period n(%): birth home 39 (33.1%); relative 10 (8.5%); relative adoption 2 (1.7%); nonrelative adoption 21 (17.8%); foster home 19 (16.1%); group care 11 (9.3%); aged out 14 (11.9%) Permanency 2 In a placement planned for permanency by the last observation: 60% Relational outcome 1 Relational permanency over 3 year observation period: 73 (64.6%) adverse event Maltreatment report over 3 year observation period: 19 (18.4%)</td></tr></table>
Risk of Bias	**Domain 1: Bias arising from the randomisation process**

	Some concerns **Domain 2a: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention)** Low **Domain 3. Bias due to missing outcome data** Low **Domain 4. Bias in measurement of the outcome** Some concerns **Domain 5. Bias in selection of the reported result** Low **Overall bias and Directness** High (No details of the randomization method. There are slight differences in gender between the arms. No allocation concealment. No blinding. Although randomization was prospective, data collection was retrospective via records. Some of the outcomes are subjective.) **Overall Directness** Partially applicable (USA study)

Maaskant 2017

Study type	Randomised controlled trial (RCT) see also Maaskant 2016: Parent training in foster families with children with behavior problems: Follow-up results from a randomized controlled trial.

Study location	Netherlands
Study setting	Foster children with behavioural problems
Study dates	January 2011 and April 2014
Duration of follow-up	postintervention and four month follow up
Sources of funding	ZonMw (the Netherlands Organization for Health Research and Development).
Inclusion criteria	Age 4 to 11 years old Care situation Foster families Emotional or mental health needs Total Difficulties Score above the clinical cut off score of 14 Behavioural needs Parent Daily Report - a mean number of more than five different types of problem behavior each day
Sample size	88 randomised
Split between study groups	PMTO = 47 CAU = 41
Loss to follow-up	PMTO = 17 CAU = 8
% Female	Not reported for total sample

Mean age (SD)	Not reported for total sample
Interventions	Intervention 1 In the PMTO group, 13 foster families (43%) received alternative parenting support or child treatment in addition to PMTO at postintervention and nine foster families (31%) at follow-up. In the CAU group, 21 foster families (63%) reported the received alternative parenting support or child treatment between baseline and postintervention assessment, and nine foster families (26%) between postintervention and follow-up assessment. In total, five families in the CAU received some form of protocolled parenting interventions which might abut to the insensitivity of PMTO (e.g. Triple P course, Video Interaction Guidance, Intensive Home Treatment).
Outcome measures	Behavioural outcome 1 Foster carer-reported Child Behaviour (Child Behaviour Checklist): Child behavior problems were measured with the Dutch version of the Child Behavior Checklist (CBCL). The CBCL and TRF consists of 113 items (6–18 years version, also used for 4–5-years-old after personal agreement of Achenbach) rated on a 3-point Likert scale. Externalizing Problems (CBCL: 35 items, TRF: 32 items, e.g., disobedient at home, destroy his/her own things, can’t sit still) and Internalizing Problems (CBCL: 26 items, TRF: 27 items, e.g., too fearful or anxious, feels worthless or inferior, worries). Placement stability 1 Number of placement breakdowns Behavioural outcome 2 Teacher-reported Child Behaviour (Teacher Report Form): the Teacher Report Form (TRF) completed by teachers. The CBCL and TRF consists of 113 items (6–18 years version, also used for 4–5-years-old after personal agreement of Achenbach) rated on a 3-point Likert scale. Externalizing Problems (CBCL: 35 items, TRF: 32 items, e.g., disobedient at home, destroy his/her own things, can’t sit still) and Internalizing Problems (CBCL: 26 items, TRF: 27 items, e.g., too fearful or anxious, feels worthless or inferior, worries). Relational outcome 1 Parenting Stress: The Dutch revised version of the Parenting Stress Index (PSI-R; Abidin, 1983; translated revised version by De Brock, Vermulst, Gerris, & Abidin, 1992; De Brock, Vermulst, Gerris, Veerman, & Abidin, 2009, NOSI-R) was used to assess parental experiences of stress and competence in the parenting situation. This parent-report inventory consists of 78 items using a four-point scale (1 = strongly agree; 4 = strongly disagree) and is divided into 13 subscales, referring to two main domains of parenting stress experience. The ‘parent domain’ (Parent Stress; e.g. being a foster parent of this child is more though than I thought it would be, it is difficult to understand what my foster child needs from me; because of being a foster parent, I cannot do other things I would like to do) refers to perceived stress regarding family factors and includes seven subscales: sense of competence (seven items), restricted role (six items), attachment (five items), depression (six items), parent health (five items), social isolation (six items) and marital relationship (five items). The ‘child domain’ (Child Stress; my foster child demands more than my other children, I don't feel my foster child appreciate my good intentions, a lot of things are upsetting my foster child) refers to stress evoked by their child's behavior and emotions and contains six subscales: adaptability (seven items), mood (six items), distractibility/ hyperactivity (seven items), demandingness (six items), positive reinforcement (five items) and acceptability to the child (seven items). Finally, a Total Stress score of parenting stress (Parent Stress + Child Stress) can be calculated. The psychometric qualities of the Dutch version of the PSI-R are acceptable to good (De Brock et al., 1992, 2009). In the present study, the Parent, Child and Total Stress score were used as outcomemeasures for parenting stress. In our sample, the Cronbach's alpha varied (from baseline to follow-up and for foster mothers and fathers) from 0.67 and 0.94 for the different subscales. The Cronbach's alpha of the Parent, Child and the Total Stress score varied from 0.93 and 0.98. Relational outcome 2 Parenting behaviour: Parental behavior was assessed with the Parenting Behavior Questionnaire (PBQ, Wissink, Deković, & Meijer, 2006). The PBQ comprises 30 items on a five-point rating scale (1=never; 5=very often), divided into six subscales (5 items each), referring to threemain dimensions of parental behavior: warmth and responsiveness (dimension parental support e.g. howoften you compliment your child?), explaining and autonomy granting (dimension authoritative control; e.g. how often you encourage your child to decide something on its own?) and strictness and discipline (dimension restrictive control e.g. how often you need to set strict rules?).
Study arms	**Parent Management Training Oregon (PMTO) (N = 30)**

	PMTO is an intensive (mostly 6–9 months with weekly sessions), individual parenting intervention in which intervention goals are set in agreement between trainer and parents. PMTO treatment is based on the social interaction learning model (SIL), which combines the principles of social learning, social interaction and behavioral perspectives. SIL emphasizes the importance of the social context in the development of children. Contextual factors (e.g., family structure transitions, parents' stress-level and children's temperament) are expected to have indirect effects on child outcomes, and are mediated by coercive processes and ineffective parenting skills. Coercive cycles in family interactions are initiated when children and parents reinforce each other's negative behavior, and these cycles often flourish in stressful contexts. In relationships characterized by coercive interactions parental expression of warmth and encouragement tend to be scarce, and the children are rarely reinforced for developing positive skills. Once coercive processes are established, they tend to be maintained by both the parent and child. The main focus of PMTO is enhancing effective and positive parenting practices, and diminishing coercive practices while making relevant adaptations for high risk contextual factors (e.g., divorce; Forgatch et al. 2005a). The five central parenting skills are: limit setting and discipline, monitoring and supervision, problem solving, positive involvement, and skill encouragement (Patterson 2005). In addition to the core parenting practices, PMTO incorporates the supporting parenting components of identifying and regulating emotions, enhancing communication, giving clear directions, and tracking behavior. The PMTO program is fully manualized. The central role of the PMTO therapist is to teach and coach parents by role play, and modeling exercises in the use of effective parenting strategies. Nevertheless, the central parenting skills and supporting parenting components offered by the therapists depend on the specific goals set for each family. Internationally the mean number of individual treatment sessions is about 25 (depending on the set goals) and sessions are generally once a week. The average number of sessions in the present study was 21.42 (SD = 7.90). In 29% of the PMTO treatments in this study only the foster mother was involved, in 71% both foster parents attended.

Study type	Randomised controlled trial (RCT)
Study location	Netherlands
Study setting	Foster children with behavioural problems
Study dates	January 2011 and April 2014

Duration of follow-up	postintervention and four month follow up
Sources of funding	ZonMw (the Netherlands Organization for Health Research and Development).
Inclusion criteria	Age 4 to 11 years old Care situation Foster families Emotional or mental health needs Total Difficulties Score above the clinical cut off score of 14 Behavioural needs Parent Daily Report - a mean number of more than five different types of problem behavior each day
Sample size	88 randomised
Split between study groups	PMTO = 47 CAU = 41
Loss to follow-up	PMTO = 17 CAU = 8
% Female	54%
Mean age (SD)	7.85 ± 2.36 years
Condition specific characteristics	Placement changes Number of previous placements: 0.96 ± 0.79 Care situation

	Non-kinship: 83%
Outcome measures	**Behavioural outcome 1** Foster carer-reported Child Behaviour (Child Behaviour Checklist): total problems at postintervention/4 month follow up: 60.63 ± 10.62/60.75 ± 10.85; externalising problems at postintervention/4 month follow up: 62.10 ± 10.09/61.68 ± 10.09; internalising problem at postintervention/4 month follow up: 54.91 ± 10.35/55.16 ± 11.24 **Placement stability 1** Number of placement breakdowns: 2 **Behavioural outcome 2** Teacher-reported Child Behaviour (Teacher Report Form): total problems at postintervention/4 month follow up: 58.07 ± 9.12/60.04 ± 8.47; externalising problems at postintervention/4 month follow up: 77.86 ± 22.11/79.37 ± 21.71; internalising problem at postintervention/4 month follow up: 55.32 ± 9.92/56.48 ± 9.78 **Relational outcome 1** Parental stress mean score (PSI-R) at postintervention/4 month follow up: total scale: 141.98 ± 36.43/146.75 ± 40.32; parent domain: 62.07 ± 16.95/64.71 ± 20.89; child domain: 79.21 ± 22.65/81.41 ± 22.08 **Relational outcome 2** Parenting behaviour (PBQ) mean score at postintervention/four months follow up: Warmth: 4.10 ± 0.67/4.06 ± 0.72. Responsiveness: 3.89 ± 0.55/3.86 ± 0.61. Explaining: 3.98 ± 0.60/4.00 ± 0.57. Autonomy granting: 3.38 ± 0.59/3.44 ± 0.56. Strictness: 2.78 ± 0.62/2.84 ± 0.67. Discipline: 2.12 ± 0.61/2.14 ± 0.61

Care as Usual (N = 33)

All foster parents received regular support services from the foster care institution. These support services typically included an appointment with a foster care supervisor once every 3–6 weeks. The supervisors were blind for the allocation of families into the control group. If necessary, foster parents from the control group were free to ask for more intensive or specialized support, including every available form of treatment or intervention except PMTO. Foster parents in the intervention group also received care as usual and were free to ask for other help besides PMTO. At posttest, foster parents of both the PMTO and CAU group were asked which (alternative) forms of support or treatment they had received and how often.

Study type	Randomised controlled trial (RCT)
Study location	Netherlands

Study setting	Foster children with behavioural problems
Study dates	January 2011 and April 2014
Duration of follow-up	postintervention and four month follow up
Sources of funding	ZonMw (the Netherlands Organization for Health Research and Development).
Inclusion criteria	Age 4 to 11 years old Care situation Foster families Emotional or mental health needs Total Difficulties Score above the clinical cut off score of 14 Behavioural needs Parent Daily Report - a mean number of more than five different types of problem behavior each day
Sample size	88 randomised
Split between study groups	PMTO = 47 CAU = 41
Loss to follow-up	PMTO = 17 CAU = 8
% Female	50%
Mean age (SD)	7.52 ± 2.30

Condition specific characteristics	Placement changes Number of previous placements: 1.05 ± 1.13 Care situation Placement type (non-Kinship): 85%
Outcome measures	Behavioural outcome 1 Foster carer-reported Child Behaviour (Child Behaviour Checklist): total problems at postintervention/4 month follow up: 63.00 ± 9.19/61.64 ± 9.47; externalising problems at postintervention/4 month follow up: 64.75 ± 9.68/63.22 ± 10.95; internalising problem at postintervention/4 month follow up: 53.89 ± 10.92/52.47 ± 10.60 Placement stability 1 Number of placement breakdowns: 3 Behavioural outcome 2 Teacher-reported Child Behaviour (Teacher Report Form): total problems at postintervention/4 month follow up: 62.03 ± 9.40/59.23 ± 9.15; externalising problems at postintervention/4 month follow up: 81.59 ± 19.60/78.80 ± 21.63; internalising problem at postintervention/4 month follow up: 55.69 ± 10.18/53.73 ± 9.69 Relational outcome 1 Parental stress mean score (PSI-R) at postintervention/4 month follow up: total scale: 158.3 ± 40.82/152.45 ± 44.29; parent domain: 70.79 ± 22.54/67.83 ± 25.15; child domain: 83.92 ± 22.49/83.92 ± 22.49 Relational outcome 2 Parenting behaviour (PBQ) mean score at postintervention/four months follow up: Warmth: 4.14 ± 0.61/4.18 ± 0.64. Responsiveness: 3.90 ± 0.60/3.90 ± 0.63. Explaining: 4.09 ± 0.50/4.09 ± 0.62. Autonomy granting: 3.51 ± 0.52/3.47 ± 0.53. Strictness: 3.18 ± 0.53/3.20 ± 0.58. Discipline: 2.24 ± 0.53/2.26 ± 0.52
Risk of Bias	**Domain 1: Bias arising from the randomisation process** Low **Domain 2a: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention)** High **Domain 3. Bias due to missing outcome data** High **Domain 4. Bias in measurement of the outcome**

	High **Domain 5. Bias in selection of the reported result** Low **Overall bias and Directness** High (In the intervention arm, 5 participants dropped out because they wished for ‘other kind of help’. There was also ‘no need for help’ in 7 instances. These reasons were not evident in the control arm. Also, the number of participants dropping out in the intervention arm was greater. The number of participants who dropped out in the intervention arm is relatively large (approximately 1/3). Foster parents from the control group were free to ask for more intensive or specialised support, including every available form of treatment or intervention except PMTO. It’s not clear that participants in the intervention arm had this too. Investigators who collected data were not blinded.) **Overall Directness** Partially applicable (Study was conducted in the Netherlands)

Macdonald 2005

Study type	Randomised controlled trial (RCT)
Study location	UK
Study setting	Foster Care
Study dates	Not reported
Duration of follow-up	Postintervention (intervention took place over 4-5 weeks), and 6 months follow up

Sources of funding	Not reported
Inclusion criteria	Care situation foster-carers from six local authorities in the south-west of England.
Exclusion criteria	Care situation foster-carers engaged in respite care
Sample size	117
Split between study groups	Training: 67 Wait list: 50
Loss to follow-up	None reported
% Female	76.1%
Mean age (SD)	mean 45 years
Outcome measures	Behavioural outcome 1 Number of behaviours found challenging (constructed index). At each time point participants were asked what behaviours they found particularly difficult or challenging. Carers reported a wide range of problems, amongst which those most frequently reported included physical aggression, Attention Deficit Hyperactivity Disorder (ADHD) and its consequences, anxiety and phobias, stealing and lying, and a variety of behaviour problems such as temper tantrums, biting spitting, screaming and eating problems. Authors anticipated that carers in the training group would find some things less challenging over time as a result of the training. On the basis of the number of problems each participant reported, an index was calculated representing the proportion of reported difficult behaviours. The index was developed by summing the number of behaviours reported as difficult and challenging by each participant and dividing this number by twenty-five (total number of behaviours that could be listed). Placement stability 1 Number of unplanned breakdowns of placement at 6 months: These data were ontained from interview data, which covered the 6 months after training. Authors tried to identify placements that came to unplanned endings that foster carers attributed (at least in part) to behaviour problems.
Study arms	**CBT-informed Parent training programme (N = 67)** The training sought to familiarize carers with an understanding of social learning theory, in terms of both how patterns of behaviour develop and how behaviour can be influenced using interventions derived from learning theory. There was an

emphasis throughout on developing the skills to observe, describe and analyse behaviour in behavioural terms—the so-called 'ABC' analysis. In the programme, these skills were developed before moving on to consider specific strategies or interventions, though the way in which the training was conducted resulted in some fluidity between sessions. In order to standardize the intervention and ensure its replicability, the trainers produced a manual for carers that provided an overview of the curriculum and associated materials. In relation to the children, the programme sought to ensure that each child's particular situation was taken into account. Authors made explicit the importance of such issues as a child's attachment history, their early childhood experiences and other significant events, and how these impact on how children experience current events and relationships. The programme also focused on the experience of foster-carers, and the quality of the relationships they enjoyed with those they fostered. Sometimes, the reason people do not respond appropriately in stressful situations is not attributable to lack of skills, or even lack of insight into how best to handle a situation. Rather, it is because of a lack of belief in one's ability to act or to bring about change. The curriculum was therefore designed to promote a sense of confidence or self-efficacy on the part of foster-carers. It did this essentially by encouraging foster-carers to apply behavioural and cognitive behavioural principles to an analysis of their own learning and their own responses to situations, and by affirming and reinforcing their endeavours. The programme also focused on other important factors, such as the quality of relationships between foster-carers and those they looked after. For example, we explored with carers how they managed when looking after children with whom close bonds were difficult to forge, whether because of a child's history of rejection, or simply because a carer found a child particularly difficult to 'like'. The first two groups met weekly for three hours over five weeks. The study groups were, however, considerably larger than those in the pilot, and authors moved to four, weekly, five-hour sessions in order to enable the participation of all group members in the remaining four groups. A follow-up day was designed as an opportunity for participants to discuss their experiences of implementing these interventions over a period of time.

% Female	77.6%
Outcome measures	Behavioural outcome 1 Proportion of behaviours found challenging (constructed index mean score) at postintervention/6 month follow up: 0.07/0.05. There were no differences between the comparison groups at any time point. Placement stability 1 Number of unplanned breakdowns of placement: 4/49 (8.2%)

Wait list control (N = 50)

<table>
<tr><td></td><td>Those in the control group continued to receive standard services and were assured that should the training prove helpful, it would be made available to them in the future.
<table><tr><td>Outcome measures</td><td>Behavioural outcome 1
Proportion of behaviours found challenging (constructed index mean score) at postintervention/6 month follow up: 0.07/0.05. There were no differences between the comparison groups at any time point.
Placement stability 1
Number of unplanned breakdowns of placement at 6 months: 4/40 (10%)</td></tr></table></td></tr>
<tr><td>Risk of Bias</td><td>Domain 1: Bias arising from the randomisation process
High
(Baseline characteristics not compared between study groups, however there were considerable differences between the numbers assigned to either group after randomisation (50 vs 67))
Domain 2a: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention)
High
(No information was reported about adherence to the interventions or whether a per-protocol approach was used for analysis.)
Domain 3. Bias due to missing outcome data
High
(>10% of missing data for placement breakdown outcome. Intervention group almost twice the missing data of the control group.. Unclear reasons for missing data.)
Domain 4. Bias in measurement of the outcome
Some concerns
Domain 5. Bias in selection of the reported result
Some concerns
(Unclear research protocol in study, and no protocol cited)</td></tr>
</table>

	Overall bias and Directness High **Overall Directness** Directly applicable (UK based)

Pasalich 2016/Spieker 2014

Study type	Randomised controlled trial (RCT) ORIGINAL TRAIL SPIEKER 2012
Study location	USA
Study setting	Children in a court-ordered placement that resulted in a change in primary caregiver
Study dates	April 2007 to March 2010
Duration of follow-up	6-month follow up and 2-year follow up
Sources of funding	National Institute of Mental Health and the National Institute of Child Health and Human Development.
Inclusion criteria	Age aged between 10 - 24 months Care situation In state dependency and who experienced a court-ordered placement that resulted in a change in primary caregiver within the 7 weeks prior to enrollment. Eligible caregivers spoke English and included foster parents (n = 89), biological parents (n = 56), or adult kin (n = 65).
Sample size	210

Split between study groups	PFR: 105 EES: 105
Loss to follow-up	16 participants (5 lost to the EES intervention and 11 lost to the PFR intervention at 6 months)
% Female	44%
Mean age (SD)	18.01 ± 4.73 months
Condition specific characteristics	Placement changes 2.7 ± 1.6 placement changes Non-white 44.8%
Outcome measures	Social outcome 1 Social competence: measured by the Brief Infant Toddler Social and Emotional Assessment (BITSEA; Briggs-Gowan & Carter, 2002). Descriptions of positive social behaviors and problem behaviors in the last month were rated on a 3-point scale (not true/rarely; somewhat true/ sometimes; very true/often). Placement stability 1 Stability was coded as present if the child had remained with the study caregiver since randomization into the study, with no temporary intermediate moves. A state child welfare administrative database provided dates of a child's birth, entry into care, any placement changes while in care, when a discharge to a permanent placement occurred, and when a child re-entered care, if ever. A placement change was defined as any move to another home recorded in the data base, even if it was labeled as a short term or temporary placement after which the child returned to a familiar home. Permanency 1 Permanency required stability plus a legal discharge to the study caregiver. Permanency could include reunification and discharge to the study birth parent, adoption by the study kin or non-kin caregiver, or legal guardianship by the study kin Behavioural outcome 2 Problem behaviour: measured by the Brief Infant Toddler Social and Emotional Assessment (BITSEA; Briggs-Gowan & Carter, 2002). Descriptions of positive social behaviors and problem behaviors in the last month were rated on a 3-point scale (not true/rarely; somewhat true/ sometimes; very true/often). Relational outcome 1 Attachment security: The primary child outcome of attachment security was measured with the Toddler Attachment Sort-45, which was scored immediately after each research home visit. The TAS45 is a 45-item modified version of the Attachment Q-Sort (AQS; Waters, 1987), a gold standard attachment measure which has been extensively validated. Authors used a sorting technique that the developers of the TAS45 termed trilemmas in which the 45 descriptive statements are presented in specific sets of three. The three items in a sample trilemma are: "Child wants to be at the center of mother's attention"; "Child is very independent"; "Child will go towards mother to give her toys, but does not touch nor look at her". The observer decides which one of the three statements in the set is most like and which is least like the child's behavior during the observation just completed. Each of the 45

<table>
<tr><td></td><td>statements appears in two trilemmas; there are 30 trilemmas in all. The scoring results in an overall security score. Two research visitors were trained to administer the TAS45 by the first author; in 16% of visits the TAS45 was coded by the two raters on-site. Inter-rater reliability was r = .92.

Relational outcome 2
Engagement: Scored from the Indicator of Parent-Child Interaction (IPCI; Baggett, Carta, & Horn, 2009). Items such as “positive feedback”, “sustained engagement”, and “follow through (including turn-taking)” were coded on a 4-point scale (never, rarely, sometimes, or often). Reliability was assessed by the IPCI trainer on 34% of coded episodes across all three time points. IPCI inter-rater agreement ranged from r = .80 to r = .84.

Behaviour outcome 3
Child Behaviour Checklist: Descriptions of behavior in the last two months were rated on a 3-point scale (not true; somewhat true/sometimes; very true/often). Four scales were used: Internalizing (36 items; Alpha = .80), Externalizing (24 items; Alpha = . 90), Sleep problems (7 items; Alpha = .70), and Other Problems (32 items; Alpha = .70).

Behavioural outcome 4
Emotional regulation and orientation/engagement: At baseline and again at the six month follow-up data collectors used 1 – 5 scales to rate the child’s behavior during administration of the Bayley-III Screening Test (Bayley, 2005) on seven of ten items from the Emotional Regulation factor and six of nine items from the Orientation/Engagement factor from the Bayley Behavior Rating Scales (Bayley 1993).</td></tr>
<tr><td>Study arms</td><td>Promoting First Relationships (N = 105)
Caregiver-toddler dyads (n = 105) randomized to the PFR intervention were offered ten weekly 60- to 75-minute in-home visits by a masters-level mental health provider from one of several local agencies. Seventy one percent of the caregivers received all ten sessions. The sessions focused on increasing parents’ sensitivity using attachment theory-informed and strength-based consultation strategies. For instance, reflective video feedback was included in five sessions using taped episodes of caregiver-child play or caregiving behavior, wherein the PFR provider guided discussion concentrating on parenting strengths and interpretation of the child’s cues. Across the sessions a variety of handouts were reviewed pertaining to topics such as “Staying Connected During Difficult Moments.” This aspect of the curriculum promoted caregivers’ understanding that toddler challenging behavior often reflects underlying unmet attachment needs (e.g., safety and comfort). PFR providers received 90 hours of training (including supervision) over six months, and there was good implementation fidelity.

<table><tr><td>Study location</td><td>USA</td></tr><tr><td>Study setting</td><td>Children in a court-ordered placement that resulted in a change in primary caregiver</td></tr><tr><td>Study dates</td><td>April 2007 to March 2010</td></tr></table></td></tr>
</table>

Duration of follow-up	6-month follow up and 2-year follow up
Sources of funding	National Institute of Mental Health and the National Institute of Child Health and Human Development.
Sample size	210
Split between study groups	PFR: 105 EES: 105
Loss to follow-up	16 participants (5 lost to the EES intervention and 11 lost to the PFR intervention at 6 months)
% Female	40%
Mean age (SD)	17.96 ± 4.97 months
Condition specific characteristics	Placement changes 2.67 ± 1.66 placement changes Non-white 51.4%
Outcome measures	Social outcome 1 Social competence score postintervention (Brief Infant Toddler Social and Emotional Assessment), mean: 16.38 ± 3.19; Social competence score at 6 months (Brief Infant Toddler Social and Emotional Assessment), mean: 17.53 ± 3.28 Placement stability 1 PFR vs comparator for placement stability at 2 years, odds ratio (95%CI): 1.19 (0.63 to 2.27), adjusted for foster/kin placement, age of child, months in child welfare, number of prior placements, multiple removals, foster carer commitment. Permanency 1 PFR vs comparator, Permanency over 2 years follow up, odds ratio (95%CI): 1.72 (0.73 to 4.04), adjusted for foster/kin placement, age of child, months in child welfare, number of prior placements, multiple removals, foster carer commitment

	Behavioural outcome 2 Problem behaviour postintervention (Brief Infant Toddler Social and Emotional Assessment), mean: 10.81 ± 6.45; Problem behaviour at 6 months (Brief Infant Toddler Social and Emotional Assessment), mean: 9.88 ± 5.74 **Relational outcome 1** Attachment security score postintervention (Toddler Attachment Sort-45), mean: 0.58 ± 0.30. Attachment security score at 6 months (Toddler Attachment Sort-45), mean: 0.53 ± 0.37 **Relational outcome 2** Engagement score (Indicator of Parent-Child Interaction) at postintervention: 2.08 ± 0.53. Engagement score (Indicator of Parent-Child Interaction) at 6 months: 2.29 ± 0.51 **Behaviour outcome 3** Child Behaviour Checklist at 6 months, mean scores: internalising problems: 7.39 ± 5.85; externalising problems: 12.87 ± 8.55; Sleep problems: 2.27 ± 2.17; other problems: 9.18 ± 6.13 **Behavioural outcome 4** Emotional regulation and orientation score at 6 month follow up: emotional regulation: 4.13 ± 0.69; orientation: 4.41 ± 0.49

Early Education Support (N = 105)

Those randomized to the comparison condition (n = 105) received Early Education Support (EES) through bachelor-prepared providers from a local community agency. EES consisted of three monthly 90-minute, in-home sessions facilitated by a child development specialist, who focused on child developmental guidance and resource and referral. The provider made suggestions for activities that would stimulate the child's cognitive and language development and assisted the caregiver to find services in the community, such as Early Head Start, for which the family was eligible. The PFR group did not receive these types of resource and referral suggestions from the PFR providers. However, families were not prohibited from seeking and utilizing any additional services to which they were entitled. That only PFR providers used relationship-focused consultation strategies (positive feedback; positive and instructive feedback; reflective comments or questions; and validating, responsive statements) and video feedback was verified in regular fidelity checks of both PFR and EES providers.

% Female	47.6%
Mean age (SD)	18.06 ± 4.49 months

	<table><tr><td>Condition specific characteristics</td><td>Placement changes 2.70 ± 1.51 placement changes Non-white 38.1%</td></tr><tr><td>Outcome measures</td><td>Social outcome 1 Social competence score at postintervention (Brief Infant Toddler Social and Emotional Assessment), mean: 16.38 ± 3.19. Social competence score at 6 months (Brief Infant Toddler Social and Emotional Assessment), mean: 17.94 ± 2.77 Behavioural outcome 2 Problem behaviour at postintervention (Brief Infant Toddler Social and Emotional Assessment), mean: 10.72 ± 6.08. Problem behaviour at 6 months (Brief Infant Toddler Social and Emotional Assessment), mean: 9.09 ± 5.76 Relational outcome 1 Attachment security score postintervention (Toddler Attachment Sort-45), mean: 0.54 ± 0.29. Attachment security score at 6 months (Toddler Attachment Sort-45), mean: 0.55 ± 0.28 Relational outcome 2 Engagement score at postintervention (Indicator of Parent-Child Interaction), mean: 2.15 ± 0.49. Engagement score at 6 months (Indicator of Parent-Child Interaction), mean: 2.38 ± 0.50 Behaviour outcome 3 Child Behaviour Checklist at 6 months, mean scores: internalising problems: 7.55 ± 4.88; externalising problems: 13.94 ± 8.35; Sleep problems: 3.12 ± 2.88; other problems: 9.99 ± 5.36 Behavioural outcome 4 Emotional regulation and orientation/engagement score at 6 months follow up: emotional regulation: 4.01 ± 0.61; orientation: 4.38 ± 0.53</td></tr></table>
Risk of Bias	**Domain 1: Bias arising from the randomisation process** Some concerns (Unclear if allocation concealment. participants in PFR were more likely to have been removed from birthparents home more than once) **Domain 2a: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention)** Low (fidelity outcomes reported and appears to be modified intention to treat analysis)

	Domain 3. Bias due to missing outcome data Some concerns (a significant proportion of attrition was as a result of change in caregiver which could be directly related to child outcomes. However, the proportion of attrition was similar between groups.) **Domain 4. Bias in measurement of the outcome** Some concerns **Domain 5. Bias in selection of the reported result** Low **Overall bias and Directness** Some concerns (Particularly large loss to follow up) **Overall Directness** Indirectly applicable (USA based study)

Price 2008

Study type	Randomised controlled trial (RCT) see also Chamberlain 2008: Prevention of Behavior Problems for Children in Foster Care: Outcomes and Mediation Effects. Chamberlain 2008: Cascading Implementation of a Foster and Kinship Parent Intervention.
Study location	USA

Study setting	Children in Foster Care
Study dates	between 1999 and 2004
Duration of follow-up	6.5 months follow up
Sources of funding	Department of scientific and industrial research; National Institute of Mental Health; US Public Health Service; National Institute on Drug Abuse.
Inclusion criteria	Age child aged 5 to 12 years Care situation all foster and kinship parents receiving a new placement; children had to have been in the new placement for at least 30 days
Sample size	700
Split between study groups	KEEP: 359 Control: 341
Loss to follow-up	Not reported
% Female	52%
Mean age (SD)	8.8 years
Condition specific characteristics	Non-white 78% (29% spoke both english and spanish, 2% spoke only spanish)
Outcome measures	Behavioural outcome 1 Child behaviour problems postintervention and at 5 months follow up: measured using the parent daily report (PDR) checklist a 30-item measure of child behavior problems delivered by telephone to parents during a series of three consecutive or closely spaced days (1 to 3 days apart). A trained interviewer asked the parent "Thinking about (child's name), during

	the past 24 hours, did any of the following behaviors occur?" Parents were asked to recall only the past 24 hours and to respond "yes" or "no" (i.e., the behavior happened at least once or did not occur). Placement stability 1 Negative exits from care (placement breakdown) over 200 day/6.5 month follow up. Foster parents were asked at the termination assessment if the child had remained in the home or had moved, and assessors coded the timing and reason for these exits. Negative exits were defined by negative reasons for the child's exit from the home, such as being moved to another foster placement, a more restrictive environment such as a psychiatric care or juvenile detention center, or child runaways. Permanency 1 Positive exits from care (permanency) over 200 day/6.5 month follow up . Foster parents were asked at the termination assessment if the child had remained in the home or had moved, and assessors coded the timing and reason for these exits. Positive exits were defined as any exit from the foster or kinship placement home that was made for a positive reason, such as a reunion with biological parent or other relative or an adoption. Placement stability 2 No change in placement over follow up (%) Relational outcome 1 Proportion of positive reinforcement: Proportion positive reinforcement was measured using a ratio score of foster parent positive reinforcement and discipline behaviors. The amount of positive reinforcement and discipline per day was computed by aggregating foster parent responses to standardized questions during a 2-hour foster parent interview, and foster parent reports of the use of reinforcement and discipline on the PDR. The foster parent interview items included measures of the frequency of positive reinforcement (How often do you use rewards?) and discipline (How often do you have to discipline?). Each item was rated on a 7-point Likert-type scale, ranging from "don't use this strategy" to "3 or more times per day." PDR items included the number of incentives the foster parent reported using per day (positive reinforcement) and the total number of disciplines used per day (discipline). Correlations between the foster parent interview and PDR scores were significant (r = .20–.28 for positive reinforcement and r = .48–.51 for discipline). An average from the two sources provided a multimethod index of these dimensions of parenting.
Study arms	**KEEP foster parent training (N = 359)** Participants in the intervention group received 16 weeks of training, supervision, and support in behavior management methods. Intervention groups consisted of 3 to 10 foster parents and were conducted by a trained facilitator and co-facilitator team. Curriculum topics were designed to map onto protective and risk factors that were been found in previous studies to be developmentally relevant malleable targets for change. The primary focus was on increasing use of positive reinforcement, consistent use of non-harsh discipline methods, such as brief time-outs or privilege removal over short time spans (e.g., no playing video games for one hour, no bicycle riding until after dinner), and teaching parents the importance of close monitoring of the youngster's whereabouts and peer associations. In addition, strategies for avoiding power struggles, managing peer relationships, and improving success at school were also included. Sessions were structured so that the curriculum content was integrated into group discussions and primary concepts were illustrated via role-plays and videotaped recordings. Home practice assignments were given that related to the topics covered during sessions in order to assist parents in implementing the behavioral procedures taught in the group meeting. If foster parents missed a parent-training session, the material was delivered during a home visit (20% of the sessions). Such home visits have been found to be an effective means of increasing the dosage of the intervention for families who miss interventions sessions. Parenting

groups were conducted in community recreation centers or churches. Several strategies were used to maintain parent involvement, including (a) provision of childcare, using qualified and licensed individuals so that parents could bring younger children and know that they were being given adequate care, (b) credit was given for the yearly licensing requirement for foster care, (c) parents were reimbursed $15.00 per session for traveling expenses, and (d) refreshments were provided. Attendance rates were high: 81% completed 80% or more of the group sessions (12+), and 75% completed 90% or more of the group sessions (14+). The intervention was implemented by paraprofessionals who had no prior experience with the MTFC behavior management model or with other parent-mediated interventions. Rather, experience with group settings, interpersonal skills, motivation and knowledge of children were given high priority in selecting interventionists. Interventionists were trained during a 5-day session and supervised weekly where videotapes of sessions were viewed and discussed.

Study type	Randomised controlled trial (RCT)
% Female	50%
Mean age (SD)	8.88 years
Condition specific characteristics	Non-white 80%
Outcome measures	Behavioural outcome 1 Child behaviour problems score (mean number of child problem behaviours per day) 5 months post baseline, mean: 4.37 ± 3.91. Adjusting for baseline child behaviour problems, and child age, a significant relationship between the intervention group and 5 month child behaviour problems: beta coefficient -0.14. Effect size was greater for a high risk subgroup (>6 child problem behaviours daily): beta coefficient -0.11 (P<0.01) compared to a low risk subgroup (<6 problem behaviours daily): beta coefficient -0.22 (P<0.01) Placement stability 1 12.2% had negative exits from care (placement breakdown) over 200 day/6.5 month follow up. In Cox regression, the relationship between intervention status and placement breakdown: beta coefficient 0.89 ± 0.47, adjusted for kinship care, child age, child gender, english primary language, days in placement at baseline, number of prior placements Permanency 1 17.4% had a positive exit from care (unclear n). Relationship between being in the intervention group and rate of positive exit from care: beta coefficient 1.96 ± 0.47 (p=0.006), adjusted for kinship care, child age, child gender, english primary language, days in placement at baseline, number of prior placements

	Placement stability 2 Number experiencing no change over follow up: 70.4% (n not reported) Relational outcome 1 Positive reinforcement score 5 months post-baseline, mean: 1.06 ± 0.60; Discipline score 5 months post-baseline, mean: 1.06 ± 1.13; Proportion positive reinforcement 5 months post-baseline, mean: 0.60 ± 0.28. A model that excluded child behavior problems but included paths from baseline intervention group, proportion positive reinforcement, and child age to termination proportion positive reinforcement showed a significant path from intervention group to termination proportion positive reinforcement controlling for initial levels of reinforcement, Beta = 0.13 (P<0.05)

Control (N = 341)

State law requires all foster parents to participate in some form of parent training and support group each year in order to maintain their licenses. Foster parents participating in the KEEP intervention were permitted to use participation in this training to count toward their licensing requirements. During the course of the year, foster parents in the control condition also participated in some type of parent training and support group made available to them through usual child welfare services.

Study type	Randomised controlled trial (RCT)
% Female	54%
Mean age (SD)	8.72 years
Condition specific characteristics	Non-white 75%
Outcome measures	Behavioural outcome 1 Child behaviour problems score (mean number of child problem behaviours per day) 5 months post baseline, mean: 5.44 ± 4.15 Placement stability 1 Negative exits from care (placement breakdown) over 200 day/6.5 month follow up: 14.3% (n not reported) Permanency 1 Positive exits from care (permanency) over 200 day/6.5 month follow up: 9.1% (n not reported) Placement stability 2

	number with no change in placement over follow up: 76.6% (n not reported) Relational outcome 1 Positive reinforcement score 5 months post-baseline, mean: 0.88 ± 0.53; Discipline score 5 months post-baseline, mean: 1.24 ± 1.20; Proportion positive reinforcement 5 months post-baseline, mean: 0.52 ± 0.28
Risk of Bias	**Domain 1: Bias arising from the randomisation process** Some concerns (unclear how randomisation was performed and whether allocation was concealed. Children in the intervention group were more likely to be Spanish-speaking than control group children, but no further differences were found between groups for age, type of care, gender, or ethnicity) **Domain 2a: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention)** Some concerns (Unclear if significant deviations between intervention groups.) **Domain 3. Bias due to missing outcome data** Some concerns (Of the 700 parents who completed the baseline interview, 81% (n = 564) provided data at termination. Comparisons of missing and non-missing cases on baseline measures showed a significant difference in foster parents' proportion positive reinforcement, t(696) = -2.95, p = .003; cases with missing data at termination were higher on this variable at baseline. There were no significant differences between the intervention group and the control group on attrition and missing data rates.) **Domain 4. Bias in measurement of the outcome** Some concerns (outcomes were self-reported from interviews with a trained interviewer. It was unclear if interviewers were aware of intervention status but a validated questionnaire was followed.) **Domain 5. Bias in selection of the reported result** Some concerns

	(many aspects of the trial protocol and methods are unclear such as: method of randomisation, allocation concealment, drop out, number who successfully completed placements, whether intent to treat analysis was used, and whether assessors of the outcomes were aware of the intervention group.) **Overall bias and Directness** High Overall Directness Indirectly applicable (USA based)

Taussig 2012

Study type	Randomised controlled trial (RCT)
Study location	USA
Study setting	Preadolescent children in foster care
Study dates	July 2002 to November 2010
Duration of follow-up	1 year follow up (18 month study period - from 3 months into a 9-month intervention)
Sources of funding	the National Institute of Mental Health, the Kempe Foundation, Pioneer Fund, Daniels Fund, Children's Hospital Research Institute, the National Institutes of Health (NIH).
Inclusion criteria	Care situation Placed in foster care by court order because of maltreatment in the preceding year; living within proximity to study site (35 minutes drive); lived with their substitute caregiver for at least 3 weeks; only children who had open cases at the start of the study time frame were included in analyses.
Exclusion criteria	Care situation When multiple members of a sibling group were eligible, 1 sibling was randomly selected to participate in the study.

	Language Monolingual Spanish speaking
Sample size	156 randomised
Split between study groups	Intervention = 79 Control = 77
Loss to follow-up	Intervention = 23 Control = 23
% Female	48.2%
Mean age (SD)	10.46 ± 0.88 year
Condition specific characteristics	Exploitation or trafficking Maltreatment type: physical abuse: 32.7%; sexual abuse: 14.5%; neglect (failure to provide): 50.0%; Neglect (lack of supervision): 75.5%; emotional maltreatment: 64.5%; Moral neglect (exposure to illegal activity): 33.6% Placement changes Placements pre-intervention: 3.18 ± 2.60 Behaviour that challenges Child Behaviour Checklist externalising score: 64.13 ± 11.27 Non-white 45.7% Care situation Nonrelative foster care: 55.5%; Relative foster care: 36.4%; Residential treatment centre: 8.2%
Outcome measures	Placement stability 1 Number of placement changes over the 18-month study period. Data were obtained from (1) baseline interviews with children and their caregivers, (2) social histories completed by caseworkers at intake, (3) legal petitions filed in the dependency and neglect court that led to foster care placement, and (4) administrative case and placement records from the statewide administrative database.

	Negative placement change whether a child had experienced a new placement in a residential treatment center (RTC) during the 18-month period. Data were obtained from (1) baseline interviews with children and their caregivers, (2) social histories completed by caseworkers at intake, (3) legal petitions filed in the dependency and neglect court that led to foster care placement, and (4) administrative case and placement records from the statewide administrative database. Permanency 1 Whether a child had attained permanency by 1-year postintervention. Case closure was used as the index of permanency. Secondary outcomes included 2 types of permanence: adoption and reunification with biological parents. Data were obtained from (1) baseline interviews with children and their caregivers, (2) social histories completed by caseworkers at intake, (3) legal petitions filed in the dependency and neglect court that led to foster care placement, and (4) administrative case and placement records from the statewide administrative database.
Study arms	**Fostering Healthy Futures (N = 56)** The 9-month FHF preventive intervention consisted of 2 components: (1) manualized skills groups and (2) one-on-one mentoring. The program was designed to be “above and beyond treatment as usual;” both children in the control and intervention groups should have received any services that would typically be provided to them through social services (eg, therapy, visitation). Although eligibility criteria required that children be in foster care at the start of the intervention, their participation continued (with appropriate consent) if they reunified or changed placements during the intervention. The intervention was mainly child focused because the skills groups were for children only, and mentoring activities involved one-on-one activities in the community. The interventionists (ie, mentors and program staff) never made recommendations to social services regarding placements or permanency goals, although mentors and program staff did report all suspected maltreatment. SKILLS GROUPS: FHF skills groups met for 30 weeks for 1.5 hours per week during the academic year and included 8 to 10 children and 2 group facilitators. The FHF skills groups followed a manualized curriculum that combined traditional cognitive-behavioral skills group activities with process-oriented material. Units addressed topics including emotion recognition, perspective taking, problem solving, anger management, cultural identity, change and loss, healthy relationships, peer pressure, abuse prevention, and future orientation. The skills group curriculum was based on materials from evidence based skills group programs, including Promoting Alternative Thinking Strategies and Second Step, which were supplemented with project-designed exercises from multicultural sources. MENTORING: The mentoring component of the FHF program provided 30 weeks of one-on-one mentoring for each child. Mentors were graduate students in social work who received course credit for their work on the project. Mentors were each paired with 2 children with whom they spent 2 to 4 hours of individual time each week. Mentors received weekly individual and group supervision and attended a weekly didactic seminar, all of which were designed to support mentors as they (1) created empowering relationships with children, serving as positive examples for future relationships; (2) advocated for appropriate services; (3) helped children generalize skills learned in group by completing weekly activities; (4) engaged

	children in a range of extracurricular, educational, social, cultural, and recreational activities; and (5) promoted attitudes to foster a positive future orientation.

Mean age (SD)	10.38 ± 0.85 year
Condition specific characteristics	Exploitation or trafficking Maltreatment type: physical abuse: 39.3%; sexual abuse: 12.5%; neglect (failure to provide): 48.2%; Neglect (lack of supervision): 78.6%; emotional maltreatment: 58.9%; Moral neglect (exposure to illegal activity): 42.9% Placement changes Placements pre-intervention: 3.20 ± 2.55 Behaviour that challenges Child Behaviour Checklist externalising problems score: 64.21 ± 11.13 Non-white 47.2% Care situation Nonrelative foster care: 53.6%; Relative foster care: 37.5%; Residential treatment centre: 8.9%
Outcome measures	Placement stability 1 TOTAL SAMPLE: Number of placement changes over the 18-month study period: 0.71%. Association between FHF intervention and placement change: OR 0.64 (95%CI 0.35 to 1.19). Adjusted for number of foster care placements before the intervention, whether a child had been placed in a RTC before the intervention, type of baseline placement, and baseline externalizing behavior problems: OR 0.68 (95%CI 0.40 to 1.16). FOSTER CARE SUBGROUP: Number of placement changes over the 18-month study period: 0.73%. Association between FHF intervention and placement change: OR 0.51 (95%CI 0.27 to 0.95). Adjusted for number of foster care placements before the intervention, whether a child had been placed in a RTC before the intervention, type of baseline placement, and baseline externalizing behavior problems: OR 0.56 (95%CI 0.34 to 0.93). Negative placement change TOTAL SAMPLE: movement to residential care over the 18-month study period: 10.7%. Association between FHF intervention and residential care: OR 0.38 (95%CI 0.13 to 1.08). Adjusted for number of foster care placements before the intervention, whether a child had been placed in a RTC before the intervention, type of baseline placement, and baseline externalizing behavior problems: OR 0.29 (95%CI 0.09 to 0.98). FOSTER CARE SUBGROUP: Number of placement changes over the 18-month study period: 10.0%. Association between FHF intervention and placement change: OR 0.23 (95%CI 0.06 to 0.96). Adjusted for number of foster care placements before the intervention, whether a child had been placed in a RTC before the intervention, type of baseline placement, and baseline externalizing behavior problems: OR 0.18 (95%CI 0.03 to 0.96). Permanency 1 TOTAL SAMPLE: attaining permanency over the 18-month study period: 57.1%. Association between FHF intervention and permanency: OR 1.67 (95%CI 0.78 to 3.54). Adjusted for number of foster care placements before the intervention, whether a child had been placed in a RTC before the intervention, type of baseline placement, and baseline externalizing behavior problems: OR 1.81 (95%CI 0.77 to 4.22). FOSTER CARE SUBGROUP: Permanency over the 18-month study period: 50.0%. Association between FHF intervention and permanency: OR 5.20 (95%CI 1.57 to 17.18).

	Adjusted for number of foster care placements before the intervention, whether a child had been placed in a RTC before the intervention, type of baseline placement, and baseline externalizing behavior problems: OR 5.14 (95%CI 1.55 to 17.07).

Care as Usual (N = 54)
both children in the control and intervention groups should have received any services that would typically be provided to them through social services (eg, therapy, visitation).

Condition specific characteristics	Exploitation or trafficking Maltreatment type: physical abuse: 32.7%; sexual abuse: 14.5%; neglect (failure to provide): 50.0%; Neglect (lack of supervision): 75.5%; emotional maltreatment: 64.5%; Moral neglect (exposure to illegal activity): 33.6% Placement changes Placements pre-intervention: 3.18 ± 2.60 Behaviour that challenges Child Behaviour Checklist score: 64.13 ± 64.13 Non-white 45.7% Care situation Nonrelative foster care: 55.5%; Relative foster care: 36.4%; Residential treatment centre: 8.2%
Outcome measures	Placement stability 1 TOTAL SAMPLE: Incidence of placement changes over the 18-month study period: 1.11%. FOSTER CARE SUBGROUP: 1.45% Negative placement change TOTAL SAMPLE: incidence of residential treatment center (RTC) during the 18-month period: 24.1%; FOSTER CARE SUBGROUP: 32.3% Permanency 1 TOTAL SAMPLE: permanency by 1-year postintervention. FOSTER CARE SUBGROUP: 16.1%

Risk of Bias	**Domain 1: Bias arising from the randomisation process** Low **Domain 2a: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention)** Low

	Domain 3. Bias due to missing outcome data Low **Domain 4. Bias in measurement of the outcome** Some concerns **Domain 5. Bias in selection of the reported result** Some concerns **Overall bias and Directness** Some concerns (There was no blinding. However, the outcomes are not particularly subjective.) **Overall Directness** Partially applicable (USA study)

Taussig 2019

Study details

Study type	Randomised controlled trial (RCT)
Study location	USA
Study setting	Preadolescent children in foster care
Study dates	July 2002 to November 2010
Duration of follow-up	1 year follow up (18 month study period - from 3 months into a 9-month intervention)
Sources of funding	the National Institute of Mental Health, the Kempe Foundation, Pioneer Fund, Daniels Fund, Children's Hospital Research Institute, the National Institutes of Health (NIH).

Inclusion criteria	Care situation Placed in foster care by court order because of maltreatment in the preceding year; living within proximity to study site (35 minutes drive); lived with their substitute caregiver for at least 3 weeks; only children who had open cases at the start of the study time frame were included in analyses.
Exclusion criteria	Care situation When multiple members of a sibling group were eligible, 1 sibling was randomly selected to participate in the study. Language Monolingual Spanish speaking
Sample size	156 randomised
Split between study groups	Intervention = 79 Control = 77
Loss to follow-up	Intervention = 23 Control = 23
% Female	48.2%
Mean age (SD)	10.46 ± 0.88 year
Condition specific characteristics	Exploitation or trafficking Maltreatment type: physical abuse: 32.7%; sexual abuse: 14.5%; neglect (failure to provide): 50.0%; Neglect (lack of supervision): 75.5%; emotional maltreatment: 64.5%; Moral neglect (exposure to illegal activity): 33.6% Placement changes Placements pre-intervention: 3.18 ± 2.60 Behaviour that challenges Child Behaviour Checklist externalising score: 64.13 ± 11.27 Non-white 45.7% Care situation Nonrelative foster care: 55.5%; Relative foster care: 36.4%; Residential treatment centre: 8.2%
Outcome measures	Placement stability 1 Number of placement changes over the 18-month study period. Data were obtained from (1) baseline interviews with children and their caregivers, (2) social histories completed by caseworkers at intake, (3) legal petitions filed in the dependency and neglect court that led to foster care placement, and (4) administrative case and placement records from the statewide administrative database. Negative placement change whether a child had experienced a new placement in a residential treatment center (RTC) during the 18-month period. Data were obtained from (1) baseline interviews with children and their caregivers, (2) social histories completed by caseworkers at intake, (3) legal petitions filed in the dependency and neglect court that led to foster care placement, and (4) administrative case and placement records from the statewide administrative database. Permanency 1 Whether a child had attained permanency by 1-year postintervention. Case closure was used as the index of permanency. Secondary outcomes included 2 types of permanence: adoption and reunification with biological parents. Data were obtained from (1) baseline interviews with children and their caregivers, (2) social histories completed by

	caseworkers at intake, (3) legal petitions filed in the dependency and neglect court that led to foster care placement, and (4) administrative case and placement records from the statewide administrative database.

Study arms

Fostering Healthy Futures (N = 56)

The 9-month FHF preventive intervention consisted of 2 components: (1) manualized skills groups and (2) one-on-one mentoring. The program was designed to be “above and beyond treatment as usual;” both children in the control and intervention groups should have received any services that would typically be provided to them through social services (eg, therapy, visitation). Although eligibility criteria required that children be in foster care at the start of the intervention, their participation continued (with appropriate consent) if they reunified or changed placements during the intervention. The intervention was mainly child focused because the skills groups were for children only, and mentoring activities involved one-on-one activities in the community. The interventionists (ie, mentors and program staff) never made recommendations to social services regarding placements or permanency goals, although mentors and program staff did report all suspected maltreatment. SKILLS GROUPS: FHF skills groups met for 30 weeks for 1.5 hours per week during the academic year and included 8 to 10 children and 2 group facilitators. The FHF skills groups followed a manualized curriculum that combined traditional cognitive-behavioral skills group activities with process-oriented material. Units addressed topics including emotion recognition, perspective taking, problem solving, anger management, cultural identity, change and loss, healthy relationships, peer pressure, abuse prevention, and future orientation. The skills group curriculum was based on materials from evidence based skills group programs, including Promoting Alternative Thinking Strategies and Second Step, which were supplemented with project-designed exercises from multicultural sources. MENTORING: The mentoring component of the FHF program provided 30 weeks of one-on-one mentoring for each child. Mentors were graduate students in social work who received course credit for their work on the project. Mentors were each paired with 2 children with whom they spent 2 to 4 hours of individual time each week. Mentors received weekly individual and group supervision and attended a weekly didactic seminar, all of which were designed to support mentors as they (1) created empowering relationships with children, serving as positive examples for future relationships; (2) advocated for appropriate services; (3) helped children generalize skills learned in group by completing weekly activities; (4) engaged children in a range of extracurricular, educational, social, cultural, and recreational activities; and (5) promoted attitudes to foster a positive future orientation.

Mean age (SD)	10.38 ± 0.85 year
Condition specific characteristics	Exploitation or trafficking Maltreatment type: physical abuse: 39.3%; sexual abuse: 12.5%; neglect (failure to provide): 48.2%; Neglect (lack of supervision): 78.6%; emotional maltreatment: 58.9%; Moral neglect (exposure to illegal activity): 42.9% Placement changes Placements pre-intervention: 3.20 ± 2.55 Behaviour that challenges Child Behaviour Checklist externalising problems score: 64.21 ± 11.13 Non-white 47.2% Care situation Nonrelative foster care: 53.6%; Relative foster care: 37.5%; Residential treatment centre: 8.9%

Outcome measures	Placement stability 1 TOTAL SAMPLE: Number of placement changes over the 18-month study period: 0.71%. Association between FHF intervention and placement change: OR 0.64 (95%CI 0.35 to 1.19). Adjusted for number of foster care placements before the intervention, whether a child had been placed in a RTC before the intervention, type of baseline placement, and baseline externalizing behavior problems: OR 0.68 (95%CI 0.40 to 1.16). FOSTER CARE SUBGROUP: Number of placement changes over the 18-month study period: 0.73%. Association between FHF intervention and placement change: OR 0.51 (95%CI 0.27 to 0.95). Adjusted for number of foster care placements before the intervention, whether a child had been placed in a RTC before the intervention, type of baseline placement, and baseline externalizing behavior problems: OR 0.56 (95%CI 0.34 to 0.93). Negative placement change TOTAL SAMPLE: movement to residential care over the 18-month study period: 10.7%. Association between FHF intervention and residential care: OR 0.38 (95%CI 0.13 to 1.08). Adjusted for number of foster care placements before the intervention, whether a child had been placed in a RTC before the intervention, type of baseline placement, and baseline externalizing behavior problems: OR 0.29 (95%CI 0.09 to 0.98). FOSTER CARE SUBGROUP: Number of placement changes over the 18-month study period: 10.0%. Association between FHF intervention and placement change: OR 0.23 (95%CI 0.06 to 0.96). Adjusted for number of foster care placements before the intervention, whether a child had been placed in a RTC before the intervention, type of baseline placement, and baseline externalizing behavior problems: OR 0.18 (95%CI 0.03 to 0.96). Permanency 1 TOTAL SAMPLE: attaining permanency over the 18-month study period: 57.1%. Association between FHF intervention and placement change: OR 1.67 (95%CI 0.78 to 3.54). Adjusted for number of foster care placements before the intervention, whether a child had been placed in a RTC before the intervention, type of baseline placement, and baseline externalizing behavior problems: OR 1.81 (95%CI 0.77 to 4.22). FOSTER CARE SUBGROUP: Permanency over the 18-month study period: 50.0%. Association between FHF intervention and permanency: OR 5.20 (95%CI 1.57 to 17.18). Adjusted for number of foster care placements before the intervention, whether a child had been placed in a RTC before the intervention, type of baseline placement, and baseline externalizing behavior problems: OR 5.14 (95%CI 1.55 to 17.07).

Care as Usual (N = 54)

both children in the control and intervention groups should have received any services that would typically be provided to them through social services (eg, therapy, visitation).

Condition specific characteristics	Exploitation or trafficking Maltreatment type: physical abuse: 32.7%; sexual abuse: 14.5%; neglect (failure to provide): 50.0%; Neglect (lack of supervision): 75.5%; emotional maltreatment: 64.5%; Moral neglect (exposure to illegal activity): 33.6% Placement changes Placements pre-intervention: 3.18 ± 2.60 Behaviour that challenges Child Behaviour Checklist score: 64.13 ± 64.13 Non-white 45.7% Care situation Nonrelative foster care: 55.5%; Relative foster care: 36.4%; Residential treatment centre: 8.2%
Outcome measures	Placement stability 1 TOTAL SAMPLE: Incidence of placement changes over the 18-month study period: 1.11%. FOSTER CARE SUBGROUP: 1.45% Negative placement change TOTAL SAMPLE: incidence of residential treatment center (RTC) during the 18-month period: 24.1%; FOSTER CARE SUBGROUP: 32.3% Permanency 1 TOTAL SAMPLE: permanency by 1-year postintervention. FOSTER CARE SUBGROUP: 16.1%

Risk of Bias

Section	Question	Answer
Domain 1: Bias arising from the randomisation process	Risk of bias judgement for the randomisation process	Low
Domain 2a: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention)	Risk of bias for deviations from the intended interventions (effect of assignment to intervention)	Low
Domain 3. Bias due to missing outcome data	Risk-of-bias judgement for missing outcome data	Low
Domain 4. Bias in measurement of the outcome	Risk-of-bias judgement for measurement of the outcome	Some concerns
Domain 5. Bias in selection of the reported result	Risk-of-bias judgement for selection of the reported result	Low
Overall bias and Directness	Risk of bias judgement	Some concerns *(There was no blinding. However, the outcomes are not particularly subjective.)*
	Overall Directness	Partially applicable *(USA study)*

Van Holen 2017

Study type	Randomised controlled trial (RCT)
Study location	Belgium
Study setting	Children in new foster care placements with behavioural problems
Study dates	January 2011 to May 2013
Duration of follow-up	post intervention and 3 months follow up
Sources of funding	Vrije Universiteit Brussel

Inclusion criteria	Age 3 - 12 years Care situation Foster parents of new foster care placements with a long-term perspective (>1 year) Behavioural needs Foster parents were eligible if their foster child had a borderline or clinical score on the externalizing broad-band or on one of the externalizing small-band scales of the Child Behaviour Checklist
Exclusion criteria	Care situation Foster placements where at least two of the following criteria were present: 1) foster parents considered terminating the foster placement during the past two months 2) were experiencing psychological distress (measured with the General Health Questionnaire (GHQ; Koeter & Ormel, 1991) and defined as a score ≥ 2) 3) their foster child had a sum score above 3 (for children < 6 years) or 5 (for children ≥ 6 years) on the critical CBCL-items. Caregiver characteristics Foster parents: with a mental/psychological disorder; who were involved in divorce proceedings; who have low cognitive ability; who are already receiving professional support for the foster child's externalizing problems Language Caregiver with insufficient knowledge of Dutch Clinical/health problem uses psychotropic medication in an inconsistent way; behavioral problems are the result of medical problems or medication, Special educational needs learning disability; autism
Sample size	63 participants
Split between study groups	Social learning theory-based training: 30 Care as Usual: 33
Loss to follow-up	Social learning theory-based training: 3 Care as Usual: 0
% Female	52.4%

Mean age (SD)	6.14 ± 2.60 years
Condition specific characteristics	Placement changes Most (77.8%) of the foster children were previously placed in out-of-home care. The current foster placement had a mean duration of 36.20 months (sd=34.79). Care situation non-kinship placements: 55.6%
Outcome measures	Behavioural outcome 1 Foster children's behavioural problems were measured with the Child Behaviour Checklist (CBCL/1.5-5-CBCL/6-18; Achenbach & Rescorla 2000, 2001). For 99 (for children younger than 6 years) and for 118 (for children over 6 years) concrete behavioural, emotional and social problems, foster mothers were asked to indicate how often these behaviours occurred (0=not true, 1=somewhat or sometimes true, 2=very true or often true). The instrument provides scores for some problem scales and three broad-band scales: internalizing, externalizing and total problems. Authors used the internalizing and externalizing scores as (general) indexes for internalizing (e.g. withdrawn, anxious, inhibited and depressed behaviours) and externalizing problem behaviour (e.g. rule breaking and aggressive behaviours). The authors of the CBCL suggest using a T-score ≥ 60 to discriminate between children with and without externalizing and/or internalizing problems (i.e. the cut-off score for borderline clinical range). Placement stability 1 Temporary (e.g. short stay at child psychiatric unit) or permanent (move to other care) breakdown over follow up from baseline to follow up (approximately 6.5 months) Relational outcome 1 Parenting stress (ijmegen Questionnaire for the Parenting Situation) at postintervention/3 month follow up: Foster mothers' parenting stress was measured using the Nijmegen Questionnaire for the Parenting Situation (NQPS; Robbroeckx & Wels 1996). Four subscales from the first part of this questionnaire (not feeling able to cope, experiencing problems in parenting the child, experiencing the child as a burden and wanting the parenting situation to be different) were used. The authors considered them as the core of parenting stress (28 items). The sum score of these four subscales is the measure of parenting stress (α0=0.95, α1=0.95, α2=0.96).
Study arms	**Social learning theory-based training (N = 30)** A detailed training manual including 10, usually weekly, home sessions was developed, describing the treatment's rationale, providing guidelines to therapists and outlining the sequence and contents of the sessions. The social interaction perspective on the development of behavioural problems and associated parenting skills (positive involvement, positive reinforcement, problem solving, effective limit setting and monitoring) was at the core of the programme. Based on a literature study on the specific needs of foster children, psychoeducation about attachment was included. The intervention has a modular design. An overview of the modules can be found in Fig. 2. Some modules are mandatory; others are optional and are only used when indicated. Guidelines about the use of these modules are included in the treatment protocol. The intervention takes a positive approach from the outset: enhancing the quality of the foster parent–foster child relationship and creating a positive atmosphere. The 'positive involvement' module involves psychoeducation about foster children's need for warmth and acceptance from their foster parents. Emotional communication skills (e.g. active listening, using I-messages) are discussed and practised. As homework assignment, foster parents are asked to introduce a daily 10-

	min play activity. The 'praising' module focuses on encouraging positive behaviour in the foster child (e.g. by giving verbal, non-verbal and indirect praise). The next two modules deal with creating predictability. The 'structure' module includes psychoeducation about how a good structure (e.g. introducing family routines) and clear expectations (e.g. formulating household rules) give foster children a sense of security. The 'effective commands' module deals with communicating expectations in an effective way (e.g. short, direct commands). To treat some specific behaviour, more actions may be needed. In the 'reward programme' module, tangible rewards are given for positive behaviours that have not increased sufficiently. This provides consistent positive reinforcement to increase these behaviours. Only after this positive approach, intervention practitioners address how to deal with misbehaviour. The 'effective limit setting' module provides psychoeducation about the basic principles of limit setting. Depending on the specific problem behaviours, a more elaborate discussion about effective limit setting can be conducted by offering one or more of the following optional modules. Each of these modules focuses on specific parenting behaviour to reduce specific remaining problem behaviours. The 'ignoring' module is proposed when foster parents often react (and thus give a lot of attention) to behaviours that are better ignored (i.e. frequently occurring mild misbehaviour such as whining). For misbehaviours that cannot be ignored (e.g. aggressive or destructive behaviour), foster parents are instructed to react consistently with a specific negative consequence ('logical consequence/loss of privilege' module). The 'time out' module is used to avoid escalation by the foster child and foster parents (i.e. putting the child in time out for specific aggressive or destructive behaviour before the situation escalates). The remaining modules can be offered once the 'reward programme' module has been offered. The 'avoiding problems' module mainly deals with increasing the predictability of difficult situations (e.g. play dates, visits to the supermarket). Foster parents learn to plan these situations in advance and communicate clearly which behaviour is expected, and the consequences for positive behaviour and misbehaviour. The 'problem solving' module provides psychoeducation about a constructive, stepwise problem solving process (defining the problem, brainstorming solutions, making a plan, executing the plan and evaluation) and teaches the foster parent how they can help their foster child to solve problems. The 'autonomy and monitoring' module provides psychoeducation about the importance of this parenting skill and offers tools to monitor young children's behaviour (e.g. asking concrete questions, checking if the child does what she/he is expected to do). Because a lack of autonomy may also occur, foster parents are helped to find a good balance in providing safety/control and stimulating autonomy (e.g. giving more responsibilities, asking the foster child's opinion). It may, furthermore, be necessary to enhance foster parents' reflective function. Two modules can be used for this purpose. The 'avoiding escalations' module provides psychoeducation about coercive processes. The therapist explores what makes it difficult for foster parents to avoid escalations (e.g. specific emotions, expectations) and what can help them to prevent escalations (e.g. relaxation). In the 'evaluating own parenting behaviour' module, foster parents are encouraged to critically reflect on their own parenting values and behaviours (e.g. influence of own parenting history on their values) in order to

	decrease resistance or help them maintain a certain approach. The final module 'a look at the future' offers foster parents a plan for dealing with future behavioural problems and tips for maintaining positive changes. % Female: Not reported Mean age (SD): Not reported Outcome measures: **Behavioural outcome 1** Internalising problems postintervention/3 months follow up (Child Behaviour Checklist): 58.26 ± 10.47/56.73 ± 12.30; Externalising problems postintervention/3 months follow up (Child Behaviour Checklist): 64.51 ± 7.50/63.01 ± 8.96 **Placement stability 1** 1 families in the intervention group experienced temporary breakdown of placement over follow up, and 1 family experience permanent breakdown of placement placement (**Relational outcome 1** Parenting stress (ijmegen Questionnaire for the Parenting Situation) at postintervention/3 month follow up: 67.40 ± 19.60/69.82 ± 20.36
	Care as usual (N = 33) The control group received treatment as usual. A regular foster care worker in Flanders monitors on average 25 foster care placements. He/she is very autonomous both in terms of the frequency of contact and the content of care offered. On average, a foster care worker has 11.5 face-to-face contacts a year per foster care placement, either with the foster parents, the foster child or the biological family. In addition, foster parents have access to external mental health services. There are large differences in the frequency and in the proportion of foster families that decide to accept such help. By registering foster care workers' activities during the intervention period, Authors found the number of personal contacts between a foster care worker and at least one member of the foster family varied from 0 to 8 (M=2.51, sd=1.79) and that 39.6% of the foster children received additional mental health services. % Female: Not reported Mean age (SD): Not reported

	Outcome measures Behavioural outcome 1 Internalising problems postintervention/3 months follow up (Child Behaviour Checklist): 61.36 ± 9.92/63.35 ± 9.11; Externalising problems postintervention/3 months follow up (Child Behaviour Checklist): 65.94 ± 8.77/68.33 ± 7.46 Placement stability 1 Over follow up, four temporary breakdowns in placement occurred in the control group Relational outcome 1 Parenting stress (ijmegen Questionnaire for the Parenting Situation) at postintervention/3 month follow up: 68.88 ± 16.06/74.61 ± 17.95
Risk of Bias	**Domain 1: Bias arising from the randomisation process** Some concerns **Domain 2a: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention)** Low **Domain 3. Bias due to missing outcome data** Low **Domain 4. Bias in measurement of the outcome** High **Domain 5. Bias in selection of the reported result** Low **Overall bias and Directness** High (No baseline characteristics of both arms to assess the success of randomisation. No blinding. Outcomes were measured by foster parents. This could lead to bias particularly since they were likely aware of the interventions.) **Overall Directness** Partially applicable

	(Study took place in Belgium)

Van Holen 2018

Bibliographic Reference	Van Holen, Frank; Vanderfaeillie, Johan; Omer, Haim; Vanschoonlandt, Femke; Training in nonviolent resistance for foster parents: A randomized controlled trial.; Research on Social Work Practice; 2018; vol. 28 (no. 8); 931-942

Study details

Study type	Randomised controlled trial (RCT)
Study location	Belgium
Study setting	three of the five Flemish provinces (Dutch speaking part of Belgium) - Foster Care
Study dates	July 2010 to September 2012
Duration of follow-up	post intervention and three months follow up
Sources of funding	The authors received no financial support for the research, authorship, and/or publication of this article
Inclusion criteria	Age children aged between 6 and 18 Care situation all new foster-care placements with a long-term perspective (>1 year) emotional or behavioural disorders Foster parents were eligible if their foster child had a borderline or clinical score on the externalizing broad band or on one of the externalizing small-band scales of the CBCL. In families with more than one eligible foster child, the foster child with more serious behavioural problems was considered in the study.
Exclusion criteria	Caregivers Foster parents who were currently involved in divorce proceedings or foster parents with a current mental health disorder, measured with the General Health Questionnaire (Koeter

	& Ormel, 1991) and defined as a score >= 2, were excluded. health problems intellectual disability, autism, unstable use of psychotropic medication (psychotropic medication use must have started at least 2 months before the start of the intervention and must be stable for at least 2 weeks before start of the intervention), and behavioral problems stemming from medical problems (e.g., Prader–Willi syndrome) or medication (e.g., anticonvulsive drugs)
Sample size	62 foster families randomised
Split between study groups	Intervention group = 31 families Control group = 31 families
Loss to follow-up	All were analysed
% Female	Gender of the foster child Intervention group = 51.6% Control group = 45.2%
Mean age (SD)	Age of the foster child in years 11.6 ± 3.46 years 12.3 ± 3.49 years
Condition specific characteristics	Type of care Foster care 100%
Outcome measures	Behavioural outcome 1 CBCL/6-18 (Achenbach & Rescorla, 2001). This questionnaire assesses child behaviour problems. For 118 concrete behavioural, emotional, and social problems, foster mothers were asked to indicate how often they had occurred on a 3-point scale. The results of the questionnaire form a total problem score, an internalizing and externalizing score, and eight problem scale scores. Authors used the internalizing, externalizing, and total problem scores as (general) indices for internalizing, externalizing, and overall behavioural problems. Behavioural outcome 2

	Nijmegen Parenting Situation Scale (Nijmeegse Vragenlijst voor de Opvoedingssituatie—NVOS; Wels & Robbroeckx, 1996). This questionnaire measures parenting stress. Foster mothers indicate on a 5-point scale how closely concrete statements relate to them. Four scales from the first part of the questionnaire were used in this study. These scales are viewed as the core components of parenting stress by the authors of the NVOS: Coping ability refers to the feeling of being able to cope with the parenting situation. For example, ‘‘Raising . . . requires a lot of my strength.’’; Problem severity refers to the severity of the problems as experienced by foster mothers. For example, ‘‘I'm glad when . . . is out for some time (e.g., at school, with friends, playing outside).’’ Viewing parenting as a burden refers to the extent to which parenting this specific child is experienced as a burden. For example, ‘‘Raising . . . is a real burden for me.’’ Wishing for changes in the parenting situation refers to the extent to which foster mothers desire the parenting situation to change. For example, ‘‘Things should go really differently between me and . . . . ’’

Study arms

Non-Violent Resistance (N = 31)

The intervention was an adaptation for foster families of the NVR treatment program for parents of violent and self-destructive children. NVR places escalation processes at the center of attention. The underlying assumption is that parental submission and power struggles are mutually enhancing and that they feed on and are fed by negative feelings. Foster parents, who previously felt helpless and were caught up in escalation with the foster child, are trained to effectively resist the foster child's negative behaviour without lashing out or giving in. To achieve this, NVR focuses on the following four intervention areas. 1) Prevention of escalation. Emotional regulation of foster parents is trained in order to prevent and halt escalating cycles. Foster parents learn to recognize escalatory patterns and identify their own and their foster child's typical reactions and the associated thoughts and feelings. Alternative ways of responding in non-escalating manners are taught and rehearsed. For example, foster parents learn to delay their response (‘‘Strike the iron when it's cold!’’) and to abstain from controlling and domineering messages (‘‘You don't have to win, only to persist!’’). 2) Resisting problem behaviour. The foster parents aim at resisting rather than controlling the child's negative behaviours. Depending on the risks and the foster child's specific problems, Omer (2004, 2011) developed well-documented techniques to help foster parents to resist problem behaviour in a respectful and nonviolent way: 3) Delivery of a formal announcement in which the foster parents declare their decision to resist the child's negative behaviours. This announcement is delivered in writing and read aloud by the foster parents. In accordance with the treatment's emphasis on parental self-control, it is written in the first person plural (‘‘We will no longer accept . . . ’’) and not in the second person singular (‘‘You will have to . . . ’’). The announcement also stipulates that the foster parents will not keep the problems secret but will seek help from supporters. Foster parents rehearse how to deliver the announcement and how to develop non-escalating responses to the foster child's reactions. 4) Performance of ‘‘sit-ins’’. The foster parents enter the child's room at a quiet time, sit down, and announce that they will sit and wait for a proposal by the child to stop the problem behaviour that triggered the sit-in: ‘‘We are here because we are no longer willing to accept the kind of behaviour you displayed. We will sit here and wait for a proposal as to how this behaviour might end.’’ The foster parents are trained to remain quiet and strictly avoid arguments or escalation. The therapist helps them to develop ways of coping with typical reactions, such as attempts to expel them, ignore them, or deride them, and instructs them as to how to end the sit-in and resume daily life. The sit-in serves as a manifestation of resistance that does not depend on the child's compliance for success and that can be performed without escalating into negative cycles of aggression. 5) Documentation of negative behaviours. The foster child's unacceptable acts are documented by the foster parents, shown to the foster child, and distributed to the supporters. Foster parents tell their foster child that they are no longer keeping the events secret and that they will send their report to whomever they feel is appropriate. Supporters are specifically asked to address the foster child in a positive way, to make clear that they know what happened, and to offer help in finding solutions for stopping those behaviours. 6) Increasing supervision by telephone rounds or parental visitation. In the telephone rounds, foster parents react to the foster child's failing to come home in time. Foster parents call a previously prepared list of friends, acquaintances, and relevant contacts, telling

them that their foster child has not come home, asking for help, and requesting them to tell the foster child that they are looking for him or her. Foster parents are rigorously instructed as to how to prevent escalation, once the foster child returns home. In the parental visitation, foster parents actually go to the place where the foster child spends his or her time without parental permission. They are instructed in detail on how to behave so as to prevent escalation. 7) Creating a network of support. Foster parents are encouraged to activate potential sources of support in their social network such as family, friends, acquaintances, and professionals (e.g., school staff). Involving other people in what is happening at home and seeking their help is a major factor in coping with the child's negative behaviour. Whenever possible, a meeting with the supporters is organized by the therapist to explain the purpose and principles of the treatment and to discuss how and when the supporters can help. When a supporters' meeting is not feasible, supporters are recruited on an individual base. Some typical roles of supporters are: to back the foster parents' acts of resistance, to offer emotional and/or practical help for foster parents and/or the foster child, to help in breaking the seal of secrecy that often surrounds negative behaviours, to mediate in situations of polarization, to help defuse situations of acute escalation, and to offer help in finding acceptable solutions. 8) Relational gestures. Foster parents are encouraged to initiate positive interactions by systematic relational gestures such as signs of appreciation, suggestions of shared activities, and symbolic gifts. Frequently used is the album or box of positive memories, which documents good times, and positive opinions about the child such as short stories, a ticket from a nice vacation, photos, and reminders of events such as a family trip, parties, and so on. Foster parents invite friends and members of the birth family to participate. These gestures are unilateral initiatives by the foster parents. They are independent of the foster child's behaviour and are aimed at promoting positive aspects of the parent–child relationship. They are acts of caring that show the foster parents' love independently of their ongoing resistance to the foster child's negative behaviours. The foster parent intervention consisted of 10, usually weekly, home sessions of 75 min and 1 telephone support session between every 2 home sessions. A detailed training manual was developed, describing the treatment's rationale, providing guidelines for each intervention area, and outlining the sequence and contents of the treatment sessions. The training manual, including training materials, can be obtained from the first author. The main modifications of the original program include (1) use of a home-visit format in order to lower barriers to service access; (2) development of practical aids, such as hand-outs, worksheets, a workbook for foster parents, and a DVD illustrating NVR techniques; (3) development of special components for foster families and foster children (e.g., guidelines describing when and how to involve members of the biological family in the support network, for instance to engage them in relational gestures); and (4) treatment administration by experienced foster-care workers who are best acquainted with the needs of foster families. Treatment in the experimental group was administered by three experienced foster-care workers who received special training in NVR consisting of 12 4-hr sessions. As part of the training, each therapist treated three foster families under close supervision. Treatment integrity and quality was ensured by fortnightly group supervision sessions.

Condition specific characteristics	Number of care placements Previous placements = 64.5% time in care Duration in care placement = 46.7 ± 53.54 months Type of care

	Foster care 100% Kinship = 54.8% non-kinship = 45.2% Type of household Single parent = 25.8% Two parent = 74.2% Number of children Biological = 1.74 ± 1.46 Foster = 1.55 ± 0.68

Treatment as Usual (N = 31)

The control group was given TAU. In Flanders, foster-care workers organize support for the foster child, optimize contacts with birth parents and family, and coach and train foster parents. More specifically, the support for foster-care situations comprises of at least seven face-to-face contacts a year. However, it is not defined with whom these contacts should take place. They can be with foster parents, foster children, birth parents, the wider context of the foster child (e.g., grandparents), and combinations of the parties involved (e.g., foster parents and foster child together). Furthermore, certain aspects of good practice (e.g., the use of care plans) are obligatory. Although foster-care workers have great autonomy within these guidelines, a caseload of 25 foster-care placements for a full-time foster-care worker hinders them from providing intensive support to foster parents. Herewith, nothing is said about the content of these contacts nor about the practices used by the foster-care worker. In addition to the regular foster-care support described above, foster parents have access to external mental health-care services for themselves or for their foster child. In short, the help offered during a foster-care placement is very diverse and heterogeneous and the support for foster families varies enormously. As a consequence, it is not unthinkable that the TAU received by foster families in a control group differs considerably between participants. To control this factor, authors asked foster-care workers to register not only their own contacts with the foster family but also referrals to external mental health services.

Condition specific characteristics	Number of care placements Previous placements = 71.0%

	time in care Duration of placement = 35.1 ± 39.91 months Type of care Foster care 100% Kinship = 64.5% Non-kinship = 35.5% Number of biological children = 1.61 ± 1.26 Number of foster children = 1.42 ± 0.62 Single parent household = 22.6% Two parent household = 77.4%

Risk of Bias

Section	**Question**	**Answer**
Domain 1: Bias arising from the randomisation process	Risk of bias judgement for the randomisation process	Low
Domain 2a: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention)	Risk of bias for deviations from the intended interventions (effect of assignment to intervention)	Low
Domain 3. Bias due to missing outcome data	Risk-of-bias judgement for missing outcome data	Low
Domain 4. Bias in measurement of the outcome	Risk-of-bias judgement for measurement of the outcome	Some concerns
Domain 5. Bias in selection of the reported result	Risk-of-bias judgement for selection of the reported result	Low
Overall bias and Directness	Risk of bias judgement	Low
	Overall Directness	Indirectly applicable *(Study was from belgium)*

Qualitative studies

Akin 2014

Study Characteristics

Study type	Semi-structured interviews
Aim of study	To understand, observe, and document practitioner perceptions of implementation of an evidence-based interventio (Parent Management Training Oregon)
Study location	USA
Study setting	This study was part of a larger project known as the Kansas Intensive Permanency Project (KIPP). KIPPwas one of six cooperative agreements in the federal Permanency Innovations Initiative (PII), which sought to reduce long-term foster care and improve permanency outcomes. Project partners defined the target population as families of children in foster care with serious emotional and behavioral problems.
Study methods	One research team member conducted all of the interviews by phone, which lasted 45 to 60 min. A semi-structured interview guide was written to administer to practitioners. Six key topics were covered: 1) practitioner background, 2) EBI training, 3) EBI coaching, 4) EBI practice with families, 5) families response to the EBI, and 6) administrative and organizational supports. All semi-structured interviews were conducted by phone, digitally recorded with the participants' permission, professionally transcribed, checked for accuracy by the interviewer, and imported into NVivo 10 for data management and analysis. Theoretical thematic analysis was used to analyze the data using multiple analysts. To further check the validity summary report was provided to study participants and they were encouraged to provide feedback. Study participants' written feedback was integrated into the final analysis of the data.
Population	Practitioners involved with delivering KIPP services - the Kansas Intensive Permanency Project (KIPP)

Study dates	Not reported
Sources of funding	Children's Bureau, Administration on Children, Youth and Families, Administration for Children and Families, U.S. Department of Health and Human Services
Inclusion Criteria	Delivering an intervention Practitioners delivering Parent Management Training Oregon
Exclusion criteria	None reported
Sample characteristics	Sample size 30 practitioners involved with delivering PMTO to parents of children who had been taken into foster care Mean age (SD) 39.5 ± 9.7 non-white ethnicity 10.7% Gender Female - 89.3% Career Social work was the primary type of education (54%), followed by marriage and family therapy (25%) and counseling (21%). Nearly half of the practitioners (46%) had three to nine years of experience working in the child welfare system and well over one third (39%) had more than ten years of experience in child welfare. One in four (25%) had some prior experience with an EBI.
Relevant themes	Theme 1 Training was appreciated - All participants praised the quality of the PMTO training, considering it educational, thorough, holistic, active, engaging, and “top notch.” Having adequate time for training sessions and a focus on learningwere also mentioned as key supports. Participants viewed trainers as experienced, engaging, and supportive; “they had great suggestions.” Likewise, they identified the benefits of the peer support they received from other trainees and networking with practitioners outside their own agency. A participant shared an important trait of the training: "I am a real experiential learner…[D]oing the workshops while we are working with clients and getting the group feedback, that was very instrumental…" Theme 2 Shortcomings of training - lack of clarity, vague answers, disorganization, long training, days, length of the training process, and repetitive content. Many participants felt frustrated and confused by unclear instructions. participants said that the training was missing content on working with families of adolescents. In addition, a few participants stated that relevant child welfare topics were not fully addressed by the training, including trauma, parental substance abuse, and parent mental illness. These practitioners referred to initial challenges in modifying PMTO to fit the needs of the child welfare population. Indeed, a number of participants reported that trainers did not seem to understand Kansas child welfare reality as evidenced by their vague answers to participants' questions. Imprecise and inexplicit responses generated frustration and dissatisfaction among participants. "…I don't think they really understand kind of what we were doing here in Kansas and things like that…to answer some of our questions they had to give very vague answers."

	Theme 3 Suggested improvements to training - While there was adequate time for training, a time gap between training and work with families was drawn out too long. Participants needed opportunity to practice their newly learned skills shortly after the training workshops. Three common suggestions for training were to: (1) add more mock videos and role-plays for illustrating sessions; (2) make a trainer available locally for several months instead of a week-long intensive training days followed by a two-month gap; and (3) establish a clear practice model structure, including topic-by-topic session agendas. Theme 4 Coaching was helpful - Most participants reported that coaching was a helpful, positive, encouraging, and “very gentle” experience, as they received feedback fromcoaches and peers. They noted the utility ofwatching other people in role-plays prior to implementing their first session. PMTO coaches were knowledgeable, kind, and focused on strengths. At first, participants felt anxious, nervous, or awkward; however, most of them enjoyed coaching after a few times. Feedback made participants feel more self-assured as therapists, helped them understand where improvementswere needed, and expanded their understanding of families. A participant summarizes their coaching experience in the following quote: "…[I]t's difficult towatch yourself and to see yourself because you do it in a group…Once we did it a few times, it was wonderful. It's very encouraging, strengths-based…for the therapist… So even though it's nerve-wracking…at the end of it you really feel supported and so that's a good thing." Theme 5 Direct feedback appreciated - As the quote reflects, PMTO coaching builds on the practitioner's strengths and slips in a little piece to improve; the emphasis on strengths is particularly good for minimizing defensiveness. Yet, a great number of participants wanted more direct feedback; a few of them had to adjust and learn to “read between the lines.” Many participants felt dissatisfied and disappointed with slow responses, vague answers, and redundant coaching. "I liked the way that they did our coaching. Itwas very strengths-based… They really support, support, support…and teach through that [support]. Sometimes I felt it could have been a little more direct. I think that's been the difficult part with my staff, is that sometimes they just wanted a littlemore of a direct answer instead of trying to read between the lines. Theme 6 Quantity of coaching sufficient - The majority of participants reported that they had an adequate amount of coaching, while a few mentioned that they “craved” for more coaching because they enjoyed it so much. Others recommended increasing coaching at the beginning of the training and for particularly complex cases, such as those involving parental substance abuse or domestic violence. One specific recommendation was to offer practitioners an option to select sessions for coaching when they have pressing questions orwould like individualized support for distinct concerns. Theme 7 Differences between different forms of coaching - A great number of participants considered that the different forms of coaching they receivedwere good, including online coaching (i.e., video conference) and ongoing coaching from supervisors. Others suggested implementing more timely and consistentwritten feedback. In addition, many participants said that the quality of the coaching depended on the coach. As participants gradually began to be coached by local supervisors, they noticed a difference in the quality of coaching. This respondent explains: "The actual ISII people, it was great. I think that it was really informative and really helped us see how they were wanting us to implement the model. It hasn't been so helpful when we do it with our supervisor, just because I think she's still learning it, and hadn't really had as many sessions as most of us did. So I just feel like it wasn't quite as helpful because she just didn't have the base of knowledge yet to go from what the trainers did." Theme 8 training a welcome opportunity - The majority of participants had limited prior knowledge about EBIs and most of themhad no previous experience implementing them. Less than third of the respondents had exposure to other evidence-based or evidence-informed programs and no participant had experienced a program as intensive as PMTO. As the following quote illustrates, a number of participants considered EBIs as beneficial, accurate, important, and the future direction of behavioral healthcare; therefore, KIPP was a welcome opportunity. "It's not just someone's idea…and, because of this evidence that we have here, we know that, you know, it works across cultures in many different situations." Theme 9 Facilitators to learning PMTO - Several factors enhanced participants' learning of PMTO. For instance, some participants were highly committed to learning, selfreflection, and a desire to make improvements to one's own practice. Additionally, their comments reflected open-mindedness and enthusiasm about EBIs, in general, and PMTO, specifically. Theme 10

	Overcoming initial skepticism - A third of the participants described a transformational process in their views of PMTO. They were initially resistant to EBIs (e.g., viewing them as rigid and difficult to implement) and skeptical about PMTO strategies, feeling unsure and uncomfortable about applying an EBI and the pressure to prove that it worked. A participant stated: “…[Y] ou can sit and listen to individuals talk about it, but you kind of reserve a little judgment…It sounds great, but is it going to work if I go and implement it?” However, their skeptical views changed. Theywere surprised by PMTO's effectiveness and the improvement they observed in families. All but one participant highlighted their compatibility with the program and their strong support for it. Participants felt that PMTO was a good fit for them because of its congruence with their own practice philosophy (e.g., strengths-based and solution-focused). They “embraced the approach.” "I believe I was set up for success with putting this into practice through the trainings that we received and the way the trainingswere delivered. Of course, there was some anxiety, like normal, put something new into practice that you're not a hundred percent trained in yet. But I definitely feel even my first session with my first family I was more prepared andhad direction and structure than I had in my past." Theme 11 Benefits to therapeutic practice - All participants reported that PMTO benefited their therapeutic practice. Most of them noticed that after PMTO training, they were more hopeful and strengths-oriented, even becoming aware of their own strengths. Specific improvements involved being: a better listener, less confrontational, more insightful and “in the moment,” more active and “hands-on,” more agenda-driven in sessions, and more conscious of time restrictions. Other participants asserted that they had better relationships with clients, understood that silence can be useful, improved their teaching skills, and learned to problem-solve with parents, not for parents.Many respondents felt satisfied with the results as they applied PMTO in their practice. The following quotesummarizes a participant's experience: "I'm more agenda-driven, which is extremely effective and helpful. I feel like I was always strength-based but I'm even more strength-based now…I do more encouragement and more praise so that has been extremely helpful. I'm more planful in my sessions. I come to a session ready with activities, ready to go." Theme 12 Challenges to previous clinical practice - A few participants had no previous clinical experience, whereas a couple of participants mentioned that they initially had to navigate their education and clinical experience with PMTO. They noted that PMTO training poses challenges to experienced therapists, as it emphasizes self-reflection and continual professional growth. This training process, however, changed these participants' practice style and revealed areas for growth. Theme 13 Applying the PMTO model - For many participants, the PMTO manual and coaching aided their skillful use of the intervention. Gaining experience in using PMTO with families also contributed to practitioners' comfort with the model. A couple of practitioners struggled with using role-plays and some families disliked them, whereas a majority reported that roleplays were readily applied in the practice setting. Giving directions, active listening, and limit settingwere among themost straightforward and uncomplicated topics to implement. As the following quote shows, most participants considered that the model's strengths focus fostered trust and rapport building. "I think that's the best way to build a therapeutic alliance with people. And so the positive focus in KIPPmade it really possible to develop great relationships with the families that I worked with." Theme 14 Customisability to tailor to need - Most participants reported that they could customize PMTO to match each family's needs, staying true to the model (as illustrated in the quote below). A minority of respondents initially considered the model rigid and difficult to adapt and noted that coaching facilitated this adaptation. For others, the model was applicable to most families whereas for a couple of participants, the flexibility of the model depended on the therapist. "Well, you're just able to customize it for each family, without straying from the model. I mean, I don't know, the way you're able to work with the families, you're able to take their specific situation and specific things that their kids are doing and going through…" Theme 15 Response by targetted families and facilitators to effectiveness - According to participants, most families responded positively to PMTO. PMTO's powerful effect was evident in the rapid improvement that families experienced, even if it was small. Even though some families felt skeptical at first, their confidence increased as they used the skills and advocated for themselves. A couple of participants noted that families recommended PMTO to everyone, even teaching PMTO skills to friends, and that teenagers reported better communication with their parents. Family response was more positive when practitioners got further into the PMTO curriculum. For instance, a respondent stated that the mid-week phone calls improved family response. "…I've even had some families who really, kind of, were dragging their feet, I mean, like, with the role-plays and stuff; but, as it went on, they were able to see that it has worked pretty well within their family, so they've been able to follow through with it." A participant explains how beneficial strengths and encouragement were: "The five-to-one ratio, fives positives to one negative…that's a huge cultural shift for us…[P]arents are seeing, you know, they're having a lot less stress when they are not focusing on all the negative stuff. They can focus on some positive things, tell their kids that they are doing a good job. The kids feel like they are being loved and accepted by their parents. So they are less rebellious. Their acting out is a lot less, you know, because they are not trying to get any kind of attention fromtheir parents. I mean they are getting positive attention from their parents because their parents are focusing on that; and, so, they don't have to act out and get that other kind of attention."

	Theme 16 Barriers to effectiveness - Family response also depended on parents' cognitive skills, functioning level, and willingness to try PMTO strategies. Some families learned PMTO skills quickly, others took longer, and some did not get them. Practitioners reported that adapting PMTO was more challenging with families with single dads, with more children, and with children with complex needs, such as blind or non-verbal autistic children. Less than a third of the participants reported having challenges adapting PMTO to the unique needs of families, including grief, domestic violence, sexual abuse, parental mental health issues, and parental substance abuse. Delivering PMTO was difficult with parents with mental health and substance abuse issues, who were purportedly more likely to dropout from treatment. However, a couple of participants clarified that these issues are indirectly addressed by PMTO; families who faced multiple contextual factors required harder work. Theme 17 Organisational facilitators - Important were supportive leadership and reasonable work expectations, as follows: "…they've been really good atworking with us and making sure that we have the resources to be able to get there and thatwe have the time, and making sure that we are not overworked, but still able to meet what we are needing to do." Participants also expressed appreciation for collaborative processes, quick turnaround on questions, and work climates that were safe for "trial and learn." "When you're adopting and implementing, I think it's all so new territory… I just feel like our agency leadership has done everything they possibly could to make this work…being supportive, being there, answering questions as they can and as fast as they can to get back with us." Key organizational supports included not rushing participants through training; sharing information quickly and continuously; making sure that staff were not overworked; carefully coordinating changes when there were staff shortages; and providing the structure, materials, and logistics for implementation. Advantages were also realized through effective communications and organizational structures that promoted peer support, teamwork, and collaboration. Some practitioners pointed to the helpfulness of fluid and effective communication throughout the implementation process; they felt their voices were heard by their agencies, describing how their agencies "listened" when participants had questions, frustrations, anxiety, or stress: "…I personally feel like my agency does a really good job, and specific people here do a really good job of making sure to keep us informed of what's going on. And, I think that that has really helped in our implementation of the model. For example, we hear your concerns, and then hearing that it's going up the chain." Theme 18 Organisational barriers - less than a third of the participants felt that they received inadequate support, resources, and encouragement from their agencies. A few of them described challenges associated with their agency's norms, policies, and centralization. Specific problems included lack of support from other staff, inability to use flexible work hours, transportation issues, heavy emphasis on paperwork, and indirect communication with trainers (e.g., not being allowed to directly ask questions to trainers). Indeed, a couple of participants felt as though the program was isolated in their agencies; they perceived resistance from other staff and had to advocate for clients within the agency due to conflicting practices or procedures (e.g., agency practices regarding families affected by substance abuse). Others considered that the lack of support from the agency was associated with the lack of understanding of the interventionmodel. They felt that the agency administrators did not understand therapists' problems, such as the hassles and workload associated with uploading videos. Few respondents wondered whether their agencies knew what to do with the model; there was lack of agreement on how to use it within the agency and the organizational structures needed to reinforce it. These participants concluded that better internal communication from upper management would have helped to create a more accommodating climate and improved the implementation. "I think there wasn't as much, there wasn't as much communication to the case managers what we were doing and what PMTO was. So there was some resistance from other agency staff members… I think better communication to them what was going on and the excitement that the upper management had could have been filtered all the way throughout the entire agency. It would've made things a little better for us." Theme 19 Practitioners suggestions for organisations - Practitioners' suggestions for organizationswere: do not be afraid of implementing new EBIs, select EBIs compatible with client needs, plan before implementing, have patience with the process, communicate excitement and information throughout the agency, share information timely, facilitate teamwork and collaboration among frontline staff, provide adequate working conditions, and listen to the struggles and suggestions of frontline practitioners. Theme 20 Need for stakeholder buy-in: Participants recognized that stakeholder buy-in was a chief factor in successful implementation. In particular, the role of the court system was acknowledged: courts were supportive of the project because of the groundwork laid by agency administrators' efforts to reach out and educate them about PMTO. More frequent among participants' comments was an emphasis on the central role of case managers. They identified case managers as a major player whose backing and cooperation was essential. Theme 21

	Short timelines as a barrier to effectiveness of this intervention - ASFA timelines were pinpointed as major system-level challenges. The high demands placed on families by the child welfare system impacted their response to PMTO. First, when families started the program, parents were in shock because their children were in the system; they often felt angry and guilty, with a negative view of themselves as parents. Practitioners had to address those negative feelings that turned to displaced resentment Thus, practitioners recommended allowing families more time to get through the PMTO curriculum and learn the new parenting skills (i.e., longer than 6 months). Second, the mismatch between the time required by the child welfare system to attend to multiple case plan tasks and the time available for the family, creates frustrating barriers for families. This is explained as follows: "There's system time and then there is time in people's lives, and those times don't match up. And people get really frustrated with that understandably so."

Study arms

Parent Management Training Oregon (N = 30)
Parent management training Oregon model Delivered in-home to individual families, focusing on parents as the agents of change, and delivered for up six months, typically, twice per week for approximately 60–90 minutes per session plus a mid-week check-in that lasted for 20–30 minutes. The curriculum was tailored to trauma and centred on teaching parents five core parenting practices: 1) positive involvement; 2) skill building; 3) supervision and monitoring; 4) problem-solving; and 5) appropriate discipline.

Risk of Bias

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes *(topics covered the benefits of the intervention for the practitioners, their clients, and the systemic and individual level barriers and facilitators)*
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes *("all" practitioners were invited to participate. However, views of parents were not sought for this study)*
Data collection	Was the data collected in a way that addressed the research issue?	Yes *(However, no discussion of data saturation)*

Section	Question	Answer
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Can't tell *(Unclear that researchers critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location)*
Ethical Issues	Have ethical issues been taken into consideration?	Can't tell
Data analysis	Was the data analysis sufficiently rigorous?	Yes *(Thematic analysis clearly designed. Contradictory data was taken into account. Multiple analysts were used to determine themes.)*
Findings	Is there a clear statement of findings?	Yes *(More than one analyst was used, respondent validation sought)*
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and directness	Overall risk of bias	Low
	Directness	Partially applicable *(Study was from USA)*

Ausberger 2014

Study Characteristics

Study type	Semi structured interviews

Aim of study	To examine strategies conference facilitators used to engage foster care youth in decision making in the context of permanency planning family team conferences.
Study location	USA
Study setting	Permanency planning family team conferences held in two foster care agencies in a large urban area.
Study methods	Data collection consisted of 18 observations of family team conferences, 18 post-observation interviews with foster care youth and 17 post-observation interviews with conference facilitators, for a total of 53 data sources. Select documents, including operating procedures and training manuals, were also reviewed. The interviews with youth were held face-to-face at the foster care agency directly following the conference. They were held in a private room and lasted between 25 min and 1 h. An interview instrument consisting of semi-structured and open-ended questions was used. The interview instrument included questions pertaining to the youth's understanding of the conference, preparation for the conference, opportunity to speak,whether they felt heard and understood, and their view of the decisions made. All interviews were audio recorded and transcribed verbatim.The interviews with facilitators were also held face-to-face at the foster care agency. All data, including the interview transcripts, observational field notes and agency documents were entered into HyperRESEARCH, a computer software program that allows qualitative data to be organized, searched, and coded. Thematic coding of themes took place. A senior qualitative researcher reviewed all memos, providing feedback regarding the emergent themes and patterns in the data. The researcher utilized various mechanisms to ensure quality data including triangulation, member checking and peer debriefing.
Population	The sample was drawn from two well-established family service agencies that contract with the New York City Administration for Children's Services to provide foster care services to youth residing in multiple boroughs in New York City. The sample consisted of foster care youth and conference facilitators
Study dates	Not reported
Sources of funding	Fahs Beck, New York Community Trust and New York Foundling, Vincent Fontana Center
Inclusion Criteria	Age aged 18 - 21

	Care Situation Youth involved in permanancy planning conferences Delivering an intervention conference facilitators
Exclusion criteria	None reported
Sample characteristics	Sample size 18 foster care youth and 10 conference facilitators Time in care The length of time spent in foster care ranged from 1.5 years to 20 years, with a mean of 7 years. Type of care Foster care. All youth in the sample, except one, had a permanency goal of Another Planned Permanent Living Arrangement (APPLA). Gender Of the eighteen youth, eight were females and ten were males. Number of previous placements The total number of placements while in foster care ranged from one to ten, with a mean of 5 placements. Age mean age 19 years old Ethnicity Eight self-identified as Black, seven as Hispanic, one as White, and two as other.
Relevant themes	Theme 1 The critical role of the facilitator - A trained facilitator employed by the foster care agency facilitated the permanency planning family team conferences. Facilitators guided the team through each stage of Team Decision Making, including the introduction to the conference structure, ground rules and participants, a discussion of youth strengths and concerns, brainstorming ideas to address the identified concerns, agreeing upon next steps, and developing an agreed upon service plan. The conferences followed a structured format however the facilitator played a critical role in positively engaging the young person in the decision-making process. The facilitation strategies employed to engage youth in decisionmaking included: 1) creating a safe space, 2) encouraging the youth voice, 3) re-balancing power, and 4) establishing a personal connection. These strategies are described in depth with examples below. Theme 2 Creating a safe space - breaking confidentiality - A consistent theme identified throughout the youth interviews was the importance of adults respecting their privacy and confidentiality. Several participants discussed situations where they shared personal information with child welfare professionals they perceived to be confidential that was subsequently shared with others. Youth expressed a sense of betrayal, feeling their trust was violated. A lack of transparency regarding the parameters of privacy can create a divide between professionals as insiders and youth as outsiders to child welfare decision-making processes. In the context of the family team conference, it was important that the facilitator took time to thoroughly explain the parameters of privacy and the young person understood them. Since the information discussed in the conference was used for case planning

	purposes, the information was considered private but not confidential. One facilitator was observed telling the young person that the information in the conference would not come back and be detrimental to them afterwards. In the post-observation interview, the facilitator explained that many youth in foster care are reluctant to open up and share information in the conference because they are afraid it will be used in negative or harmful manner. Her goal is to create a safe space where youth feel comfortable sharing information and engaging freely in the discussion. She explains the parameters of privacy, but also addresses their fears directly by emphasizing the collaborative nature of decision-making and informing them that no decisions will be made without their input and awareness. Theme 3 Creating a safe space - trust building exercises - In addition to discussing the parameters of privacy, some facilitators created a safe and collaborative environment by building trust among the conference participants. As illustrated in one conference the facilitator began by instructing each participant to write their name and relationship to the youth on a folded piece of cardboard, which she then placed on the table facing inward so everyone could viewit. The facilitator then took the time to have each participant introduce themselves by their name and relationship to the youth. The note card visualization coupled with the verbal introduction highlighted the important role each participant played in supporting the youth in the decision making process. Theme 4 Encouraging the youth voice - Another consistent theme in the youth interviews was the importance of having a voice in the family team conference. Youth wanted the opportunity to talk, be heard and have their perspective considered. The facilitator played an instrumental role in including youth in the conversation and making them feel like an equal member of the team. Facilitators used various engagement strategies including, verbal affirmations, non-verbal communication, everyday language, and humor. Facilitators used verbal affirmations to engage youth in the conference. For example, some facilitators used positive action words to describe the youth's behaviors such as successful, independent, consistent and diligent. The use of positive language when describing the youth's actions led youth to open up and engage in the discussion. They also encouraged other members of the group to focus on youth strengths, rather than deficits. Facilitators also used non-verbal communication to engage the youth in the discussion such as physical presence, maintaining eye contact, smiling, nodding, and stating, “uh hum” and “ok.” Through the use of non-verbal communication, facilitators sent a message to the youth that they were physically present and interested in what the youth had to say. As demonstrated through the words of one youth who reflected on her experience with the conference facilitator, “I felt really positive about her. I was always getting positive vibes from her. Every time I looked at her she always had a smile. And, that's the first time I met her, so that's really good for me to feel.” Facilitators used everyday language to communicate with the youth in the conference. Child welfare professionals often rely on professional jargon, which can create a divide between professionals and youth. Examples of such language include the use of codes, acronyms or technical language. In order to engage youth in the discussion, it was important to substitute professional jargon with more developmentally appropriate language. For example, one facilitator stated in the post-observation interview, when determining whether a youth has a permanent resource, rather than asking, “who are your permanent resources” she asks, “Who do you call when you get a really good grade or you got that job? Who do you call to share that with?” "So, every once in a while, I'll have to get into their world. So, they relate to things like, “Do you feel me?” You know, “Do you feel me? I'm tryin' to tell you somethin' very important.” You know, we would say, “Do you understand,” but the kids say, you know, “You feel me?” So, sometimes when I, when I can get there with him, you know, he smiles more. You know, he lets down a little bit more of a guard and, and it gets better. Two facilitators reported using humor to engage youth in the conference. One facilitator noted that although it's not a topic addressed in training, humor makes a big difference in terms of working with and connecting to youth. "“I just try to make the conference like as, it's, for the teenagers, actually like as laid back as possible. Like I'll joke with them, tell jokes,whatever, to try to make it a little more laid back…” Theme 5 Re-balancing power - An important goal of the conference facilitator was to level the playing field so that all participants are provided the opportunity to speak, have their perspective heard, feel respected, and collaborate in the Team Decision Making process. Facilitators were responsible for managing power dynamics so youth and professionalswere true collaborators, rather than the adults or professionals dominating the discussions. The idea of adults/professionals collaborating with youth in decision-making was novice and/or challenging for some participants. Therefore, it was the role of the facilitator to re-balance power when the adults were dominating the discussion. Facilitators accomplished this in multiple ways including keeping the focus on youth, seeking their perspective and advocating for their perspective. Theme 6 Rebalancing power - Several facilitators noted the importance of keeping the conference focused on the youth, including asking adults to remain quiet and/or re-directing the discussion when adults attempt to promote their views. In one instance, the facilitator was observed asking the foster mother and caseworker to stop talking and listen to the youth. The facilitator noted in the post-observation interview, “my role and my joy is to be able to turn it around and, as a facilitator, kind of quiet the rest down and say, ‘Well, we know your opinion, you know, I know your opinion,’ and keep redirecting it back to the youth.” In the post-observation interview with the youth, she noted that the conferencewas “about me” and the facilitator “listened to me. That was good.” Similarly, another youth praised her facilitator for shifting power dynamics to focus on her perspective. She said, “I feel like she's (facilitator) more concerned about what I have to say than anybody else in the room. Because, you know, plenty of times she stops the meeting and says, ‘How come I only hear you all talk and I don't hear Monique?When we're here for her.’”

	Theme 7 Another re-balancing power strategy was to seek the youth perspective and brainstorm ways to assist them in meeting their planning goals. In one conference the youth reported an interest in obtaining employment in the medical field. The facilitator brainstormed the steps necessary to learn about educational and professional opportunities, and how other conference participants could support the young person in accomplishing this goal. In the post-observation interview, the facilitator noted that foster care youth are often told what they can't do, but they need to be encouraged to accomplish their goals. She said, "So, he may have all these things he thinks but if somebody doesn't say, 'But you could do that. Of course you can.' Then, I don't know if he even realizes that that's something I could even do." She went on to state, "It starts with a thought. "You hear what I said. Sit down and think about it. You got to think about it. Research it. Figure out how much it makes. Does it make enough for you? Do you want to go to school that long?" It starts with a thought." Similarly, in another conference the youth reported that she wanted to graduate from high school. The facilitator responded positively by asking what she needed to do to graduate. The youth responded that she needed to go to class and said she was risking failing science. The facilitator probed further, asking about the specific steps the youth would take to pass science. The youth discussed steps she could take including, waking up on time and going to the makeup labs. The facilitator elaborated upon the discussion by focusing on concrete steps the youth can employ to pass her science class, including a discussion regarding how the foster parent and case planner could support the youth in getting up on time, getting on the bus and attending her science labs. These ideas were then documents in the action plan. **Theme 8** Rebalancing power - advocacy - Another important mechanism for re-balancing power was advocating for the youth perspective. At times this meant challenging the agency perspective and revealing potential agencymissteps. For example, in a conference with a youth residing in a mother child residence, the youth complained that for the past two weekends when she came home from work the door to the facility was locked and she had to sit outside with her child for over an hour. The case planner attempted to place responsibility on the youth by saying that she needs to call the staff and notify them when she is coming home. In response, the youth reported she told the Assistant Manager of the residence that she will be home between 3:30 and 4 pm. The facilitator responded by advocating the youth perspective, stating to the agency, "we need to come up with a plan to deal with this." The facilitator then focused on the agency's actions, asking the case planner a series of questions until it was acknowledged that the agency was indeed at fault because the Director had been on vacation and things had "fallen through the cracks." The facilitator then brainstormed a plan to address the situation. A similar situation occurred in another conference where a youth noted that she was not reimbursed by the agency for travel expenses to and from college. The facilitator questioned the agency about the reimbursement. The case planner conceded that she submitted the paperwork for reimbursement but it was not approved. The youth protested that it wasn't fair that the agency told her she would be reimbursed and then didn't approve it. The facilitator sided with the youth asking the supervisor for a further explanation. In response the supervisor said he would look into it and excused himself from the room. After a short time, the supervisor came back into the room noting that the staffmember who deals with financial reimbursement wasn't in the office but they will look into the situation further. The facilitator reiterated the importance of the youth getting her reimbursement. She wrote on the action plan that the agency would address the reimbursement issue and come up with a plan going forward for transportation during each holiday break. In both examples, the facilitator supported the youth perspective, at times assuming an advocacy role. The facilitator allowed the youth to voice their concerns, adopted their perspective and placed responsibility on the agency to address the concerns. The facilitator then brainstormed action steps to rectify the situation. The action steps became part of the written service plan, holding all parties accountable. **Theme 9** Establishing a personal connection - remembering and celebrating goals - A consistent theme in the youth interviews was the personal connection (or lack of connection) youth experienced with the facilitator. Youth felt positively engaged in the conference when they perceived the facilitator to take a genuine interest in them. One mechanism mentioned by youth to determine whether the facilitator took an interest in them was their knowledge about the case. For first time facilitators, it meant being familiar with the case history and permanency planning goals. For repeat facilitators, it meant remembering the case history, permanency planning goals and checking in with participants on the progress from the previous conference as illustrated in one conference when the facilitator began with a round of applause for the youth for meeting her goal of graduating from high school. In the post-observation interview, the youth reported feeling "like a star" because the facilitator remembered and publicly acknowledged her goal from the previous conference of finishing high school. The youth perceived the facilitator to be proud of her. **Theme 10** Establishing a personal connection - continuity of facilitators - not retelling story - While the FTC model does not call for continuity of facilitators several participants mentioned it as a factor in being able to establish a personal connection. From the facilitator perspective, it was helpful to be familiar with the individuals involved in the case, the case history and the case planning goals. By facilitating multiple conferences the facilitator became an "insider" to the case. As illustrated through the words of one facilitator: ""I'm able to recall faces, and recall certain events, and incidents and situations, which make it, give it a personal touch. And they say, "Okay, you know, she recalls. So, it was important to her to some given extent what happened to me or what I expressed in the previous conference. That she is able to uh, bring it up now." So, you know, that has really uh, created some sort of rapport between myself and the youth." Youth reported feeling more engaged in the conference when they had previous exposure to the facilitator. They discussed the importance of not having to re-tell their story. They also discussed the importance of already established trust and rapport. In a post-observation interview with a youth observed to be very engaged in the conference, he reported, "It's just like when we have meetings, I am not nervous 'cause I feel like it's just me and her (facilitator) and I just, we just, connected." In contrast, youth

	who was not familiar with the facilitator felt more reluctant to open up. One such youth reported, “I won't talk to her (facilitator) like, about like anything, 'cause I don't really know her that much.” He went on to note that he prefers discussing personal topics such as medication and depressionwith his case planner and foster parent because he has a relationship with them. Theme 11 Personal connection - limitations - Although youth responded positively to facilitators who established personal connections, some facilitators did not perceive this to be their role. They saw their role as a neutral “outside” party to the case. One such facilitator discussed the importance of maintaining professional boundaries with the youth. She saw the case planner as the appropriate person to establish a connection with the youth, since the case planner works closely with the youth. The perspective of the facilitator as the outside neutral party was contradictory to the preference of youth to have a personal connection with the facilitator. In fact, youth expressed reluctance to open up and share information with facilitator they did not know well. Given that youth are asked to share sensitive information and make important decisions that impact their life in the context of the conference, relational concerns were important to them.

Study arms

Family Team Conferencing (N = 18)

Common terms include Family Group Decision Making, Family Group Conferences, Family Team Conferencing, Permanency Teaming Process, and Team Decision Making. Family team decision-making is a strength based, family and community focused intervention. There is an emphasis on empowering parents to take responsibility for their children and on the rights of children, youth and parents to be involved in the assessment and decision-making focused on child safety, permanency and well-being. Additionally, there is recognition of the need to for decision making to be culturally sensitive. Family Team Conferencing brings together a teamof people, ideally including family members, community members, service providers, advocates and foster care agency staff, to make case related decisions. Children aged 10 and older are invited to attend and participate in the family team conferences.

Risk of Bias

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes

Section	Question	Answer
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Can't tell *(Unclear why the participants selected were the most appropriate to provide access to the type of knowledge sought by the study. All were over the age of 18 yet family group conferences occur at younger ages. no discussions about why some people chose not to take part.)*
Data collection	Was the data collected in a way that addressed the research issue?	Yes *(However no discussion of saturation of data)*
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Can't tell *(Unclear if researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location)*
Ethical Issues	Have ethical issues been taken into consideration?	Can't tell
Data analysis	Was the data analysis sufficiently rigorous?	Yes
Findings	Is there a clear statement of findings?	Yes *(and triangulation, respondent validation, more than one analyst were used for validation)*
Research value	How valuable is the research?	The research has some value *(Some transferrability issues since cohort was older and did not include those who did not attend family team conferences)*
Overall risk of bias and directness	Overall risk of bias	Moderate

Section	Question	Answer
	Directness	Partially applicable *(Study was from the USA)*

Castellanos-Brown 2010

Study Ch`aracteristics

Study type	Semi structured interviews
Aim of study	The key questions of the study were: (a) What is the process of a youth's transition to a family setting? (b) How do TFC parents assess a youth's appropriateness for placement in their home? and (c) What factors are important as youth settle into a family setting?
Study location	USA, Baltimore
Study setting	The Woodbourne Center in Baltimore: a private social service agency serving youth from several public systems, including child welfare, mental health, and juvenile justice.
Study methods	Semi-structured interviews. Authors followed an interview guide and revised it as needed to meet the study goals. The interview guide included several open-ended questions about the transition process; probes were used during the interviews to elicit more detailed information. Each interview lasted between 21 and 53 minutes (M = 32 minutes). All interviews were digitally audio recorded. Content analysis of transcripts from digital recordings was used to identify themes in participants' interviews. Coders initially read through the transcripts multiple times to identify consistent themes raised by participants. Coders then met to compare and discuss these themes and create a codebook.
Population	treatment foster parents who had experienced a youth transitioning from a group setting
Study dates	Not reported

Sources of funding	the Christopher O'Neil Foundation
Inclusion Criteria	Delivering an intervention Adults who were current or former TFC parents with Woodbourne Center in Baltimore
Exclusion criteria	None reported
Sample characteristics	Sample size 22 treatment foster care parents Age between 50 and 69 years of age Ethnicity Most of the participants (95%) were Black and the majority (55.6%) Carer characteristics The TFC parents had diverse levels of experience in fostering, ranging from fostering for less than 1 year to 20 years (M = 6.5 years), and more than half of respondents had fostered four or more children
Relevant themes	Theme 1 Getting aquainted - vists to ensure suitability - For many of the TFC parents, the youth being considered for TFC were placed at the agency's diagnostic center. This allowed the TFC parents to visit the youth and often take the youth on a day pass or even a trial overnight visit. These opportunities to become acquainted and begin building a relationship were often valued by TFC parents. One TFC parent said, "I think it's important to have a day visit and a weekend visit before you make your final decision." Another TFC parent said that she knew from the visit that the placement would be successful: "He came right in and blended right in with the family. It was like he was part of the family and I liked that." The visits were helpful not just to assess the match between the youth and foster parents, but also to observe other family dynamics the youth would be joining. "When I do that one visit, I have my daughter around; she's very involved. She's in and out of here all the time. So if I'm going to have a [youth] visit, I make sure that she and her family will be here to see how they connect." Some TFC parents had to consider how a new foster youth would adjust with other youth in the home. As 1 TFC parent recounted, "Me and another foster child that I had, the three of us went on an outing and I just wanted to get a general idea about their relationship….That's important, too, to include the other child if you have more than one child in the home." Incorporating the foster youth into the family was mentioned by various TFC parents as being an important consideration when deciding whether to accept a youth into their care. Theme 2 Getting aquainted - feeling rushed to make a decision/timing - Timing. The time that elapsed between first hearing about a child and the start of placement varied from a few hours to a few weeks. Although not specifically asked about, one theme that emerged was that some TFC parents expressed feeling rushed by the transition process of a youth being placed in their home. For example, 1 TFC parent described, "Man, it was quick. It was very quick because his time at the diagnostic center was almost up, so they kind of moved kind of quickly on the process because he didn't have no place to go. He was going to leave [the short-term center] and end up at a group home or some place like that." There seemed to be a push/pull between child welfare policies that emphasize youth living in family settings and the desire for TFC parents to feel adequately informed and prepared to receive the child. One TFC parent recounted a recent example: "We got a call that day, they wanted them placed that day, which we know is the nature of the beast. So you are trying to make a decision really quick and you are trying to ask questions and you are asking a team of people who may not know the information. I'm asking questions, I've got to call my husband, transfer all that, write all that down, and even talk to our kids here because it's a team here." TFC parents recognize the pressures within the system even when there is some lead time for placements. One TFC parent said, "The agencies do the best that they can, but there's only so much they can do.…The way they are set up, you can only have so many visits and you have to make a decision—am I gonna take the child or not? Because they have to get these children into a home. That's the thing, they have to try to get them in a normal home environment." It was interesting to note that there was not a clear relationship between the amount of time involved in the transition and the experience of feeling

	rushed. Some TFC parents who received youth within hours of first being notified about the youth did not express any concerns about the timing, while other TFC parents who had a week or more to weigh the decision mentioned that the process seemed "real quick." This finding suggests that TFC parents differ on the amount of time they feel is needed to prepare for the transition. Theme 3 Getting aquainted - information gathering - TFC parents used a variety of methods to gather information for making a decision about whether or not to accept a youth into their home. Some TFC parents reported asking the caseworker many questions about the youth or reading the youth's records, in addition to meeting and visiting. One TFC parent described the importance of reviewing youth records. "Oh, when I look at the chart. To me, the chart is everything…I don't accept [a child] without the chart because I don't want to be surprised." Another respondent emphasized the importance of asking questions: "I ask questions if I don't get enough information. I want to know more extensively about the child's behavior. That way that will give me a general idea as to know whether I want to parent that child or if I'm competent enough to parent that child." Other respondents seemed to require little information to make the decision to accept a youth. Rather than querying the placement worker and files, 1 TFC parent explained, "I just work with what I have. Because there's no way you can tell that by looking at a person or meeting them the first time and I don't think that's giving a person a real chance. Just to meet them and not really…you know, it takes time to get to know a person and they unfold themselves like an onion." TFC parents also recognized the pitfalls of overreliance on a youth's records or previous history. "I try not to judge the child by the info they give you. Sometimes they just need a chance….You just have to let them come in and give them a chance and find out for yourself. Is this child really all that's written on paper?" One TFC parent explained, "I know they all [are] going to have some type of problem and I know that when you love children and work with them, it takes a while, but they can change." When TFC parents were asked what types of information they wanted about a youth they were considering accepting into their home, they mentioned characteristics related to the youth's behaviors, their background, and family experiences. Certain problem behaviors were frequently mentioned as important factors in assessing their willingness to foster a youth. Several TFC parents specifically mentioned they wanted to know whether the child had been a "firesetter," was "violent," and if they acted out sexually. Other less commonly reported issues that were mentioned as important to consider included being pregnant, lying, stealing, running away, and anger management issues. At times, TFC parents reported not receiving information they wanted about the youth. For example, 1 TFC parent reported learning that a child had a bedwetting problem that was not disclosed prior to placement. Another TFC parent said of a youth with attention deficit issues: "I didn't know that he had it or anything about it." Other types of information not received were explanations of why previous placements had disrupted or a youth's involvement in sexual activities. TFC parents had different explanations for why information they wanted was not received. In some situations, the information may not have been available in a youth's record or may not have ever been reported previously. For example, 1 respondent said, "A lot of things were not in her chart and I don't think [the agency] knew. She played with fire, she's having sex. That was not in her chart." Some TFC parents blamed the state child welfare system for not sharing the youth's records with the agency providing the placement services. Explained 1 TFC parent, "A lot of information, if [the state child welfare system] doesn't disclose to [the placement agency] right away, then we don't know about it." Other TFC parents suspected that the placement social worker purposely withheld information from them because they wanted the child placed. "I feel like most times, it's a 'don't ask, don't tell' situation." One TFC parent said, "It seems like they just kinda gave me fluff stuff." Another said, "I can understand, too, because sometimes they may want to place a child in an emergency and they don't want to disclose certain information because you look at this so-called innocent child and you want this child placed, but that's not the right way to do things." One TFC parent summarized the combination of factors that leads to an information gap: "Some percentage is that they don't have it; another percentage is that they don't want to share it; and another might be, what, I don't know, who knows." Theme 4 Getting settled - clothing and personal items - TFC parents seemed prepared to provide personal care items for youth as needed, but often found that youth also needed new clothes. TFC parents said such things as, "And what she came with was like rags," "Underwear too small, pants raggedy," and "They usually have about 2 or 3 pair of underwear that's too small, the socks are really dirty if they have matching pairs, which is almost never. They have no hair supplies, no bath stuff. They usually don't have no haircut, no adequate shoes, no kind of toiletries. One child, she didn't have no jacket." Suggestions for improving the adequacy of clothing included receiving a clothing grant when a child is placed (N = 5). Several TFC parents commented on how they took ownership of their youth's appearance. For instance, 1 TFC parent said, "I'm really particular about what they wear and how they look. I took all the stuff she had and threw it in the trash pretty much because you are a representation of me….So if they come and their clothes are not adequate with me, then I don't let them wear that stuff." Providing for the youth's clothing needs seemed to make an impression on the youth. For example, 1 respondent said, "The child was wearing small clothes and nobody could see it but me. So I went out to Marshalls and I spent $300. I'll never forget that. That night, before he went to school, I bought him all new clothes and automatically, that child loved me." However, TFC parents were sometimes reluctant to invest so substantially in a youth newly-placed in their home. For example, 1 respondent said, "That was very unfair to me. I didn't think it was fair because what happens if this child doesn't work out well in my home….I had to go out and buy him an entire wardrobe—from inside to outside and a haircut. But everything turned out okay." Theme 5 Getting settled - school transitions - Some TFC parents reported issues transitioning youth from their previous school to their new school. To illustrate, a TFC parent said, "It took me almost a month to get her registered in school." Another mentioned, it "seems like [the agency] should have gotten all that and passed that package with the child, but it seems like [the agency] and the city couldn't get their handshake together, so that was the hang-up there." Others reported no problems in that transition. For example, 1 respondent said, "It was pretty smooth. They didn't miss any school at all."

	Theme 6 Getting settled - mental health services transitions - In this TFC program, all youth were expected to receive weekly outpatient therapy. Transitioning youth to new mental health providers was made easier for most TFC parents because this agency's workers provide referrals to providers near the TFC home. The TFC parents also appreciated being able to choose the therapist they wanted to work with. Medical and dental services seemed equally straightforward. A TFC parent could have their caseworker transfer a youth's files to a provider of the parent's choice or the caseworker would help identify possible local providers. For example, 1 respondent said, "He had to go to a different therapist. I looked around in the neighborhood to find something that was close. So we go to [community mental health] center. As soon as he got here to the house, he started going to therapy." TFC parents reported few difficulties in logistics regarding securing services for youth in their home. TFC parents who were less experienced reported greater reliance on their caseworkers for help in navigating the process of getting settled, whereas more senior TFC parents knew the ropes well. For instance, 1 TFC parent said, "Usually we transfer them. Like I transfer all my kids to where I usually take all my kids. It's the same therapist. We know each other and we have a good rapport." Overall, TFC parents seemed satisfied with the quality of auxiliary services their youth received. Theme 7 Getting settled - agency support - The strengths of the program identified by TFC parents may have facilitated the getting acquainted stage of the transition process. These strengths highlighted various supports that were mentioned as being helpful to TFC parents. Eight TFC parents mentioned they had a good relationship with their TFC worker. Examples include, "I have an excellent worker, the intake lady was excellent," and "Lately, I've been having some really great social workers." Training was mentioned by 5 TFC parents as being a beneficial source of support. Respite was mentioned twice and referrals were mentioned by 1 TFC parent. Additionally, 2 TFC parents said the agency was "supportive." For example, 1 TFC parent said they do a "good job in communication and in supporting the parents. I know they are constantly trying to develop more support for the foster parents to help them when they got children that is getting into some problems and they do have some things that they can work with." Six mentioned the staff, counselors, or social workers at this agency were strengths. Theme 8 Getting adjusted - adjustments to family life - Youth transitioning from group care settings are adjusting not only to their foster family, but also sometimes to family life in general. Some youth seemed to lack experiences that are common in most families. For example, 1 TFC parent recalled having a youth in her home who admitted never before having a set bedtime. Another TFC parent was surprised by a youth's dietary habits. "One girl I had, she was eating out of a can. I told her you're not supposed to eat out of a can and she got so ashamed." A TFC mother described her efforts to treat her foster youth similarly to how she treated her biological children as a "mainstreaming" process: "If he stays on task and graduates and makes me proud of him, I will give him a party in the backyard….See, I did that for my kids, so it's like mainstreaming him." Theme 9 Getting adjusted - disruptions - When youth coming from group care or other settings transition to TFC, struggles in the transition can lead to placement disruptions. In this sample, more than half of the respondents had experienced at least one disruption of a child leaving their home. Reasons cited for disruptions included lying, running away, skipping school, stealing, and sexual behaviors. From the descriptions provided by TFC parents, disruptions often occurred after an increasing build-up of problems over time. For example, "She was constantly being thrown out of school, so that was a constant. School started in August and by September she had been thrown out of school like 6 times. And I told her I couldn't keep going to the school like that…I have to work, too…so they found her another placement." As youth problems escalated or maintained at high levels of intensity, TFC parents seemed to reach a breaking point. One respondent said, "She steals everything that isn't nailed down and after a while I just got sick of it. Having to go get something or going to wear something and it not be there anymore. I just couldn't tolerate it anymore." For some TFC parents the persistence of difficult youth behaviors was too much for them to handle. Theme 10 Getting adjusted - evidence of postive transition - Although not specifically asked about, many TFC parents shared evidence of a positive transition for youth they fostered, and they were proud and happy to share their success stories. One TFC parent said, "She graduated and she's going to school…she was able to get an apartment, she shared it with another young lady for the first year and now she has her own place through a program. She's working and going to college. She's one of my successes, a success story." Another TFC parent said about a former youth in her care, "She's doing quite well and they also gave her a voucher to get her driver's permit. She's doing well and that's what I would like to see all the children attain." A third said, "I just want that child to be successful so that child can say someone loved me enough to help me to be successful, so that's really my goal. Two of my children have done just that—graduated."

Study arms

Treatment Foster Care (N = 22)
Woodbourne's TFC program does not follow a national model such as MTFC, which combines foster parent training with youth behavior training, and involves a multidisciplinary treatment team and individualized treatment plans for youth (Fisher & Chamberlain, 2000). However, all youth in this TFC program receive individual outpatient therapy or family therapy with current or biological caregivers. Woodbourne's TFC program includes some of the quality features identified in blueprint programs, including small caseloads for TFC workers and ongoing training for TFC parents, and often TFC youth are placed individually in homes.

Risk of Bias

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes *(However, saturation of data was not discussed)*
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Can't tell *(Unclear that researchers examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location? How did the researcher respond to events during the study)*

Section	Question	Answer
Ethical Issues	Have ethical issues been taken into consideration?	Can't tell
Data analysis	Was the data analysis sufficiently rigorous?	Yes
Findings	Is there a clear statement of findings?	Yes *(Multiple analysts were also used)*
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and directness	Overall risk of bias	Low
	Directness	Partially applicable *(Study was from the USA)*

Frederico 2017

Study type	Focus Groups Mixed Methods
Aim of study	The overall aim of the evaluation was to review the effectiveness of the Circle Program in achieving its objectives; review the outcomes for children and young people, carers and families; and to make recommendations for further development of the program. The evaluation aimed to add to the knowledge and understanding of the needs of children who enter TFC and how best to meet their needs and achieve improved outcomes for them.
Study location	Australia
Study setting	Children allocated to the Circle Programme - Treatment Foster Care

Study methods	Data were collected and analysed from (i) case assessments; (ii) focus group interviews with therapeutic foster carers, generalist foster carers, foster care workers and therapeutic specialists; (iii) an online survey for carers and workers; and (iv) interviews with therapeutic specialists involved in the Circle Program. Seven focus groups were conducted jointly with Circle and generalist foster carers and professional workers. Forty-three participated in focus groups which were mixed groups including therapeutic foster carers and generalist foster carers, foster care workers and therapeutic specialists. Interviews with therapeutic specialsts Two joint interviews were conducted with the two therapeutic specialist providers to examine their therapeutic practice approach and their compliancewith the guidelines and barriers to effective delivery. A separate teleconference was undertaken with child protection staff to explore their experience of Circle as no child protection worker was able to attend the focus groups. Two joint interviews were conducted with representatives of the two therapeutic specialist providers to examine the therapeutic practice approach and its compliance with the guidelines and barriers to effective delivery. All interviews and focus groups were digitally recorded and transcribed verbatim. The data from focus groups were analysed to identify common themes.A separate teleconference was undertaken with child protection staff to explore their experience of Circle as no child protection worker was able to attend the focus groups. Two joint interviews were conducted with representatives of the two therapeutic specialist providers to examine the therapeutic practice approach and its compliance with the guidelines and barriers to effective delivery. All interviews and focus groups were digitally recorded and transcribed verbatim. The data from focus groups were analysed to identify common themes.
Population	therapeutic foster carers and generalist foster carers, foster care workers and therapeutic specialists.
Study dates	Not reported
Sources of funding	Centre for Excellence in Child and Family Welfare Inc.
Inclusion Criteria	Carer situation therapeutic foster carers and generalist foster carers, foster care workers and therapeutic specialists. Delivering an intervention The Circle Programme - Therapeutic Foster Care
Exclusion criteria	None reported
Sample characteristics	Sample size Forty-three therapeutic foster carers and generalist foster carers, foster care workers and therapeutic specialists.

Relevant themes	Theme 1 The Circle Program was felt to be more likely to promote reunification with family or enter kinship care than among children in a generalist foster care placement. Factors contributing to the child's relationship with their family of origin are identified in comments below: "The way the parents are treated and welcomed and their unique knowledge recognized contributes to the success of Circle (Therapeutic specialist) Families generally don't come to every meeting but we encourage their attendance when they do come. In GFC, a carer has to be very assertive to create relationships with birth families, but it's a much more natural process in Circle because of care team meetings" (Foster care worker) Theme 2 Factors felt to promote greater retention of carers - Focus group data highlighted factors deemed to be influential to carer retention such as support, training, ongoing education and access to flexible funds to obtain services. Comments highlighted the value of participation in regular care teammeetings. Carers spoke of their commitment to their role as a Circle carer, highlighting the experience of support, training and ongoing education. Theme 3 Access to flexible brikerage funds - Access to flexible brokerage funds was also critical. These funds were described by carers as supporting children to participate in normative community activities, for example a dance class or organized sport.Where a child required a specialist assessment (e.g. speech therapy) that was not available through public funding within a reasonable time frame, brokerage funding could be used. A key message from carers was the importance of accessing such discretionary funds to meet a child's needs in a timely way. Theme 4 Carers treated as professional equals - The Circle Program was described by some carers as elevating the role of the foster carer to one that is 'equal' to the other professionals on the care team. This, combined with the Circle Program training, professionalized the role of the foster carer, and some carers reported increased levels of confidence in their competence. Theme 5 Equal system of carers - The egalitarian nature and common purpose of the care team were features mentioned by a number of focus group participants as having significance in their experience of TFC. Theme 6 Network of support for carers themselves - Carers also commented that the success of the Circle Program was linked to the professional support provided: feeling 'listened to', having their opinions 'valued' and being 'supported' in their role as foster carer. In the focus groups, carers discussed their role and participation in the Circle Program with passion and enthusiasm. The wellbeing of the carer was also a focus of care teammeetings with one carer commenting that someone always asked her how she was at care meetings and 'They really want to know how I am'! Theme 7 Contents of training - Training in trauma theory, attachment and selfknowledge were also identified as essential components by foster carers and foster care workers alike. "The education helps you not to take it personally and respond better and to keep the end in sight which is the relationship with the child'"(Carer). Theme 8 The key role of the therapeutic specialist - Therapeutic specialists were identified by all stakeholders as core to the Circle Program's success. Circle carers and foster care workers highlighted the value of this role in guiding assessment and the care of the child. The availability of the therapeutic specialist was considered a particular strength given their knowledge; and ability to assist carers in understanding the child and their needs. Their role was active in guiding the foster carer in their day to day response to the child and this was experienced as very supportive and was seen to facilitate a more immediate and appropriate response in meeting the child's needs. The therapeutic specialist could also extend their focus to include the child's family of origin as from the commencement of placement the aim is for the child to reunify with their family if the family can meet their needs. As many of the families of origin had themselves experienced trauma, it is important that they be assisted to heal and change to be available for the care of their child/young person. Theme 9

	Building a support network for the child - Feedback from focus groups and the survey highlighted the importance of building a support network for the child/young person. This network included teachers, extended family and others in addition to themembers of the care team. The following quote highlights the theme in the feedback: 'The amazing camaraderie across the care team that is generated by the therapeutic specialist driving a continual focus on the child and the child's needs…. we really are a circle of friends around the child' (Foster Care Worker).

Study arms

Treatment foster care - The Circle Programme (N = 43)
The Circle Program, introduced in Victoria as part of a State Government funded home-based care system, aimed to ensure that 'all children receive the therapeutic response they require when they require it…'. The program was positioned within a 'philosophical framework that supports and promotes child-centred practice and the principles of children's rights' and 99 placements were initially funded. The conceptual framework was informed by trauma-informed principles and resilience theory, and positions the child in care at the centre of the program. The care environment is defined as 'relationships, home, family, school and networks created by the primary carer; and engagement of the child and the family of origin where possible to promote family reunification, or long term stable care for the child'. The care team members include: the Foster Care Worker, the Therapeutic Specialist, the Child Protection Practitioner, Foster Carer and the Birth Family. Additional roles are added as needed to match each child's requirements. The core elements of the program are:- • Training in trauma and attachment. • Children entering The Circle Program are Child Protection clients and two thirds are to be new entrants to care. • Assessment of the child and an intervention plan led and coordinated by a therapeutic specialist • Individually tailored care teams designed to meet the specific needs of every child and young person entering The Circle Program. • As far as possible the family of origin were to be involved in the assessment process.

Risk of Bias

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes *(However, qualitative methods were not appropriate to evaluate effectiveness of the intervention in terms of likelihood of reunification.)*

Section	Question	Answer
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Can't tell *(Researchers do not discuss how participants were selected for the study, and why these were the most appropriate or why some chose not to take part)*
Data collection	Was the data collected in a way that addressed the research issue?	Can't tell *(Researchers have not made focus group or interview methods explicit Setting not justified. Saturation of data was not discussed..)*
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Can't tell *(Unclear that researchers critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location)*
Ethical Issues	Have ethical issues been taken into consideration?	Yes
Data analysis	Was the data analysis sufficiently rigorous?	Can't tell *(Thematic analysis process was not described explicitly.)*
Findings	Is there a clear statement of findings?	Yes *(Validation/triangulation from multiple sources was used (mixed methods))*
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and directness	Overall risk of bias	High
	Directness	Partially applicable *(Study was from Australia)*

Section	Question	Answer

Kirton 2011

Study Characteristics

Intervention	**Multidimensional treatment foster care (N = 31)** Multidimensional treatment foster care, in its UK incarnation, reflected New Labour's concerns for joined up working between social care, education, and health agencies. There were important differences between the context and operation of MTFC in the UK compared to the USA. These included the location of MTFC within the care system rather than in a criminal justice setting. Another difference was that planned returns to birth families were relatively rare. Instead, the focus was on improved contact and relationships rather than training birth parents to pick up the model of care taught by Oregon Social Learning Centre. Government guidance suggested initially concentrating on those who were likely to progress in the programme, to build confidence, before moving on to harder cases. In evaluating the workings of the OSLC model it is useful to highlight two distinct but related challenges. The first is the different profile of UK participants compared with the US counterparts, and the greater emphasis on voluntary participation. Second, the highly prescriptive nature of the model can be seen as giving rise to tensions between the need for creative adaptation to the UK welfare system and the benefits of strict adherence to the programme.
Study type	Semi structured interviews
Aim of study	to explore the experiences of multidimensional treatment foster care
Study location	UK
Study setting	local evaluation of MTFC within one of the pilot local authorities.
Study methods	Semi-structured interviews were conducted to explore respondents experiences of working within and perceptions of the MTFC model. No further information was provided about thematic analysis.

Population	Foster carers (8), children's social workers (6), supervising social workers (2), individual therapists, birth family therapists, skills workers (3), social work assistants, programme supervisor (1), programme manager (1), members of the management board (4)
Study dates	Not reported
Sources of funding	Not reported
Inclusion Criteria	None reported
Exclusion criteria	None reported
Sample characteristics	Sample size 31 interviews were conducted: Foster carers (8), children's social workers (6), supervising social workers (2), individual therapists, birth family therapists, skills workers (3), social work assistants, programme supervisor (1), programme manager (1), members of the mamagement board (4) Number of previous placements half of the children had had ten or more placements Age roughly three quarters of the children were aged 13 or over.
Relevant themes	Theme 1 A common language and focus: One of the main strengths offered by the OSLC model was a degree of focus or 'common language' (seen as crucial in a multi-disciplinary team) and clarity of expectations for young people: "We're all very clear about what we're working towards and it helps in not splitting that group around the child. (Team member)" Theme 2 The emphasis on rewards and punishments was generally regarded as crucial, both for its transparency and potential for setting and maintaining boundaries: "If they don't earn it, they can see it, there's something there that they can see, you can hold up in front of them and show them. (Foster carer)" Theme 3 Taking the emotion out of the situation: Another strength was the perceived capacity for the model, with its relatively neutral and technical language, to 'take the emotion out of the situation' and to avoid escalation in the face of anger and outbursts: "In a way it stops people really feeling too criticised because it's like ... if someone says to you 'off model'that's like, 'Oh well, I can get back on the model.' (Team member)" "You need to be quite calm and not easily fired up, to be able to just walk away when they're ranting and raving and they're in your face and they're shouting at you, and just walk away and let them calm down. (Foster carer)" Theme 4 Limitation 1: certain aspects of it needed to be 'Anglicised': Where they occurred, flexibilities tended to reflect either cultural differences or acquired practice wisdom. Within its UK context, some team members saw the programme being more holistic and less focused on 'breaking the cycle of offending', an emphasis sometimes couched in the language of 'leniency': "Helping that child develop ... in whatever way they need and meeting their needs to enable them to move to independence or whatever goes next to it. (Team member)"

	Theme 5 Limitation 2: , it would work for some young people but not others; **Theme 6** Limitation 3: the longer-term benefits of the programme were uncertain **Theme 7** Sticking to the model as a team: A clear majority of interviewees saw themselves and the programme sticking closely to what they understood as 'the model', while often disclaiming any detailed knowledge of it. This partly reflected the routinisation of practice and perhaps the strength of team ethos: I know ... as a team we work towards the model and it's the Oregon model that we follow but it feels much more like we're working to our team model. (Team member) Broad adherence reflected a number of factors. First, the model appeared to 'make sense' to most of those involved, with several foster carers claiming (though with perhaps some oversimplification) that this had been the basis of their own childrearing: It's basically the way I brought my own children up, which is good children get lots of nice things and naughty children get nothing, but I do it with points. Second, the consensus was that, albeit with some flexibility (see below), the model 'worked' but that this required fairly strict adherence: We're very close to the model on most things and whenever we stray I have to say that it kicks us in the teeth. (Team member) A third factor was that of external monitoring and reporting mechanisms, whether from the NIT or OSLC itself. While this sometimes involved elements of 'presentation' to outside audiences that differed from day-to-day realities, it also served to reinforce the programme's logic and philosophy. **Theme 8** Followed in spirit rather than to the letter: Much of course, depended on how far the model and its weighty manuals were to be followed 'in spirit' or 'to the letter'. For example, one team member argued that expectations of young people in terms of healthy eating and eschewing of hip hop or rap music were unnecessarily restrictive and perhaps 'unrealistic'. While most foster carers came to find the award and deduction of points reasonably straightforward, the challenges, such as balancing consistency and individualisation and handling value judgements, should not be underestimated: "My lifestyle to somebody else's might be totally different and what I accept in my house is different to what somebody else accepts in theirs. (Foster carer)" **Theme 9** What constitutes normal teenage behaviour? - Additional challenges included what constituted 'normal teenage behaviour' and how far the focus for change should rest with 'large' and 'small' behavioural problems respectively. These issues were, however, usually resolved fairly easily, with foster carers happy with their degree of discretion. Parental Daily Reports were sometimes seen as 'a chore' (Westermark et al, 2007), but almost universally valued for their capacity to concentrate minds on behaviours, to ensure daily contact between foster carers and the programme and help 'nip problems in the bud'. "It makes me think about if things have happened, how I can do them better or how we can both do it better. So it's reflection for me. (Foster carer)" **Theme 10** parental daily report - The data yielded were seen as useful for identifying trends and one-off or recurrent 'spikes' that might reveal behavioural triggers, such as contact visits or school events and as having a potential 'predictive' value for disruptions and optimal transition timing (Chamberlain et al, 2006). There were concerns that the prescribed list of behaviours was in places too 'Americanised' (eg 'mean talk') and that selfharm (not infrequent within the programme) was not listed separately but under destructiveness, requiring annotation to distinguish it from instances of 'kicking the door in'. Similarly, there was no reference to eating disorders other than 'skipping meals'. The question of whether behaviours were 'stressful' was clearly dependent to a degree on foster carers' tolerance and time of completion: "The next morning or the night time everything's died down and it probably isn't such a big deal ... [do] you give yourself that time just to calm down before you put it in the behaviour or should you do it when it happens? (Foster carer)" Concern was also expressed that the Parental Daily Report's focus on negative behaviours was not entirely congruent with the programme's aims of accentuating the positives (see below), a situation that was seen as having a cultural dimension, with one team member commenting, albeit as a generalisation, on how US counterparts in MTFC tended to be 'more upbeat about things' and hence less likely to dwell on negative behaviours. **Theme 11** Engagement was crucial to outcomes but highly variable and prone to change over time: "She couldn't give a monkey's. It didn't matter what I'd say she was not gonna . . . And she stayed with me for three months and then she decided she'd had enough and went. (Foster carer)" More generally, however, engagement levels were thought to be high, with some respondents indicating surprise at the apparent willingness to accept a restrictive regime with its initial 'boot camp' withdrawal of privileges: "I find it bizarre that they engage with it really quite well ... I kind of think if I was a 13-year-old lad ... would I really want to be negotiating buying my free time, my time out with points? But they do ... and they stick to it. (Team member)"

Theme 12

Need for persistence: Situations were described where young people would rail against restrictions and thwarted demands but ultimately comply. While the motivational value of an identifiable goal (such as return home) was recognised, sustaining interest day-to-day was equally important and required delicate judgements from foster carers as the following contrasting approaches indicate: "My young man likes to look at his points on a daily basis so we go through them with him and then we sit down and work out how he's gonna use his rewards and what he's aiming for next. I have to say that I don't sit down and discuss points with [young person] every night because she will just rip it up and throw it at me and tell me what a load of bollocks it is"

Theme 13

finding and tailoring the right rewards - Equally important, however, was finding the right rewards and appropriate means of earning them (although one young person was said to 'just like getting points'), something that might entail individual tailoring: "She needs to score points really, really highly, so whereas one foster carer might give one of the lads ten points for doing what she did, she may need to earn 50 for it to mean something. (Team member)" If this raises questions of 'inconsistency', it was justified in terms of motivation, individual pathways and progression through the programme (Dore and Mullin, 2006). Similar logic had meant 'massaging' points to prevent a drop in levels, where this might provoke running away or placement breakdown: "I think with some young people they ... just wouldn't manage being on level one and therefore it is slightly adapted to sort of manage that. (Team member)"

Theme 14

are normal activities privileges? - Transfer of placements into the programme also raised questions of how far previously 'normal' activities could be recast as privileges to be earned. Over time, this had reportedly given rise to some variations or changes of practice, for example, on televisions in bedrooms or consumption of fizzy drinks.

Theme 15

Need for redemption and engagement with point and level system - A key element of the OSLC philosophy is 'turning it around', allowing loss of points to be redeemed by subsequent good behaviour or positive reaction to the deduction. Although (some) foster carers felt this approach potentially made light of misdemeanours, the overall working of the programme was supportive of it: "Instead of giving her five points that she'd normally have I'll say, 'Well, you did that really well. I'll give you 15 for that today.' (Foster carer) You hear them talking about 'I really turned it around today' ... [or]'I'm working towards my points.' You actually hear the children saying, 'I know I need to be on this programme'. . . they ... have that insight. (Team member)" One young person had reportedly asked his foster carer not to let him out in case he got into trouble and forfeited a much desired holiday, something that was seen as a significant shift in thinking and timescales.

Theme 16

A behavioural model or an attachment model? Behavioural programmes are sometimes criticised for lacking depth or concentrating on 'symptoms rather than causes', a debate we explored in interviews. Foster carers tended to focus on their own specific role in dealing with behaviours and saw the addressing of any 'underlying' problems as being the responsibility of others, especially the individual therapist, as in 'I'm just trying to break a pattern but it's not actually solving why they do it.'Also emphasised strongly was the temporal focus on present and future, by comparison with attachment models 'looking backwards'. If in some senses, practice remained firmly within a behavioural framework, this was not seen as precluding consideration of attachment issues, whether at the level of understanding – 'I find it quite hard not to think about things in terms of attachment' – or in outcomes: "I think what's been helpful is people have sort of said, 'Oh, it's not an attachment model' and I just have been able to say to them, 'What do you think actually putting a containing and caring environment around a child does?' ... It's not the kind of ... Pavlov's dogs type thing that everyone thinks about when they think about behavioural models. (Team member)"

Theme 17

Importance of appropriate matching: While in principle, behavioural approaches tend to de-emphasise the importance of relationship, the crucial importance of matching (which tended to involve consideration of several young people for one (or two) foster carer vacancies) was widely recognised and seen as a key area of learning within the programme: "I think we're getting it right more often than not and I think that's reflected in the ... reduction of disruptions. When we do get it wrong we get it wrong very spectacularly! (Team member)"

Theme 18

Move on placements: Marrying MTFC's twin aims of providing time-limited 'move on' placements while effecting sustainable behavioural change required complex judgements as to the optimal timing of transitions (Cross et al, 2004). Opinion was divided on this (national guidance had suggested a shortening of placements from around 18 to nine months) between those emphasising the time needed to deal with 'long-term damage' or the dangers of 'relapse' and those worried about stagnation, disengagement or young people

	'outgrowing the programme'. While practice wisdom and programme data were seen as aiding decision-making, follow-on placements remained a significant problem. In some instances, this had been resolved by the young person remaining with their MTFC (respite) carers, although this usually entailed the latter's loss to the programme. Consideration had also been given to the establishment of 'step-down' placements to provide a more gradual reduction in structure and support (NIT, 2008). However, such provision is challenging in terms of recruitment. Several young people who had left MTFC had subsequently kept in contact, and interestingly this included some early and late leavers as well as graduates. Theme 19 Foster carers satisfaction with the level of support and out of hours service - Foster carers were extremely positive about levels of support in MTFC – 'Just absolutely amazing', 'I have to say brilliant. 100 per cent brilliant' – and some commented on how this had prevented disruptions that might otherwise have occurred. 'Enhanced' (relative to 'mainstream' fostering) features included higher levels of contact with supervising (and assistant) social workers and a structured pattern of short breaks or 'respite care'. In addition to their primary role of granting some relief from pressures, these arrangements sometimes evolved into follow-on placements after disruptions, helping to provide important elements of continuity. Another crucial 'enhanced' feature was a dedicated out-of-hours service staffed by members of the team, which, though used fairly modestly (typically one or two calls per day), was highly valued for its provision of a crucial safety net: "There's nothing more reassuring ... that you can ring someone up and actually hear that person on the end of the phone, it's not some call centre or someone you've never met before. (Foster carer)" Use of the out-of-hours service ranged from serious incidents involving offending, (alleged) sexual assaults, suicide concerns and violence or damage in the foster home, to reassurance on medical issues and dealing with difficult behaviours. Theme 20 While the roles of therapists and skills workers sometimes raised issues of co-ordination with foster carers, their capacity to ease pressures at times of difficulty was valued by carers. Theme 21 the foster carers' weekly meetings. These served both to ensure fairly prompt attention to issues, but also afforded the opportunity for mutual support and problem-solving Theme 22 Success of co-ordinated working - There has been little research on the operation of teamwork within MTFC or its external relations. Despite significant staff turnover and some reworking of roles, the programme had also benefited from continuity in some key positions and a capacity to fill vacancies relatively quickly. From interviews and observation, internal roles appeared to be fairly clear and well co-ordinated, although the team's relatively small size had inevitably given rise on occasion to questions of flexibility, with tensions between willingness to help out and the maintenance of role boundaries (eg on provision of transport or supervision of contact): "On the whole, given that we have got a bunch of quite disparate professions ... we've got a conjoined CAMHS, education and social care team, there's a lot less conflict than I thought there might be. (Team member)" The workings of MTFC both facilitate and require high levels of communication, combining multifarious opportunities for contact with a need to pass on information regarding 'eventful' lives and high levels of activity on the programme. With occasional, and usually fairly specific exceptions, team members regarded communication as very effective, while foster carers were generally positive about their participation: 'They do value your input and they value your knowledge and your sort of past experience.' Theme 23 Leadership of programme supervisors - The role of Programme Supervisor (PS) as key decision-maker – variously referred to as 'Programme God' or 'the final word'– was crucial within the team. While some team members reported taking time to adapt to this, it was widely acknowledged that the PS and indeed 'the programme' could act as a lightning rod to defuse conflicts involving young people and their foster carers: "Always it's'[PS], says' ... in answer, so my [young person] wishes that [PS] would drop dead at any moment. But that takes a huge amount off of me because it's not me who's saying it. That's absolutely been brilliant. (Foster carer)" Theme 24 Clash with the children's social worker - Like any specialist programme, MTFC has faced challenges in its relationships with CSWs (often exacerbated by turnover among them) regarding the balance between a necessary transfer of responsibility on the part of CSWs while they continue to hold case accountability (Wells and D'Angelo, 1994). Despite routinely sent information and discussions with the PS, almost all CSWs interviewed expressed some concerns, usually involving either not knowing of specific incidents (eg entry to hospital) or more ongoing matters, such as the content of counselling. For some, the concern was simply about being 'out of the loop', while for others it was the potential for exclusion from decisionmaking and conflict with statutory duties: "It seemed to me that the treatment fostering team pretty much took on responsibility for the case, which is fine, but if anything goes wrong then don't make me accountable." From a programme perspective, there were occasional references to CSWs who 'found it hard to let go', or whose misunderstanding caused confusion. As one foster carer put it, 'they start telling these kids all sorts of things and you're thinking "no actually, they can't"', although it should be noted that some CSWs were viewed very positively. A more common concern, however, was that some CSWs 'opted out' once the young person entered MTFC, although this was often acknowledged (on both sides) as understandable given the workload pressures facing children's social workers: "[. . .] was the sort of child I used to literally wake up worrying about and I don't now because somebody else is doing that worrying. (CSW)" Encouragingly, CSWs also referred to improving communication, with some plaudits for MTFC being

<table>
<tr><td></td><td>approachable and responsive. The programme had attempted to improve liaison by visiting teams and by inviting children's social workers to attend meetings, although these offers had not been taken up, with CSWs reporting diary clashes and imprecise timings to discuss 'their' charges. It was also noted that the very specific workings and language of MTFC were not always well-integrated into Looked After Children (LAC) review processes.

Theme 25
Social workers were positive about the programme - "He was a really, really difficult young man and they've really supported him and provided him with a stable home environment, really, really firm boundaries which he's really needed . . . I think the placement's been fantastic. She would have met the criteria [for secure accommodation] in terms of running off ... self-harming ... And now the self-harming is very ... very limited. It changed his life around to be perfectly honest. Yeah, I'd go that far." This is not, of course, to say that time in MTFC represents any form of panacea, but recognition of its impact in often difficult circumstances: "He's only absconded three times in six months or so and it's only ever been running off from school and he's back by nine o'clock ... whereas before he was missing for days on end. (Team member) There are obviously still concerns about her emotional welfare and there will be, but she was a very, very damaged girl for lots and lots of reasons, but there was a time where I thought she just might ... not survive. (CSW)" The idea that even 'failed' placements might nonetheless carry some residual benefit for young people – particularly those in 'multiple disruption mode' was also expressed by some.</td></tr>
<tr><td>Risk of Bias</td><td>
<table>
<tr><th>Section</th><th>Question</th><th>Answer</th></tr>
<tr><td>Aims of the research</td><td>Was there a clear statement of the aims of the research?</td><td>Yes</td></tr>
<tr><td>Appropriateness of methodology</td><td>Is a qualitative methodology appropriate?</td><td>Yes</td></tr>
<tr><td>Research Design</td><td>Was the research design appropriate to address the aims of the research?</td><td>Yes</td></tr>
<tr><td>Recruitment Strategy</td><td>Was the recruitment strategy appropriate to the aims of the research?</td><td>Can't tell
(Researchers did not discuss how the participants were selected or why these were the most appropriate to access the type of knowledge sought by the study)</td></tr>
<tr><td>Data collection</td><td>Was the data collected in a way that addressed the research issue?</td><td>Can't tell
(Setting was not justified. Methods were not made explicit or justified. Unclear the form of the data and saturation of data is not discussed.)</td></tr>
<tr><td>Researcher and participant relationship</td><td>Has the relationship between researcher and participants been adequately considered?</td><td>Can't tell
(No evidence that the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location)</td></tr>
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	Ethical Issues	Have ethical issues been taken into consideration?	Yes
	Data analysis	Was the data analysis sufficiently rigorous?	Can't tell *(No in-depth description of the analysis process. Unclear if thematic analysis was used. Unclear how the categories/themes were derived from the data. Unclear how the data presented were selected from the original sample to demonstrate the analysis process. Unclear if sufficient data presented to support the findings. Unclear if researcher critically examine their own role, potential bias and influence during analysis and selection of data for presentation)*
	Findings	Is there a clear statement of findings?	Can't tell *(No adequate discussion of the evidence both for and against the researcher's arguments or the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst))*
	Research value	How valuable is the research?	The research has some value *(Qualitative findings relate to one specific intervention of interest. Findings are discussed in relation to current policy and practice.)*
	Overall risk of bias and directness	Overall risk of bias	High
		Directness	Partially applicable *(Data was likely collected prior to 2010)*

McMillen 2015

Aim of study	The study was designed to address a number of questions. Feasibility questions focused on recruitment of youth and foster parents, randomization, and tolerance of the intervention and research protocols. Programmatic questions were also addressed. What would stakeholders think of new intervention components and roles? Were programmatic changes needed before moving forward with a larger trial?

Study location	USA
Study setting	A pilot RCT study of treatment foster care for older youth with psychiatric problems
Study methods	Qualitative data was collected as part of a randomised controlled trial. Qualitative interviews with youth focused on experiences with and opinions of TFC-OY program components. Sample questions and prompts included the following. “Tell me about your experience with this part of the program.” “What do you like about it?” “What do you not like about it?” “What could be done differently to make this part of the program better?” Qualitative interviews with foster parents were conducted two months after placement and at the end of the placement or the end of the program. Foster parents were asked about successes, how the provided training helped or did not help them foster the youth in their home, what things the staff did that were found to be helpful and what could be done differently to make the program better? All qualitative interviews were audio recorded and professionally transcribed. Content analysis, based on straightforward analytic questions, was the qualitative analytic approach. This approach examines language content and intensity in a subjective interpretation of classifications, themes and patterns.
Population	Older youth with high psychiatric needs from residential out of home care programs
Study dates	Not reported
Sources of funding	U.S. National Institutes of Health
Inclusion Criteria	Age 16 to 18 years old Care Situation Were in state child welfare custody and served by a private agency, and were residing at a residential facility Time in care had been in the foster care system for at least 9 months Mental health Had IQ of 70 or greater but had been hospitalized for psychiatric illness in the past year or were receiving psychotropic medications;
Exclusion criteria	None reported

Sample characteristics	Sample size 7 participants were recieved treatment foster care for older youth and 7 were assigned to care as usual Mental health problems History of psychiatric hospitalisation 86% in the TFC group and 100% in the CAU group; psychotropic medication at first interview was 100% in both groups Gender 71% had female gender in both groups Age age at first interview in treatment foster care group 17.19 ± years, in treatment as usual group 17.25 ± 0.93 years Exploitation or maltreatment Physical abuse history 57% in TFC group and 57% in CAU group; physical neglect history 29% in TFC group and 14% in CAU group; sexual abuse history 86% in the TFC group and 29% in the CAU group
Relevant themes	Theme 1 How would foster parents and staff tolerate the intervention? - second feasibility worry was that the TFC-OY intervention would be difficult for foster parents to tolerate. This was confirmed. In addition, some staff found the work stressful. In weekly meetings and in the qualitative research interviews, foster parents reported that the youth were extremely difficult to parent. Despite training that focused on the needs of youth with psychiatric problems, the foster parents reported being surprised by the amount of emotional volatility in the young people they served, the low levels of what they perceived as emotional maturity, and high needs for monitoring and supervision. The following quote from a foster parent is exemplary. “It is challenging every day because I just have to pay attention to her moods more. The hardest thing is that I have to monitor her so closely and I have to watch what I say.” No parent or youth described an extended period of time when life settled into a comfortable routine. It always felt like stressful work to the foster parents. The experience was not easy for the TFC-OY staff either. One Life Coach was surprised by the low level of emotional functioning of youth in an office setting. "It seems like all at once, the kids started being very chaotic and disrupting things all over the place, and everyone was coming into my office, all in a row. Boom, boom, boom. And it was just chaos, chaos, chaos, chaos. Crisis. Running away from appointments. Breaking things. And it was for a month straight.” Theme 2 What would stakeholders think of the innovations in the treatment foster care model? - The skills coach component was uniformly appreciated by foster parents, the program supervisor and the youth. When asked about the skills coach component, the youth tended to report things the coach had done for and with them that were related to positive youth development. "She took me outside and she helped me find a job. She took me out to eat. She helped me get my driver’s license. She helped me get my permit. Helped me with my homework. She helped me learn how to make a grocery list, pay bills, audit. She helped me with a lot of things.” Multiple stakeholders commented on the positive relationships that youth developed with their skills coaches, as exemplified in this quote from a staff member. "They’ve been able to build a relationship with the kids that doesn’t have any strings attached. The kids look at them as somebody who’s on their side and doesn’t want anything from them.” Theme 3 What would stakeholders think of the innovations in the treatment foster care model? - A second component that drew positive comments from stakeholders was that of the psychiatric nurse. Care managers appreciated the medication and diagnostic review provided by the nurse. They provided numerous examples of how they used this review and knowledge in their interactions with mental health providers. While some youth did not understand why they were receiving psychoeducation about their mental health problems from a nurse, others greatly appreciated it, explaining that it changed how they monitored their symptoms and how they approached their psychiatric providers. Theme 4 What would stakeholders think of the innovations in the treatment foster care model? - The role of the life coach was a difficult one to execute. Initially, the role was focused on interpersonal skills the youth needed to succeed in the foster home, but was later supposed to involve life planning and psychoeducation. Two life coaches worked in the program and both found their role frustrating. "To talk with them about school and work and STDs and their grief issues and their placement issues and what they did in school and their upcoming court hearing….you can’t do all that so it was…at times it was a little overwhelming to try to basically do what I thought I was being asked to do.”

	Theme 5 What would stakeholders think of the innovations in the treatment foster care model? - The family consultant role was less well received. The family consultant made many unsuccessful efforts to re-engage biological relatives and other nominated individuals into the lives of youth in TFC-OY and executed one successful effort, involving an older sibling. The role was also expensive (using a master's level mental health professional). In the end, the principal investigator concluded that the family consultant role would be eliminated going forward and that needed family work would be conducted by the program supervisor. **Theme 6** Qualitatively, did stakeholders think there were clinical successes? - Stakeholders perceived qualified clinical successes. One example quote is from a caseworker who thought that the youth's participation was beneficial even though her stay in an initial foster home placement lasted only a few months. ""I think what was most helpful for her out of the experience was just knowing that she could be in a home, and that she realized that she had more control over her behavior than she thought she did. She'd say, 'You know, I'm crazy, I can't live in a foster home.' That kind of stuff. And so I think her being in that foster home, even though it was four months, she was like no other time I've seen her." Another qualified success was described by this foster parent, who saw substantial improvements in functioning in a youth she served. "She improved so much in her attitude toward others. It doesn't mean that she was without problems at the end, but it did mean that she seemed to start to get it. And that is the type of thing you feel really good about" **Theme 7** Were program changes needed? - Since it was decided that it was permissible to alter the intervention mid-pilot in order to have an intervention worthy of testing at the end of pilot period, two modifications to the protocols were made several months into the intervention: 1) redefined roles for team members; and 2) efforts to address emotional dysregulation. Some of the life coach's responsibilities were offloaded to other team members. The skills coaches became responsible for helping youth plan for more independent living and the psychiatric nurse became responsible for providing psychoeducation about mental health problems. These modifications were considered successful, as viewed by stakeholders in qualitative interviews at the end of the project. Most glaring was the need to develop intervention components to address youth emotion regulation problems. Six of the foster parents interviewed qualitatively reported that the young people served in their homes experienced severe emotional outbursts; typically youth were seen as quick to become emotional and remaining emotionally volatile for substantial periods of time. In their qualitative interviews, foster parents used words like "fuming mad," "raging mad," "explosive," "just rage," "outbursts," "out of control," and "blowing up." This was seen and reported by program staff as well. These are the words of one of the life coaches who phrased the problem as one related to borderline personality issues and the possibility of incorporating components from a treatment for borderline personality disorder, Dialectical Behavior Therapy or DBT, known for addressing emotion regulation problems "If they have Axis Two with Cluster B stuff going on, I don't think that the families are prepared for what kind of emotions that can bring up… So I don't know if there needs to be some sort of training for the foster parents, training to know how to handle that. Have the foster parents go through some sort of DBT training themselves? So that they're at least speaking the same language to remind them to use their skills." During the last six months of the pilot, TFC-OY staff explored the potential of using processes and materials from DBT in TFC-OY to address youth emotion regulation problems. Staff received initial DBT training from a certified trainer and a DBT skills group was mounted with the foster youth to teach interpersonal effectiveness and mindfulness skills. The groups were well received by youth who attended them, but attendance was a problem, mostly due to logistics, such as distance from youth placements to the group site, work schedules, and transportation issues. By the end of the pilot, the intervention team concluded that any future trials or implementation of TFC-OY should be delayed until new intervention components were developed to address emotion regulation problems.

Study arms

Treatment Foster Care for older youth (N = 7) Several features from the MTFC model were retained with modest adaptation. 1) The program supervisor ran the weekly team and foster parent meetings and was responsible for communication within the team and with the young person's family support team and agency case manager. This person was available via phone to foster parents on nights and weekends. 2) Foster parents met weekly with each other and the program supervisor to identify problem behaviors to target and develop strategies to be used in the home to address these concerns. Each role was specified in detailed manuals. Guiding philosophies were: to serve youth in families and communities, provide positive developmental opportunities, foster

connections, encourage and enrich vital skills, limit access to negative peers, involve young people, have fun, individualize services, communicate among parties, recognize young people when they do well, plan-fully prevent problems, and help young people understand their mental health issues. Additions to the MTFC system included: A role for a psychiatric nurse was to assist in clarifying mental health diagnostic status and medications and to facilitate continuity of mental health care as youth transitioned into treatment foster care and across foster care homes. A family consultant role was designed to build community supports for youth to live more independently. The role of a master's level life coach was created (in lieu of a therapist) to assist youth in the transition to the foster home and in preparation for their next steps in the community. A new point and privilege system was developed for use in the foster home, with three phases designed to wean youth off of daily behavioral management charting. In the first phase, daily privileges were earned from the prior day's point total, with the young person's behavior rated by foster parents in ten areas (each worth ten points). Behavior, points and privileges were reviewed with the young person each evening. In the second phase, the points were eliminated, with privileges for the next day determined after an evening review of the ten domains (with no points assigned). In the third phase, a more general daily review between youth and foster parent was encouraged, but privileges were not determined on a daily basis. Skills coaches (different from life coaches) who worked with youth outside the foster home at least weekly, focused on independent living skill acquisition and healthy activities in the community. A 16-h TFC-OY foster parent training was created and manualized that emphasized description of the young people foster parents would be asked to work with, an overview of the program, noticing problem and cooperative behaviors, encouraging youth, the point system, teaching independent living skills, and creating opportunities for youth. Youth retained their private agency case manager and their family support team. The family support team in this context was a group of adults (and the youth) who were consulted on case decisions at least once monthly including on placement decisions and treatment directions.

Risk of Bias

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes

Section	Question	Answer
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes *(Setting not justified, saturation of data not discussed.)*
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Can't tell
Ethical Issues	Have ethical issues been taken into consideration?	Can't tell
Data analysis	Was the data analysis sufficiently rigorous?	Can't tell *(Unclear that researchers took into account contradictory data. Method of coding not made explicit.Unclear that researchers critically examine their own role, potential bias and influence during analysis and selection of data for presentation)*
Findings	Is there a clear statement of findings?	Yes *(More than one analyst was used during analysis)*
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and directness	Overall risk of bias	Moderate
	Directness	Partially applicable *(USA-based study)*

Lee 2020

Study Characteristics

Study type	Semi structured interviews Evaluation of an intervention Treatment foster care
Aim of study	the study explored the following questions: (1) What do TFC parents need to know? and (2) What are the best practices for training and supporting them?
Study location	USA
Study setting	A project in the USA focused on building collaborative relationships between mental health therapists and child welfare workers.
Study methods	Semi structured interviews. The semi-structured interview protocol was focused on the current landscape of TFC practice, the competencies needed by TFC parents, and innovations or best practices in providing training to TFC parents. The interviews were intended to build a broad understanding of the current state of TFC practice as well as the “what” and “how “of equipping TFC parents. Recognizing that TFC practice nationally encompasses a range from highly structured manualized programs to more home-grown efforts, authors wanted to identify the essential elements of TFC parenting practice and how these are mastered through training and supports. The semi-structured interview protocol asked experts to describe what TFC parents needed to be successful and what training or supports should be provided to them. Two members of the research team (both with child welfare practice and research experience) independently read through the notes from each interview to identify comments from the experts that were relevant to the study’s research questions: what TFC parents need to know and how they can be best prepared and supported. The comments that both coders independently agreed were relevant to the research questions were then re-read and labelled with initial themes. Thematic analysis was performed by two researchers. Respondent validation was performed.
Population	University based researchers and Treatment Foster Care Practitioners.

Study dates	Not reported
Sources of funding	National Center for Evidence-Based Practice in Child Welfare
Inclusion Criteria	Involvement in an intervention Participants represented varied content expertise that was relevant to the study i.e. practitioners and developers of treatment foster care.
Exclusion criteria	None reported
Sample characteristics	Sample size Across the 23 participants, 11 had significant practice and administrative experience in TFC, with an average of over 20 years of experience in child welfare, and treatment foster care specifically. Seven of the experts were university-based researchers who have published studies on TFC or developed TFC models that have been empirically tested. Of the 7, six were full professors or serving at the top rank at their institution. Finally, five of the experts were primarily knowledgeable about best practices in training and knowledge transfer in child welfare. They worked in child welfare training settings or otherwise have significant experience in designing, delivering, and evaluating training content.
Relevant themes	Theme 1 Parent vs. Treatment Provider - Several experts commented on the challenges TFC parents face in balancing their role as a caregiver with the expectation to be a professional. As one expert described, "TFC foster parents must be able to walk the line of being a treatment professional and being a caregiver: connect to kids in a positive way but also follow a treatment plan and implement good interventions." In treatment foster care, the experts emphasized how the TFC parent is responsible for creating an environment that provides a therapeutic experience for youth. Although the TFC parent may not have a clinical education or license, several experts expressed that "TFC parents are the ones who create the change." Youth in a treatment foster care placement may also be receiving therapy outside the home, but "the foster family is the agent of treatment, not therapy from the outside." The home setting itself is intended to be transformative. "TFC foster parents as the therapeutic component should be seen as 'the key' action in the model. The therapists are important, but the foster parents are the key with their day-to-day interaction that is of optimal importance." Although many TFC parents have experience and competence with parenting, this is no guarantee that they will be effective as a TFC parent. "It's a different relationship and different skill set than parenting your own children," expressed one expert. Because of the professional expectations, the TFC parenting role requires more than just parenting expertise. This includes being "…willing to take supervision– not just insist on doing things the way they did with their own kids." This tension between being a caregiver and being a treatment provider is not just about different competencies but also about embracing this expanded role. One expert implored that "if foster parents saw themselves in the role of being helpers, that would be really good." TFC parents are caregivers, but must have the skills and mindset to be more than just caregivers. Theme 2

	Parent Expertise vs. Worker Expertise - As TFC parents are empowered to have larger roles as experts of the youth in their home, they may struggle to collaborate effectively with their TFC social worker. One of the workforce dynamics commonly found in TFC agencies is that TFC parents may have more life and parenting experience while TFC social workers may have more formal training and education in treatment approaches. As one expert described, "Workers who have less experience than the foster parent is an issue because they are often young and they have no information and no history of the foster child." Another stated, "Staff don't have the skill or background, which is frustrating for the foster parents. TFC social workers really can't help them… and then TFC parents don't get the help they need." The different types of expertise is not just a problem for the TFC parents. For TFC social workers, playing a supervisory or coaching role with experienced TFC parents can be intimidating. As one expert described, "Sometimes the least experienced staff are doing the most challenging role: overseeing someone older with more life and parenting experience. There are a lot of barriers there." This tension may inhibit the social worker from providing validation to the TFC parent's role as a treatment provider. To manage this tension, the experts offered several ideas. Operating from the perspective of a strengths-based partnership was one suggestion: "How can you look at strengths of a worker and strengths of the TFC family and how you can partner together?" Recognizing that each type of expertise can have value and contribute towards the family's success is key. For example, when managing bureaucracy within the system, "social workers know to climb the ladder, but parents often do not." Similar to how the TFC parenting role needs to be understood as more than just parenting, TFC social workers may benefit from recognizing the expertise they can offer. As one expert suggested, "You have to emphasize this is a professional role so building up and empowering workers to be seen as experts. Having the structure of in-home observation and home visits make it more of a professional encounter and may communicate that the worker has credibility." These tensions illustrate the complexity of treatment foster care. Attempting to reverse the traditional top-down power structure of service delivery can create friction for TFC parents as they navigate their dual role as caregivers and interventionists and for social workers that are tasked with empowering these parents while also demonstrating their own value. Theme 3 Treatment Team Membership - By nature of their role, TFC parents will interact with a number of professionals who are also involved in the life of their child. As such, it is essential that TFC parents are "able to be a team member and see themselves as part of a team." One expert described these team skills as being able to "work closely with the caseworker, open to invasiveness with the caseworker coming to your home and having expectations of you; partnership with clinical interventionists, school systems, and court appointed advocates, and developing relationships with this person as well. Also partnering with the community to support the youth's religious and ethnic identity, keeping the child engaged in whatever community the child is used to." These diverse and multiple connections are important for the youth and the TFC parent has primary responsibility in maintaining them. One expert emphasized the central importance of the TFC parent with their social worker. "If there is a good working relationship [between the TFC parent and their social worker], then they will work better…. If it is one of mutual respect, they will work well together. They need to be respectful of each other's experience and prior roles as we inch them closer to doing something different." Working together with their treatment team are essential skills for TFC parents to be successful. Theme 4 Advocacy - As experts on the TFC child in their home, parents need to be able to advocate on behalf of the child. One TFC expert described this as "TFC parents should be the voice for the youth." This means not being afraid to speak up for the child in an active way. "Foster parents need to be assertive when working with professionals within various systems because they are the child's primary advocate; TFC parents know the child more than anyone. Because they know the child better than anyone else, they can talk about what that child needs and is experiencing." The TFC experts noted advocacy may occur in various settings, including education, medical, and behavioral health services. Theme 5 Systems Knowledge - Treatment foster care services span both the child welfare system and the behavioral health system, each of which are complex organizations that TFC parents need to know how to navigate. As one expert explained, "Understanding the system is really important…. It would be really helpful for caregivers to know the system in their state, how things are funded, and what each system's role is to the child." This includes knowing "how do you get access to services? What if you don't think the services are helping? What else is out there?" One expert also mentioned knowing how to communicate within these systems: "Being able to speak clearly and rationally, not emotionally and understanding the language of those systems." Equipping TFC parents with knowledge about how these systems work can prepare them for their complex role. Theme 6 Managing Challenging Behaviours - Parenting youth with emotional and behavioural issues requires specialized skills. The experts noted that TFC parents should have the capacity to identify when a youth may require clinical care: "recognize mental health problems, especially if that child needs a referral. Foster children benefit if the TFC parent has a basic awareness of when a kid is having a behavioural or mental health problem." Understanding the child's behaviour through a trauma lens is important. "Knowing about adverse childhood experiences and how trauma can affect long-term health, but that you can intervene and that reinforces the need for mental health services. This helps parents better understand and cope with some of the behaviours." In addition to insight about the purpose behind the child's behaviour, TFC parents benefit from understanding how their own reactions may be a factor in the child's behaviour. One expert noted that "as a TFC parent, a common occurrence is getting your buttons pushed (foster parents reacting to kids instead of being proactive and stepping back,

	walking away and gaining control). … If foster parents can learn how to not react in the moment, how to take care of themselves and how to model that for our kids, that's huge." As these quotes illustrate, behaviour management competency requires knowledge and insight as much as techniques and strategies. Theme 7 Experiential Training - Universally, the experts encouraged hands-on learning opportunities during training for TFC parents. One of the experts explained, "A lot of families are not oriented to academic learning. It's great to give foundational information, but it has to be operationalized." One TFC expert recommended to "do a lot of experiential pieces in the training: practicing and role play. Keep it very behavioural." Another expert suggested, "giving them a skill, having them practice in class, and then work with the kids at home." As summarized by one expert: "the more interactive, the better." Theme 8 Ongoing Skill Building - The experts seemed to agree that a single training event without follow-up would have little impact. As one expert noted, "Follow-up to training is what is most important. Once a parent has a child in their home they utilize the training and tailor it to the child they are working with. Training is only as good as the follow-up and support." This ongoing skill building could be in the form of a coach that could provide follow-up consultation and refining of skill development. One expert suggested that the "Biggest support (to provide TFC parents) is coaching… This is more important than the training… Coaches who they can call in the moment could be really helpful." Another expert reinforced this sentiment by concluding that "ongoing coaching is what really changes practice." Theme 9 Peer Support - The experts emphasized the value of engaging other TFC parents in training and supporting TFC parents who are newer to the role or struggling. As one expert and TFC provider noted, "We used to have all training done by professionals. Now, we have parent trainers. This has been an incredible piece of our success. Parent voice to other parents is so important." Learning from other parents was viewed as both credible and encouraging for TFC parents. As one expert explained: "There is a lot of learning that happens in peer-to-peer interaction. It's important to know the things you are experiencing are similar for other people. Peer interaction offers support, normalization, and behavioural strategies to figure out how to be positive with the kid most of the time." The benefits were attributed to not just the recipient, but also for the experienced TFC parent who is able to exercise this leadership and service. "TFC parents are willing to be mentors and it's a real validation to them and a way they can share their competencies."

Risk of Bias

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	Yes
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Yes
Data collection	Was the data collected in a way that addressed the research issue?	Yes *(However, no discussion of setting or data saturation)*

Section	Question	Answer
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Can't tell
Ethical Issues	Have ethical issues been taken into consideration?	Yes
Data analysis	Was the data analysis sufficiently rigorous?	Yes
Findings	Is there a clear statement of findings?	Yes
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and directness	Overall risk of bias	Low
	Directness	Partially applicable *(non-UK based study)*

Tullberg 2019

Study Characteristics

Study type	Focus Groups
Aim of study	To explore different aspects of the experiences of TFC parents, identify multiple ways in which they need support, and provide recommendations for foster care agencies looking to retain skilled foster parents and increase the quality and stability of children's experience in TFC programs.
Study location	USA
Study setting	New York City Atlas Project TFC programs

Study methods	Each foster care program assisted in the recruitment of participants through dissemination of flyers and provided facility space in which to host each group. Focus groups were loosely guided by a semi-structured protocol designed to elicit feedback from participants in three broad topic areas: (1) relationships and communication with foster care agency staff; (2) tools and training; and (3) mental health services and clinical care. Groups were moderated by an experienced independent qualitative data consultant and facilitated by the Atlas Project's Project Coordinator, an ACS employee, who also served as note-taker. All groups were audio recorded and each group lasted approximately 90 minutes. Data were analysed using thematic analysis. This method of analysis was chosen because it provides a flexible and useful research tool, free of theoretical constraints, that lends itself well to working within participatory research paradigms. To ensure rigor, two authors independently reviewed content and reached agreement via discussion on the major themes.
Population	Treatment Foster Carers
Study dates	Not reported
Sources of funding	The Atlas Project was funded by the Administration for Children, Youth and Families and Substance and Mental Health Services Administration.
Inclusion Criteria	Carer situation TFC foster parents at each of the six participating New York City Atlas Project TFC programs
Exclusion criteria	None reported
Sample characteristics	Sample size 75 treatment foster carers Carer characteristics Experience ranged from new to 28 years
Relevant themes	Theme 1 Teamwork - TFC foster parents asserted that 'teamwork' with foster agency staff and other service providers was the key to working most effectively on behalf of the children in their care. Participants acknowledged their role as a TFC foster care parent as a "challenging" one that required an enhanced set of skills. Said one participant, "you have a lot of regular foster parents that are not equipped to meet that need so that's why [the children] are being pushed up to therapeutic … cause not all foster parents can handle that situation." Given the challenges of providing care to children in treatment foster care, TFC foster parents across groups repeatedly emphasized the importance of developing strong care teams founded on relationships built of mutual respect and characterized by consistent, clear communication. Participants who expressed satisfaction with their care team were positive about their roles. They felt included in decision-making around their child and were routinely kept abreast of important information: "The worker and the sociotherapist [work together] so I won't be bombarded with different people at my house every day. Try to come at the same time. We have a good relationship. They come, they laugh, sometimes they spend more time than they are supposed to, cause we're joking around. Then we get down to the point. We write down everything, makes sure everyone understands, including the child. [She] writes down everything that is expected of the child [and everyone gets a copy]." 'Good' caseworkers embraced TFC foster parents as part of the team and valued "work[ing] together." Participants even expressed the desire to train with

	caseworkers "… at the same time, so we know how to confront and we know how to handle the problem as a team, not as an individual." Describing the process, one parent said "It take[s] a village to raise a child … you know when people's hearts are really in it and there are people whose hearts are not in it. It's all of us [not just the foster parents]. Cause we [staff and TFC foster parents] supposed to do this together." The importance of respect, engagement, and clear communication was also evident in TFC foster parents' relationships with clinicians, and their belief in the efficacy in mental health treatment overall. Participants satisfied with their child's mental health care routinely referenced the benefit of therapy for their children: [The therapist] documents everything, they have a good relationship, they open up to [their therapist] and everything. Good communication. What works is the therapist and me sit down going over all the behaviours and bring that child into the conversation afterwards and then putting down consequences, so the therapist is aware of what's going on so that they can talk to them using a bird's eye view. They can then explain consequences that come as a result of behaviour – as agreed on by therapist, foster parent, and child. So we're on the same page. Conversely, participants who described poor relationships with foster care staff and mental health professionals cited poor communication, illuminated by behaviours such as last-minute cancellations of visits or meetings, and ignored messages and calls. They perceived information as being guarded, as opposed to shared, and felt left out of decision-making around their child. These participants also described feeling a lack of respect from staff and/or clinicians who privileged academic "knowledge" over "the experience that counts, the practice that counts." At times, TFC foster parents even feared retaliation if they expressed concerns about situations in the home or about their relationships with staff: When you [talk to] the supervisor or the social worker on the phone, you have to be careful about what you say. Because sometimes they will take what you say and turn it around [agreements from members of group] and basically start 'blackballing' you. Cumulatively, experiences such as these left these participants feeling frustrated, unsupported and, at times, unsure how to handle difficult situations. They did not feel a part of a team, but on their own, including during times when children's behaviour was escalating: I mean I've seen the worker ease out. They see the kid ready to go off, and they like they forgot their water bottle. See you later. If you need any help … they are walking out the door. One participant with many years of experience as a therapeutic foster parent believed that the only way to ensure successfully, mutually respectful relationships between team members was when that expectation came from the agency's leadership: "I think the agency is changing because it is under new regime … in retrospect there was a culture of foster parents and case workers, times have changed so drastically. And I felt that they felt they were more educated than the average foster parent so there was a condescending arrogance that permeated their status so subsequently there was friction … you know they didn't respect the foster parents, they didn't respect the fact that we were carrying the weight, the entire weight, and without us they wouldn't have a job, if truth be told. So when I came here and the current person came on board, he's trying to somewhat mend the fences … because he understands that past culture, he's trying to mend the fences between the foster parents and the case planners … he wants them to recognize that they're not the be all and end all [several members of the group murmur agreement], that we hold a very important part in this picture and that they have to respect us whether they like it or not and I think a lot of it came from the fact that they were overworked … a lot of cases was thrown on them … they were dumped on, so we were the ones that they dumped on, but that is coming to an end." **Theme 2** Support - Focus group participants desired various aspects of support they sought from both their foster care agencies and their peers. Perhaps surprisingly, support was not seen as a one-way street; participants also felt that, given their extensive experience working with children with complex needs, they were in the position to, and wanted to, support their caseworkers for the benefit of the children in their care. - Support from the agency - Participants across groups repeatedly discussed the importance of agency support in their ability to maintain children in their home and their overall feelings of satisfaction with their role. TFC foster parents described several ways their agencies demonstrated support (or the lack of it). Agencies provided professional support by giving TFC foster parents information about their child prior to placement, helping TFC foster parents obtain services for children in their home, and providing TFC foster parents with specialized training that addressed the more complex clinical needs of children in TFC programs. Agencies could also provide emotional support, via their staff members, when there was conflict with a child in their care. **Theme 3** Providing information on children prior to placement - Across the focus groups, many participants raised concerns about not having information about new children prior to placement. This was a particular problem for TFC foster parents due to the complex nature of many of their children's histories. Groups were replete with participants' experiences of taking placements without information about the behavioural, emotional, or medical health needs of children: "When I got my child, they did not tell me the severity of her. I had to find out by me asking questions. I got her straight from [the hospital]. And I went to [the hospital] a couple time to visit her to make sure we was a match and I had to ask the doctors what's her diagnosis, what's her problem? And she's 6 years old, suicidal, tried to stab the teacher – what if she feels that way around my daughter? So I had to think and build her trust and build my trust, but I learned this from me dealing with her. Sometimes when a child is coming from [the agency] … they don't come with no information for the child … one situation we was going on a trip and the child was pregnant and we didn't know nothing about it … we was going to water rides and we didn't know nothing." "A child had medication in their hand and we didn't know nothing about it … a meeting happened a week later … that she supposed to be on medication … nobody never told us that the child supposed to be on medication." TFC foster parents described the challenges of balancing the needs of their overall household with the needs of children in their care, especially those with dangerous, threatening, and/or other disruptive behaviours. Some suggested foster agencies deliberately withheld initial information to make a placement appear to be a good fit. In one exchange between participants, one advised another against accepting placements without "paper": Then don't accept that child, 'cause you know that child has much more problems than that. Don't do it. It sounds so beautiful— I say – give me the real deal on this child. They say 'okay well this child starts fires and has bedbugs' – I say heck to the no, are you serious? No, absolutely not. At times, these 'partial truths' led to disruptions in placement and frustration on the part of TFC foster parents when team meetings only occurred after the fact, when they wanted a child removed from

	their home: "They don't tell you all the story, you find out from the child little by little what's going on … then when you want to have that child removed from your home … they tell you, you have to have a meeting with ACS … I said to the worker, I didn't have a meeting with ACS when you brought him to my home so why should I have a meeting with ACS to remove them from my home?" Theme 4 Obtaining services and resources on behalf of children - Some TFC foster parents, especially those who were new to therapeutic care, did not feel that they were being given the resources that they needed by the agency in their new, more challenging roles. Said one participant; "Since I've been in the therapeutic division, there's been no support; little to no support." Another said, "I don't have the help I was told I was gonna get." Half of them [caseworkers] don't even know how to get kids the services they need … this is serious if you have a kid that needs special care the caseworkers doesn't even know how to service the child and then you have to do the homework for the caseworker and then they disagree with you and they are making the wrong decisions. …" Theme 5 Providing access to specialized training and professional development. - TFC programs also demonstrated support by providing specialized training and professional development. "Training … even as a therapeutic foster parent … it's an ongoing thing. We're still learning. It's a process for us, it's a process for our case planners … we deal with children with a lot of different diagnoses." The value of trainings was enhanced when knowledge and skills were reinforced within the care team, for example, during weekly visits from the child's in-home caseworker. One parent noted the reason she was able to work with the children she did was because the agency provided "a lot of training" and they made it easy for parents to access "if you can't come to the agency, you can do it online." In some groups, participants brainstormed about types of training they wished they had to better address the special needs of their children – they bounced ideas off their group-mates and discussed issues of concern – one parent suggested training around issues related to child development, such as sexual health, and the safe and appropriate way to handle these types of discussions with TFC children. One participant commented "it can be uncomfortable…for me…I need training for how to [talk about these issues]." Another brought up hygiene. "How do you tell them to clean themselves properly? You can't sit there with them, you can't be there alone in the bathroom with them … I feel like they should have a class for the kids where they can go over [this] … if it's your own child, you can show them how to wash themselves so when they are of age, they can do it themselves." With these children, "it's difficult cause it's what they learned, and you don't know exactly what they were instructed." Another agreed: "you'd expect them to know that – but [for some] how would they know?" Other suggested topics included trainings for diagnoses like autism, health conditions in teens, like diabetes and sexually transmitted infections. Those who did not believe their agencies provided enough specialized training were willing to obtain it from other sources; one participant said that "in terms of certifications and trainings, I go outside to ACS," while another said "I'll go on the internet and find my own classes." Theme 6 Emotional support during conflict - In most of the groups, TFC foster parents described situations in which they felt staff members did not support them when there was conflict with a child in their care; at times staff were described as siding with the child during such conflicts, and at other times they were described as being absent and unsupportive: "We should sit down and speak with the child … I've found that some of these workers are afraid, they want to agree with the child [general agreement murmured in the group, "want to be their friend"] … you're creating friction." "The worker gets to be friendly with the kids and they don't care about what you going through … cause they only see the kid for 10 minutes, 15 minutes, an hour at most … we have the kid all day … when they see the kid, the kid telling them this and that, that's not true – that is not true. [Another participant comments "There's two sides to the story."] But they don't care what you say … they just try to tell you lean more this way, lean more that way but it's really hard when these kids, these teenagers, I have teenagers, are out of control, they want to do it their way, they want to set the rules in your house, and you have to do what [the teenagers] say." "When I first came to the agency, I was new at foster care period… The older workers, the ones that been here for years … they know how to play, how to write the notes, to say that they've been to your house when they haven't been… so they was telling me they didn't have to come as long as [the behaviour specialist] was coming, they didn't have to come and we ran into a lot of friction because a lot of stuff was going wrong in the home and I didn't know what to do because I was new to it … I was talking to the behaviour specialist at the time, she really helped me and got me through it … really guided me through the process and once I learned you know I was like, 'oh no, you can't do that,' because they used to threaten me 'oh I'm gonna close your house, you can't do this, and you supposed to do this,' and I'm like, 'what did I do? I didn't do nothing wrong' … and some of those people are gone because of what they were doing, it finally caught up with them, but I really had a rough time." TFC foster parents who felt supported by their agency during periods of conflict described the things their agency did to make it easier for them to maintain difficult placements. One TFC foster parent said her agency did "everything" from setting up needed appointments with therapists "right away for the child" to picking up things at school. She reflected: "I feel like they are there for me … it's really important because sometimes you feel overwhelming … some kids, you feel like, 'what am I going to do?' – but you have phone numbers for everything." Theme 7 Peer support - The ability to connect with their peers was something many participants considered integral to meeting their needs for camaraderie and support: "as foster parents we should all be together, we need to bond somewhere." One parent angrily decried the idea of support from the agency (to applause from her group-mates) and emphasized the importance of peer

	support: "What assistance (referring to the agency)? We think we gonna come in here and lash out our feelings. Cause this is all we have …this is our support, right here." Participants wanted their agencies to provide them with social and emotional support in a safe place, where they could talk openly with other TFC foster parents about their feelings and discuss challenging issues they believed their agency could not—or would not—want to address: "When we're under investigation by ACS [for alleged maltreatment against a foster child] who do you reach out to? They (people at the agency) don't want to talk to us. It's your first time going through it, you don't know what's coming at you, I think that's the worst. Unless you know another foster parent going through the same thing, that's the only support you have. Some TFC foster parents suggested that this peer support should be provided in a more formal form—such as having an 'advocate' to provide them with an official voice within their agencies: "We do need a advocate … I don't think a worker's gonna be a advocate … I think it has to be a foster parent who knows exactly … what's going on, what we deal with because most of these workers don't have foster kids in their home. They have kids but they not foster kids." Another described reaching the point where she was ready to leave the agency, then finding the strength to talk to a "high-level staff person" at her agency, and telling that person: "I want you to consider this, for us, the foster parents, when you have a chance … want to tell you the frustration [we] feel … we have no support… we need the voice for foster parents, we need [an] advocate ... We need that person you go to and they address any concern or anything and they keep it, like you say, confidentiality, so things can go better …a lot of agencies DO have an advocate for foster parents." **Theme 8** Support of others - This theme of 'support' was not simply reflected in the direct needs of TFC foster parents themselves; in some cases participants also expressed empathy for caseworkers, many of whom are new to the field. A few parents believed through advocacy they could and should take on the challenge of addressing issues like worker burden. One parent described this by saying: "When we have new social workers … [the] problem come because there is not enough staff members … the staff is too weak, the caseload is too much for one person. Those social workers, they have to write up notes, they have to follow-up this, they have to make sure the dots are in place. This is a job…if you have a social worker and the social worker have 13 kids to look after, this is a lot. So, the caseload, we have to advocate for them to have a smaller caseload. Others described supporting new caseworkers as they transitioned into their roles: "I've had one or two caseworkers who I think were too wet behind the ears, you know, they weren't experienced enough, I think they should have been followed with someone, someone should have walked them through for the first two or three weeks, before they were sent out on their own, but when I realized that, I kind of step back and not really pressure them too much because we've all been in situations where we're new and we don't know what we're doing … have to give people that time to grow and to become familiar with their new territory." "The new ones, they need to learn. They not really trained with these children, so they have to learn … When the young social workers come, they learn from us … if they come high up here they won't learn. [Discusses specific caseworker:] If you see someone humble like [this caseworker], you extend yourself and they will learn and you will learn from them because there are things they know that we don't know. [It] doesn't matter that they cannot handle sometimes rough situations, but they know things that we don't know and we have to work together to make this work." **Theme 9** Transitions - Consistent across all groups were reports of frequent and, sometimes, destabilizing transitions in the form of staff turnover or staff changing positions within their agency. As a result, participants widely agreed that strategies for managing transitions should be included as part of staff and foster parent training, and that additional resources— both for children and for themselves—were needed during periods of change. **Theme 10** Need to prepare and assist children through transitions - Concerns about staff transitions focused primarily on the impact of transitions on the mental health of children; "every time you turn around they are changing caseworkers on them … and then they feel like they just tired of them." Participants emphasized the toll repeated transitions could take their children, but most said agencies did not prepare them adequately for changes: "[Describing the child's questions:] "Why would they change my therapist, I love her … Are you and poppa going to leave me too?" "It bothered him. He was like; 'This is my third worker in six months.' So it really, really done something to him. He was really close with this worker and I don't think it's fair for the children. Kids have to get used to a new worker all over again … get adjusted … and that kind of angers them too … different foster home, new caseworker … no stability … because of what they been through." More than one participant reported addressing transitions by telling their child to focus more on the stability of their (parent-child) relationship than the one with his/her caseworker: "Children get past that quickly, if we can get past it quickly … I teach my kids – 'the workers can come or go, you're with me' you have to rely on me, we have to have a bond. If we don't have a bond, no matter what the worker's telling you it won't work, because that worker will probably, eventually leave … so we have to be on the same page.' That's one of the ways I deal with the workers changing. Other participants, however, described frequent transitions leaving children feeling increasingly hostile, as the experience of system-related losses were left unaddressed: "I have this child and it took her a while to get an attachment to the worker and as soon as it happened, he left. Now there's a new worker and she like 'what?' She's aggressive towards the new worker because [in the child's words] 'she don't know me from a hole in the wall … she's judging me … ' [I] had to tell the worker to go back and read the file to learn more about the child and her issues and behavioural triggers ('she snaps real quick'). The child was upset. [She] had become attached to the other worker: 'I need him back, I need him here.' For the children, they get used to a caseworker, and the caseworker leaves. [Caseworkers are] overworked and underpaid… they will come to your house [late] for a visit and they are not getting paid overtime so eventually they're stressed out and they leave and it's not good for the children. They get used to that worker … I had a child that was really upset that her caseworker left. And when the new one came… she was really nasty towards the caseworker and the caseworker wasn't really great either – so the child

	kept saying 'well I'm not going to be home' so we never really had a visit. The kids, they're angry and I'm gonna tell you why they're angry. They see all these caseworkers comin' in and outta the house. Like it's ridiculous. The kids in my house have no respect for their workers. And when you listen to them you expect … what they're saying it make a lot of sense. You know how they talk to my worker? [Voicing one of her children]. 'What the f— are you doing here? At the end of the day – you here to get a degree? What you here for? You only going to be here for 5 minutes. Yo get the f— away from my door.' Explaining further, this participant said she asked the children about why they acted that way towards their caseworkers. "[Voicing her children:] 'They're in here and outta here to go to college. They don't care nothing about us.' My teenagers is real nasty and disrespectful to their workers, but I do see what they're talking about. But what can you do about it? Like it [is] true a lot of them do go to school and get their degrees." Theme 11 Need to prepare and assist foster parents through transitions - Children were not the only ones impacted by staff transitions. Several participants also commented on how adjusting to new workers affected them emotionally: "Never mind about the kids feeling abandoned. I feel abandoned, too … 'cause every time you get used to a worker … so they can work with you with the case, there is a new one coming in. And you have to tell them about the child. They coming in with all the degrees and think they know about the child because they know about therapeutic kids but it is impossible unless you are hands on." Staff transitions did not occur only as a result of people leaving the agency. The "great" caseworkers were often promoted to different positions within the agency: "I have three social workers that became supervisors here and it means a lot when you get social workers that becomes supervisors that means that person is doing their job well. Although TFC foster parents often voiced pride in their workers' achievements, there was also a tacit understanding that the best workers would likely not remain in their positions for long. As the net effect was still a 'loss' for the TFC foster parent and child, the term 'turnover' was used not only to refer to workers leaving the agency, but those who left caseworker positions as they advanced within the agency as well: "Had three different caseworkers. Two have now changed position and are supervisors. I just got a new worker and she's pretty good. So I just hope she sticks around, but the turnover is ridiculous. Even when workers stayed within an agency, it didn't mean smooth transitions: "My worker, he didn't let me know, until three days [before he left his position]. He did give me three days. … And I said 'what? I'm going through all this stuff with this girl and you're telling me three days?' But he's still in the agency, but he moved up to something else. That's what everybody is doing. They're tired of being these workers, they're moving up. Tired of going out in the field doing all that hard labor. They moving up." "She was a very good caseworker and I didn't know until a month after she left. I found out when I went someplace else and I seen her in the building." Theme 12 Need to prepare caseworkers following transitions - Though children experienced the brunt of the emotional costs of transitions, foster parents' accounts also shed light on the needs of the new caseworkers assigned to them once their former caseworker left. TFC foster parents described times during which caseworkers, even supervisors, were not properly prepared, often leaving them to fill in the gaps. At times, this was ascribed to staff not having (or taking) the time to familiarize themselves with the case history and the child's clinical needs, especially with respect to complex TFC cases, following a transition. For example, one TFC foster parent explained a situation in which both the caseworker and supervisor left prior to a case conference with ACS. Though this TFC foster parent and the previous worker documented the improvements the biological mother had made to regain custody of her children, these efforts fell through the cracks during the transition—with the new foster agency staff focusing solely on the negative things the biological mother had done. "It's a problem. You're [referring to the biological mother] trying to do better and improve yourself to get your child back. They try to throw her under the bus. I had to speak up for her." Although she felt uncomfortable involving herself in the discussion, this TFC foster parent felt she had to stop the meeting and inform the workers the progress the biological parent had made, including arranging for services for her children with special needs, in order to be reunited with them. "I believe the new workers [are] supposed to take time. Read. Do your homework." [others in the background say 'yeah'] "I ran the show that day … I mean, don't you have the paperwork there?" In addition, many participants described transitioning to caseworkers that were not only new to their case, but also new to the foster care system and without much training or preparation from the agency. "We have a lot of young social workers. They are very inexperienced. They are fresh out of college. Going to work, into the field. They have no idea how to approach [the issues]. The majority of these caseworkers are very young …They are making inexperienced decisions." These caseworkers were also seen as lacking familiarity with community supports and services for their children. As one participant described it, "this is serious … if you have a kid that needs special care, the caseworker doesn't even know how to service the child … you have to do the homework for the caseworker." Theme 13 Methods identified to ease transitions - Participants agreed that more structured, consistent communication and support was needed around caseworker transitions—for everyone involved. At the very least, participants wanted to be informed in advance of impending departures, and, if possible, given the opportunity to meet with both workers, to facilitate transitions: "They absolutely have to have a meeting with the foster parent and the new worker. If there is a new worker coming on your case, and you wasn't aware of it ... the first thing that should happen is you're asked to come into the office, meet the new worker, have the child with you, and could you please bring your dossier … your questions, your concerns [several participants agreeing] … you know this worker is new, you know they don't know your child so bring it – tell them what they can do to help the child be more comfortable, work it out…We have to be ready. We need to prepare ourselves, so we have those things. The [new] social worker that take the case they should read and talk to the psychiatrist, psychologist, therapist … have

	knowledge about what is going on. Most participants acknowledged that therapeutic foster care staff have difficult, demanding jobs ("overworked and underpaid"), but nevertheless stressed that taking the time to provide foster parents with a 'seat at the table' during transitions to new staff would be beneficial to everyone. Theme 14 Transitions between therapeutic and regular care - Although the issue of managing transitions between 'regular' and 'therapeutic' care was not identified during all of the foster groups, we include it here because of the NYC foster care system's shift to regarding TFC as a short-term intervention. Some TFC foster parents described working very hard with their children to stabilize behaviours, then seeing the child "downgraded" to regular foster care (which involved staying in the same foster home but receiving less intensive services and often less financial support). Participants in this situation felt unsupported in this transition, and noted that their child still had special needs that became more challenging to meet given the decrease in agency support: "I was in therapeutic and I like therapeutic better, to me. Cause its easier, you know what you're dealing with and that's what I started off with … but they put me into the regular because my child was doing so much better now they downgraded me … because she's doing so good, we gonna step you down, but the people that you have [working in regular foster care], they don't understand the therapeutic children." Foster parents felt 'regular' care staff were less knowledgeable and did not understand the needs of children and families previously in therapeutic care. Several foster parents also noted that children transitioning between levels of care would be assigned a different worker and supervisor, which created one more unnecessary and difficult disruption. These parents suggested the same workers continue with the child throughout care: "Maybe they need to be multi-trained so that they can stay with the same worker, because like the child I have … it made it difficult … jumping from person to person, that's not comfortable for her."

Study arms

Treatment Foster Care (N = 75)

Therapeutic foster care (TFC), also known as treatment foster care, is a specialized level of treatment for children in care that have significant emotional and behavioural needs.

Risk of Bias

Section	Question	Answer
Aims of the research	Was there a clear statement of the aims of the research?	No
Appropriateness of methodology	Is a qualitative methodology appropriate?	Yes
Research Design	Was the research design appropriate to address the aims of the research?	Yes

Section	Question	Answer
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Can't tell *(Appears to be a convenience sample, demographics of sample not clear, or why they were selected)*
Data collection	Was the data collected in a way that addressed the research issue?	Yes *(no discussion of saturation of data)*
Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Can't tell
Ethical Issues	Have ethical issues been taken into consideration?	Can't tell
Data analysis	Was the data analysis sufficiently rigorous?	Yes
Findings	Is there a clear statement of findings?	Yes *(two authors independently reviewed content and reached agreement via discussion on the major themes)*
Research value	How valuable is the research?	The research is valuable
Overall risk of bias and directness	Overall risk of bias	Moderate
	Directness	Partially applicable *(USA-based study)*

Appendix E – Forest plots

No forest plots were produced for this review question as meta-analysis was not attempted.

Appendix F – GRADE tables and CERQual tables

Grade tables

Parent Management Training Oregon (PMTO) vs Care as Usual (CAU)

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
Placement instability rate over 6-month observation: assessed using administrative data (annualised placement rate = (number of placements/days in foster care)*365))								
1 (Akin 2015)	Parallel RCT	121	**MD -0.30 (-0.60 to -0.00)**	Very Serious[1]	N/A	Serious[2]	Serious[3]	Very low
Number of placement breakdowns over 4-month follow up: unclear how assessed								
1 (Maaskant 2017)	Parallel RCT	88	OR 0.52 (0.09 to 3.06)	Very Serious[4]	N/A	Serious[5]	Very Serious[6]	Very low

1. Downgrade two levels due to very serious risk of bias. Subjects were aware of their assignment group prior to agreeing to study participation. Few baseline characteristics reported. Some differences but unclear if significant. 1:1 Randomisation resulted in considerably more in the intervention group. Unclear if there were deviations from assigned intervention, this is likely since more participants were assigned to the intervention group than control group despite 1:1 randomisation (in order to fill PMTO case load). Though missing data did occur, this study is not clear how much data was missing and proportion between groups. Low risk for placement stability that was determined using administration data. Information on conduct of trial was insufficient and there was no protocol cited.
2. Downgrade one level for serious indirectness since study was based in USA.
3. Downgrade one level for serious imprecision since estimate of effect crossed 1 line of MID (defined as 0.5*SD in the control group = 0.4).
4. Downgrade two levels due to very serious risk of bias. In the intervention arm, 5 participants dropped out because they wished for 'other kind of help'. There was also 'no need for help' in 7 instances. These reasons were not evident in the control arm. Also, the number of participants dropping out in the intervention arm was greater. The number of participants who dropped out in the intervention arm is relatively large (approximately 1/3). Foster parents from the control group were free to ask for more intensive or specialised support, including every available form of treatment or intervention except PMTO. It's not clear that participants in the intervention arm had this too. Investigators who collected data were not blinded.).

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
5. Downgrade one level for serious indirectness since study was based in Netherlands. 6. Downgrade two levels for very serious imprecision since estimate of effect crossed two lines of MID (defined as OR 0.8 and 1.25).								

Multi-dimensional Treatment Foster Care for preschoolers (MTFC-P) vs CAU

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
Time to placement disruption over 12 months: placement disruption defined as exiting the current placement for a negative reason e.g. removal deemed in the best interest of the child/requested by the caregiver (not including nonnegative reasons for placement disruptions e.g. changing circumstances in the home unrelated to child behaviour, clinical transitions, permanent foster placements, adoptions, and biological family reunifications- placement records from child welfare system)								
1 (Fisher 2011)	Parallel RCT	137	MD -0.63 (-1.85 to 0.59)	Not Serious	N/A	Serious[1]	Serious[2]	Low
Number of children who experienced placement disruption over 12 months: placement disruption assessed as above								
1 (Fisher 2011)	Parallel RCT	137	OR 0.53 (0.18 to 1.61)	Not Serious	N/A	Serious[1]	Very Serious[3]	Very Low
Number of placement disruptions over 12 months: placement disruption assessed as above								
1 (Fisher 2011)	Parallel RCT	137	MD 0.00 (-0.11 to 0.11)	Not Serious	N/A	Serious[1]	Not Serious	Moderate
1. Downgrade one level for serious indirectness since study was based in USA. 2. Downgrade 1 level for serious imprecision since confidence intervals crossed 1 line of MID (defined as 0.5*SD in the control group = 1.32) 3. Downgrade 2 levels for very serious imprecision since confidence intervals crossed 2 lines of MID (defined as 0.8 and 1.25 for odds ratios)								

Multi-dimensional Treatment Foster Care for adolescents (MTFC-A) vs CAU

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
Number of out-of-home placements at 1-year follow up: assessed using data from social case record (changes in out-of-home placement e.g., foster home or residential care)								
1 (Bergstrom 2016)	Parallel RCT	46	MD -0.10 (-0.54 to 0.34)	Very Serious[1]	N/A	Serious[2]	Serious[3]	Very low
Number of out-of-home placements at 3-years follow up: change in out-of-home placement assessed as above								
1 (Bergstrom 2016)	Parallel RCT	46	MD -0.30 (-1.64 to 1.04)	Very Serious[1]	N/A	Serious[2]	Serious[4]	Very low
Negative treatment exit at 1-year follow up: assessed using data from social case record (placement breakdown or exiting a minor treatment facility to enter a more secure one e.g. leaving foster care and entering institutional care)								
1 (Bergstrom 2016)	Parallel RCT	46	OR 0.24 (0.04 to 1.25)	Very Serious[1]	N/A	Serious[2]	Serious[5]	Very low
Negative treatment exit at 3-years follow up: negative treatment exit assessed as above								
1 (Bergstrom 2016)	Parallel RCT	46	OR 0.78 (0.24 to 2.56)	Very Serious[1]	N/A	Serious[2]	Very Serious[6]	Very low

1. Unclear if allocation concealment. the MTFC group had significantly more families with an immigrant background. Few baseline characteristics reported other than those on which randomisation was performed. No information provided about whether there were deviations from treatment, or whether intent-to-treat analysis was used. Unclear if missing outcome data, approach to missing outcome data and whether missing data varied between comparison groups. Unclear information about the conduct of trial and no protocol cited. Participants were juveniles at risk for immediate out-of-home placement (awaiting placement in out of home care). However, all but one participants (treatment/control group) were in out of home care during the course of the study.
2. Downgrade one level for serious indirectness since study was based in Sweden.
3. Downgrade one level for serious imprecision since confidence intervals crossed 1 line of MID (defined as 0.5*SD in the control group = 0.5)

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
4. Downgrade one level for serious imprecision since confidence intervals crossed 1 line of MID (defined as 0.5*SD in the control group = 1.2) 5. Downgrade 1 levels for serious imprecision since confidence intervals crossed one line of MID (defined as 0.8 and 1.25 for odds ratios) 6. Downgrade 2 levels for very serious imprecision since confidence intervals crossed 2 lines of MID (defined as 0.8 and 1.25 for odds ratios)								

Family Group Decision Making (FGDM) vs CAU

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
Mean number of placement moves over 5-year observation period: assessed using administrative records (mean number of placement moves)								
1 (Berzin 2008)	Parallel RCT	50	MD -0.01 (-0.84 to 0.82)	Very Serious[1]	N/A	Serious[2]	Very Serious[3]	Very low
1. Downgrade two levels for very serious risk of bias: No information with regards to the randomization method. No information with regards to the baseline characteristics comparisons for each arm of the 2 studies. Allocation concealment was not possible. 2. Downgrade one levels for serious indirectness since study was based in USA 3. Downgrade two levels for very serious imprecision since confidence intervals crossed two lines of MID (defined as 0.5*SD in the control group = 0.76)								

Middle School Success (MSS) vs CAU

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
Number of placement changes over 36 months: assessed using child welfare system record (any placement disruptions)								
1 (Kim 2011/Kim 2013)	Parallel RCT	100	MD -0.43 (-0.94 to 0.08)	Very Serious[1]	N/A	Serious[2]	Serious[3]	Very low

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality

1. Downgrade two levels for very serious risk of bias: unclear if allocation concealment; approximately 10% loss to follow up by 2 years; analysis of outcomes at various time points appeared to be decided post-hoc; results (apart from results for substance use and delinquency) appear to have been selected on the basis of results across multiple time points.
2. Downgrade one level for serious indirectness since study was based in USA.
3. Downgrade one level for serious imprecision since confidence intervals crossed 1 line of MID (defined as 0.5*SD in the control group = 0.6)

Family Finding Intervention (FFI) vs CAU

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
Number of placement breakdowns over 3 year observation period: placement disruptions assessed using case records and administrated data								
1 (Landsman 2014/Boel-studt 2017)	Parallel RCT	243	MD -0.08 (-0.67 to 0.51)	Very Serious[1]	N/A	Serious[2]	Not Serious	Very low

1. Downgrade 2 levels for very serious risk of bias: No details of the randomization method. There are slight differences in gender between the arms. No allocation concealment. No blinding. Although randomization was prospective, data collection was retrospective via records. Some of the outcomes are subjective.
2. USA-based study, mark down once for indirectness

CBT-informed Parent Training Programme (CBT-PTP) vs CAU

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
Number of unplanned placement breakdowns over 6 months: caregiver-reported number of unplanned breakdowns								

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
1 (Macdonald 2005)	Parallel RCT	89	OR 0.80 (0.19 to 3.42)	Very Serious[1]	N/A	Not Serious[2]	Very Serious[3]	Very low

1. Downgrade 2 levels for very serious risk of bias: Baseline characteristics not compared between study groups, however there were considerable differences between the numbers assigned to either group after randomisation (50 vs 67). No information was reported about adherence to the interventions or whether a per-protocol approach was used for analysis. >10% of missing data for placement breakdown outcome. Intervention group almost twice the missing data of the control group. Unclear reasons for missing data. Unclear research protocol in study, and no protocol cited.
2. UK-based
3. Downgrade 2 levels for very serious imprecision since confidence intervals crossed 2 lines of MID (defined as 0.8 and 1.25 for odds ratios)

Promoting First Relationships (PFR) vs Early Education Support (EES)

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
Placement stability at 2 years: assessed using child welfare administrative database (remained with the study caregiver with no temporary intermediate moves)								
1 (Pasalich 2016/Spieker 2014)	Parallel RCT	210	OR 1.19 (0.63 to 2.27)[1]	Very Serious[2]	N/A	Serious[3]	Very Serious[4]	Very low

1. Adjusted for foster/kin placement, age of child, months in child welfare, number of prior placements, multiple removals, foster carer commitment.
2. Downgrade 2 levels for very serious risk of bias: Unclear if allocation concealment. participants in PFR were more likely to have been removed from birthparents home more than once. Fidelity outcomes reported and appears to be modified intention to treat analysis. A significant proportion of attrition was as a result of change in caregiver which could be directly related to child outcomes. However, the proportion of attrition was similar between groups. Particularly large loss to follow up.
3. Downgrade 1 level for serious indirectness since study was based in USA
4. Downgrade 2 levels for very serious imprecision since confidence intervals crossed 2 lines of MID (defined as 0.8 and 1.25 for odds ratios)

KEEP foster parent training (KEEP) vs Training As Usual (TAU)

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
Negative exits from care over 6.5 months: foster-parent reported negative reasons for the child's exit from the home e.g. moved to another foster placement, a more restrictive placement, or child runaways								
1 (Price 2008)	Parallel RCT	700	OR 0.83 (0.54 to 1.29)[1]	Very Serious[2]	N/A	Serious[3]	Very Serious[4]	Very low
Number experiencing no change over 6.5 months: foster parent reported no change in placement								
1 (Price 2008)	Parallel RCT	700	OR 0.73 (0.52 to 1.03)[1]	Very Serious[2]	N/A	Serious[3]	Serious	Very low

1. Odds ratios were estimated from reported percentages for these outcomes (unclear amount of missing data)
2. Downgrade 2 levels for very serious risk of bias: unclear how randomisation was performed and whether allocation was concealed. Children in the intervention group were more likely to be Spanish-speaking than control group children, but no further differences were found between groups for age, type of care, gender, or ethnicity; Unclear if significant deviations between intervention groups. Of the 700 parents who completed the baseline interview, 81% (n = 564) provided data at termination. Comparisons of missing and non-missing cases on baseline measures showed a significant difference in foster parents' proportion positive reinforcement, t(696) = -2.95, p = .003; cases with missing data at termination were higher on this variable at baseline. There were no significant differences between the intervention group and the control group on attrition and missing data rates. many aspects of the trial protocol and methods are unclear such as: method of randomisation, allocation concealment, drop out, number who successfully completed placements, whether intent to treat analysis was used, and whether assessors of the outcomes were aware of the intervention group.
3. Downgrade 1 level for serious indirectness since study was based in USA
4. Downgrade 2 levels for very serious imprecision since confidence intervals crossed 2 lines of MID (defined as 0.8 and 1.25 for odds ratios)
5. Downgrade 1 levels for serious imprecision since confidence intervals crossed 1 lines of MID (defined as 0.8 and 1.25 for odds ratios)

Fostering Healthy Futures (FHF) vs CAU

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
Incidence of placement change over 18-month observation period: assessed using administrative records (change in placement)								
1 (Taussig 2012)	Randomised Controlled Trial	156	OR 0.68 (0.40 to 1.16)[1]	Serious[2]	N/A	Serious[3]	Serious[4]	Very low
Negative placement change over 18-month observation period: assessed using administrative records (new placement in a residential treatment centre)								
1 (Taussig 2012)	Randomised Controlled Trial	156	OR 0.29 (95%CI 0.09 to 0.98)[5]	Serious[2]	N/A	Serious[3]	Serious[4]	Very low

1. Adjusted for number of foster care placements before the intervention, whether a child had been placed in a RTC before the intervention, type of baseline placement, and baseline externalizing behaviour problems.
2. Downgrade 1 level for serious risk of bias: There was no blinding. However, the outcomes are not particularly subjective. Insufficient information to say that the trial was analysed in accordance with a pre-specified plan.
3. Downgrade 1 level for serious indirectness since study was based in USA
4. Downgrade 1 level for serious imprecision since estimate of effect crossed 1 line of MID (defined as 0.5*SD in the control group)
5. Adjusted for number of foster care placements before the intervention, whether a child had been placed in a RTC before the intervention, type of baseline placement, and baseline externalizing behaviour problems.

Social Learning Theory-based Training (SLT) vs CAU

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
Breakdown in placement over 3 months: foster-carer reported temporary (e.g. short stay at child psychiatric unit) or permanent (move to other care) breakdown over follow up)								

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
1 (Van Holen 2017)	Randomised controlled trial	63	OR 0.52 (0.09 to 3.06)	Very Serious[1]	N/A	Serious[2]	Very Serious[3]	Very low

1. Downgrade 2 levels for very serious risk of bias: No baseline characteristics of both arms to assess the success of randomisation. No blinding. Outcomes were measured by foster parents. This could lead to bias particularly since they were likely aware of the interventions.
2. Downgrade 1 level for serious indirectness since study was based in Belgium
3. Downgrade 2 levels for very serious imprecision since confidence intervals crossed 2 lines of MID (defined as 0.8 and 1.25 for odds ratios)

Non-Violent Resistance training vs treatment as usual

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
Breakdown in placement over 3 months: foster-carer reported (unclear how defined)								
1 (Van Holen 2018)	Randomised controlled trial	62	OR 0.77 [0.19, 3.19]	No concerns	N/A	Serious[1]	Very Serious[2]	Very low

1. Downgrade 1 level for serious indirectness since study was based in Belgium
2. Downgrade 2 levels for very serious imprecision since confidence intervals crossed 2 lines of MID (defined as 0.8 and 1.25 for odds ratios)

CERQual tables

Experience of practitioners delivering Parent Management Training Oregon (PMTO)

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
Training of practitioners						

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
Quality of the training was appreciated. "Educational, thorough, holistic, active, engaging". Adequate time for training sessions. Trainers were experienced, engaging, and supportive. Peer support from other trainees was also beneficial and networking with practitioners outside their own agency.	1	**No concerns**	**Minor concerns** Theme covered several aspects of what contributes to "high quality training"	**Serious concerns** Only 1 study contributed to this theme.	**Minor concerns** Study was from outside of the UK	Very Low
Shortcomings of training - lack of clarity, vague answers, disorganization, long training, days, length of the training process, and repetitive content. In addition, a few participants stated that relevant child welfare topics were not fully addressed by the training, including trauma, parental substance abuse, and parent mental illness. Failure of trainers to understand the nuances of the child welfare work. While there was adequate time for training, a time gap between training and work with families was drawn out too long. Participants needed opportunity to practice their newly learned skills shortly after the training workshops.	1	**No concerns**	**Minor concerns** Theme covered several aspects of training short comings	**Serious concerns** Only 1 study contributed to this theme.	**Minor concerns** Study was from outside of the UK	Very Low
Suggested improvements to training - Three common suggestions for training were to: (1) add more mock videos and role-plays for illustrating sessions; (2) make a trainer available locally for several months instead of a week-long intensive training days followed by a two-month gap; and (3) establish a clear practice model structure, including topic-by-topic session agendas.	1	**No concerns**	**Minor concerns** Theme covered three different ways in which training could have been improved.	**Serious concerns** Only 1 study contributed to this theme.	**Minor concerns** Study was from outside of the UK	Very Low
Helpfulness of coaching components - Most participants reported that coaching was a	1	**No concerns**	**No concerns**	**Serious concerns**	**Minor concerns**	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
helpful, positive, encouraging, and “very gentle” experience. They received feedback from coaches and peers. Utility of watching other people in role-plays prior to implementing their first session. PMTO coaches were knowledgeable, kind, and focused on strengths. Feedback made participants feel more self-assured as therapists, helped them understand where improvements were needed, and expanded their understanding of families. Direct feedback was appreciated. Amount of coaching was generally found to be adequate. A great number of participants considered that the different forms of coaching they received were good, including online coaching (i.e., video conference) and ongoing coaching from supervisors.				Only 1 study contributed to this theme.	Study was from outside of the UK	
Facilitators to learning PMTO – some participants were highly committed to learning, self-reflection, and a desire to make improvements to one's own practice. Additionally, their comments reflected open-mindedness and enthusiasm about EBIs, in general, and PMTO, specifically. Others experienced an overcoming of initial skepticism during the process.	1	**No concerns**	**No concerns**	**Serious concerns** Only 1 study contributed to this theme.	**Minor concerns** Study was from outside of the UK	Very Low
Changes to clinical practice						
Benefits to therapeutic practice - All participants reported that PMTO benefited their therapeutic practice. Most of them noticed that after PMTO training, they were more hopeful and strengths-oriented, even becoming aware of their own strengths.	1	**No concerns**	**Minor concerns** Theme covered several different ways in which PMTO training had improved the	**Serious concerns** Only 1 study contributed to this theme.	**Minor concerns** Study was from outside of the UK	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
Specific improvements involved being: a better listener, less confrontational, more insightful and "in the moment," more active and "hands-on," more agenda-driven in sessions, and more conscious of time restrictions. Other participants asserted that they had better relationships with clients, understood that silence can be useful, improved their teaching skills, and learned to problem-solve with parents, not for parents. Many respondents felt satisfied with the results as they applied PMTO in their practice.			practice of the practitioners.			
Barriers to applying the PMTO model in clinical practice - A few participants had no previous clinical experience, whereas a couple of participants mentioned that they initially had to navigate their education and clinical experience with PMTO. They noted that PMTO training poses challenges to experienced therapists, as it emphasizes self-reflection and continual professional growth. This training process, however, changed these participants' practice style and revealed areas for growth.	1	**No concerns**	**No concerns**	**Serious concerns** Only 1 study contributed to this theme.	**Minor concerns** Study was from outside of the UK	Very Low
Customisability of the intervention - Gaining experience in using PMTO with families contributed to practitioners' comfort with the model. A couple of practitioners struggled with using role-plays and some families disliked them, whereas a majority reported that roleplays were readily applied in the practice setting. Giving directions, active listening, and limit setting were among the most straightforward and uncomplicated topics to implement. Most participants	1	**No concerns**	**Minor concerns** Some inconsistence with a minority of the participants finding PMTO to be a rigid model of care.	**Serious concerns** Only 1 study contributed to this theme.	**Minor concerns** Study was from outside of the UK	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
reported that they could customize PMTO to match each family's needs, staying true to the model. A minority of respondents initially considered the model rigid and difficult to adapt and noted that coaching facilitated this adaptation.						
Response by targeted families - According to participants, most families responded positively to PMTO. PMTO's powerful effect was evident in the rapid improvement that families experienced, even if it was small. Even though some families felt skeptical at first, their confidence increased as they used the skills and advocated for themselves. A couple of participants noted that families recommended PMTO to everyone, even teaching PMTO skills to friends, and that teenagers reported better communication with their parents. Family response was more positive when practitioners got further into the PMTO curriculum.	1	**No concerns**	**No concerns**	**Serious concerns** Only 1 study contributed to this theme.	**Minor concerns** Study was from outside of the UK	Very Low
Barriers to effectiveness - Family response depended on parents' cognitive skills, functioning level, and willingness to try PMTO strategies. Some families learned PMTO skills quickly, others took longer, and some did not get them. Practitioners reported that adapting PMTO was more challenging with families with single dads, with more children, and with children with complex needs, such as blind or non-verbal autistic children. Less than a third of the participants reported having challenges adapting PMTO to the unique needs of families, including grief, domestic violence,	1	**No concerns**	**Minor concerns** Theme covered several different barriers to the effectiveness of PMTO	**Serious concerns** Only 1 study contributed to this theme.	**Minor concerns** Study was from outside of the UK	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
sexual abuse, parental mental health issues, and parental substance abuse. Delivering PMTO was difficult with parents with mental health and substance abuse issues, who were purportedly more likely to dropout from treatment. However, a couple of participants clarified that these issues are indirectly addressed by PMTO; families who faced multiple contextual factors required harder work.						
Organisational facilitators - Important were supportive leadership and reasonable work expectations. Participants also expressed appreciation for collaborative processes, quick turnaround on questions, and work climates that were safe for "trial and learn. Key organizational supports included not rushing participants through training; sharing information quickly and continuously; making sure that staff were not overworked; carefully coordinating changes when there were staff shortages; and providing the structure, materials, and logistics for implementation. Advantages were also realized through effective communications and organizational structures that promoted peer support, teamwork, and collaboration. Some practitioners pointed to the helpfulness of fluid and effective communication throughout the implementation process; they felt their voices were heard by their agencies, describing how their agencies "listened" when participants had questions, frustrations, anxiety, or stress.	1	**No concerns**	**Minor concerns** Theme covered several different organisational facilitators to the effectiveness of PMTO	**Serious concerns** Only 1 study contributed to this theme.	**Minor concerns** Study was from outside of the UK	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
Organisational barriers - less than a third of the participants felt that they received inadequate support, resources, and encouragement from their agencies. A few of them described challenges associated with their agency's norms, policies, and centralization. Specific problems included lack of support from other staff, inability to use flexible work hours, transportation issues, heavy emphasis on paperwork, and indirect communication with trainers (e.g., not being allowed to directly ask questions to trainers). Indeed, a couple of participants felt as though the program was isolated in their agencies; they perceived resistance from other staff and had to advocate for clients within the agency due to conflicting practices or procedures (e.g., agency practices regarding families affected by substance abuse). Others considered that the lack of support from the agency was associated with the lack of understanding of the intervention model. They felt that the agency administrators did not understand therapists' problems, such as the hassles and workload associated with uploading videos. Few respondents wondered whether their agencies knew what to do with the model; there was lack of agreement on how to use it within the agency and the organizational structures needed to reinforce it. These participants concluded that better internal communication from upper management would have helped to create a more	1	**No concerns**	**Minor concerns** Theme covered several different organisational barriers to the effectiveness of PMTO	**Serious concerns** Only 1 study contributed to this theme.	**Minor concerns** Study was from outside of the UK	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
accommodating climate and improved the implementation.						
Practitioners suggestions for organisations - Practitioners' suggestions for organizations were: do not be afraid of implementing new EBIs, select EBIs compatible with client needs, plan before implementing, have patience with the process, communicate excitement and information throughout the agency, share information timely, facilitate teamwork and collaboration among frontline staff, provide adequate working conditions, and listen to the struggles and suggestions of frontline practitioners.	1	**No concerns**	**Minor concerns** Theme covered several suggestions to organisations to facilitate the PMTO intervention	**Serious concerns** Only 1 study contributed to this theme.	**Minor concerns** Study was from outside of the UK	Very Low
Stakeholder buy-in - Participants recognized that stakeholder buy-in was a chief factor in successful implementation. In particular, the role of the court system was acknowledged: courts were supportive of the project because of the groundwork laid by agency administrators' efforts to reach out and educate them about PMTO. More frequent among participants' comments was an emphasis on the central role of case managers. They identified case managers as a major player whose backing and cooperation was essential.	1	**No concerns**	**Minor concerns** Theme covered multiple important stakeholders	**Serious concerns** Only 1 study contributed to this theme.	**Minor concerns** Study was from outside of the UK	Very Low
Short timelines as a barrier to effectiveness of this intervention - ASFA timelines were pinpointed as major system-level challenges. The high demands placed on families by the child welfare system impacted their response to PMTO. First, when families started the program, parents were in shock because their children were	1	**No concerns**	**No concerns**	**Serious concerns** Only 1 study contributed to this theme.	**Minor concerns** Study was from outside of the UK	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
in the system; they often felt angry and guilty, with a negative view of themselves as parents. Practitioners had to address those negative feelings that turned to displaced resentment Thus, practitioners recommended allowing families more time to get through the PMTO curriculum and learn the new parenting skills (i.e., longer than 6 months). Second, the mismatch between the time required by the child welfare system to attend to multiple case plan tasks and the time available for the family, creates frustrating barriers for families.						

Experience of foster care youth and conference facilitators undertaking Family Team Conferencing

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
The critical role of the facilitator - A trained facilitator employed by the foster care agency facilitated the permanency planning family team conferences. Facilitators guided the team through each stage of Team Decision Making, including the introduction to the conference structure, ground rules and participants, a discussion of youth strengths and concerns, brainstorming ideas to address the identified concerns, agreeing upon next steps, and developing an agreed upon service plan. The conferences followed a structured format however the facilitator played a critical role in positively engaging the young person in the decision-making process. The facilitation strategies employed to engage youth in decision making included: 1) creating a safe space, 2) encouraging the youth voice, 3) re-balancing power, and 4) establishing a	1	**Minor concerns** *Unclear why the participants selected were the most appropriate to provide access to the type of knowledge sought by the study. All were over the age of 18 yet family group conferences occur at younger ages.*	**No concerns**	**Serious concerns** Only 1 study contributed to this theme.	**Minor concerns** Study was from the USA	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
personal connection. These strategies are described in depth with examples below.						
Creating a safe space – addressing fears about breaking confidentiality - A consistent theme identified throughout the youth interviews was the importance of adults respecting their privacy and confidentiality. Several participants discussed situations where they shared personal information with child welfare professionals they perceived to be confidential that was subsequently shared with others. Youth expressed a sense of betrayal, feeling their trust was violated. A lack of transparency regarding the parameters of privacy can create a divide between professionals as insiders and youth as outsiders to child welfare decision-making processes. In the context of the family team conference, it was important that the facilitator took time to thoroughly explain the parameters of privacy and the young person understood them. Since the information discussed in the conference was used for case planning purposes, the information was considered private but not confidential. One facilitator was observed telling the young person that the information in the conference would not come back and be detrimental to them afterwards. In the post-observation interview, the facilitator explained that many youth in foster care are reluctant to open up and share information in the conference because they are afraid it will be used in negative or harmful manner. Her goal is to create a safe space where youth feel comfortable sharing information and engaging freely in the discussion. She explains the parameters of privacy, but also addresses their fears directly by emphasizing the collaborative nature of decision-making and informing them that no	1	**Minor concerns** *Unclear why the participants selected were the most appropriate to provide access to the type of knowledge sought by the study. All were over the age of 18 yet family group conferences occur at younger ages.*	**No concerns**	**Serious concerns** Only 1 study contributed to this theme.	**Minor concerns** Study was from the USA	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
decisions will be made without their input and awareness.						
Creating a safe and collaborative environment - trust building exercises - In addition to discussing the parameters of privacy, some facilitators created a safe and collaborative environment by building trust among the conference participants. As illustrated in one conference the facilitator began by instructing each participant to write their name and relationship to the youth on a folded piece of cardboard, which she then placed on the table facing inward so everyone could view it. The facilitator then took the time to have each participant introduce themselves by their name and relationship to the youth. The note card visualization coupled with the verbal introduction highlighted the important role each participant played in supporting the youth in the decision-making process.	1	**Minor concerns** *Unclear why the participants selected were the most appropriate to provide access to the type of knowledge sought by the study. All were over the age of 18 yet family group conferences occur at younger ages.*	**No concerns**	**Serious concerns** Only 1 study contributed to this theme.	**Minor concerns** Study was from the USA	Very Low
Encouraging the youth voice - Another consistent theme in the youth interviews was the importance of having a voice in the family team conference. Youth wanted the opportunity to talk, be heard and have their perspective considered. The facilitator played an instrumental role in including youth in the conversation and making them feel like an equal member of the team. Facilitators used various engagement strategies including, verbal affirmations, non-verbal communication, everyday language, and humor. Facilitators used verbal affirmations to engage youth in the conference. For example, some facilitators used positive action words to describe the youth's behaviors such as successful, independent, consistent and diligent. The use of positive language when describing the youth's actions led youth to open up and engage in the discussion. They also encouraged other members of the group to focus on	1	**Minor concerns** *Unclear why the participants selected were the most appropriate to provide access to the type of knowledge sought by the study. All were over the age of 18 yet family group conferences occur at younger ages.*	**Minor concerns** Theme covered several aspects of practically encouraging the youth voice. Unclear the number of participants who agreed with each of these aspects.	**Serious concerns** Only 1 study contributed to this theme.	**Minor concerns** Study was from the USA	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
youth strengths, rather than deficits. Facilitators also used non-verbal communication to engage the youth in the discussion such as physical presence, maintaining eye contact, smiling, nodding, and stating, "uh hum" and "ok." Through the use of non-verbal communication, facilitators sent a message to the youth that they were physically present and interested in what the youth had to say. Facilitators used everyday language to communicate with the youth in the conference. Child welfare professionals often rely on professional jargon, which can create a divide between professionals and youth. Examples of such language include the use of codes, acronyms or technical language. In order to engage youth in the discussion, it was important to substitute professional jargon with more developmentally appropriate language.						
Re-balancing power - An important goal of the conference facilitator was to level the playing field so that all participants are provided the opportunity to speak, have their perspective heard, feel respected, and collaborate in the Team Decision Making process. Facilitators were responsible for managing power dynamics so youth and professionals were true collaborators, rather than the adults or professionals dominating the discussions. The idea of adults/professionals collaborating with youth in decision-making was novice and/or challenging for some participants. Therefore, it was the role of the facilitator to re-balance power when the adults were dominating the discussion. Facilitators accomplished this in multiple ways including keeping the focus on youth, seeking their perspective and advocating for their perspective. E.g. Several facilitators noted the importance of keeping the conference focused on the youth, including asking adults to remain quiet and/or	1	**Minor concerns** *Unclear why the participants selected were the most appropriate to provide access to the type of knowledge sought by the study. All were over the age of 18 yet family group conferences occur at younger ages.*	**No concerns**	**Serious concerns** Only 1 study contributed to this theme.	**Minor concerns** Study was from the USA	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
re-directing the discussion when adults attempt to promote their views.						
Brainstorming to support meeting goals - Another re-balancing power strategy was to seek the youth perspective and brainstorm ways to assist them in meeting their planning goals. In one conference the youth reported an interest in obtaining employment in the medical field. The facilitator brainstormed the steps necessary to learn about educational and professional opportunities, and how other conference participants could support the young person in accomplishing this goal. Similarly, in another conference the youth reported that she wanted to graduate from high school. The facilitator responded positively by asking what she needed to do to graduate. The youth responded that she needed to go to class and said she was risking failing science. The facilitator probed further, asking about the specific steps the youth would take to pass science. The youth discussed steps she could take including, waking up on time and going to the makeup labs. The facilitator elaborated upon the discussion by focusing on concrete steps the youth can employ to pass her science class, including a discussion regarding how the foster parent and case planner could support the youth in getting up on time, getting on the bus and attending her science labs. These ideas were then documented in the action plan.	1	**Minor concerns** *Unclear why the participants selected were the most appropriate to provide access to the type of knowledge sought by the study. All were over the age of 18 yet family group conferences occur at younger ages.*	**No concerns**	**Serious concerns** Only 1 study contributed to this theme.	**Minor concerns** Study was from the USA	Very Low
Rebalancing power - advocacy - Another important mechanism for re-balancing power was advocating for the youth perspective. At times this meant challenging the agency perspective and revealing potential agency missteps. For example, in a conference with a youth residing in a mother child residence, the youth complained that for the past two weekends when she came home from work the door	1	**Minor concerns** *Unclear why the participants selected were the most appropriate to provide access to the type of knowledge sought by the study. All were over*	**No concerns**	**Serious concerns** Only 1 study contributed to this theme.	**Minor concerns** Study was from the USA	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
to the facility was locked and she had to sit outside with her child for over an hour. The case planner attempted to place responsibility on the youth by saying that she needs to call the staff and notify them when she is coming home. In response, the youth reported she told the Assistant Manager of the residence that she will be home between 3:30 and 4 pm. The facilitator responded by advocating the youth perspective, stating to the agency, “we need to come up with a plan to deal with this.” The facilitator then focused on the agency's actions, asking the case planner a series of questions until it was acknowledged that the agency was indeed at fault because the Director had been on vacation and things had “fallen through the cracks.” The facilitator then brainstormed a plan to address the situation. The facilitator allowed the youth to voice their concerns, adopted their perspective and placed responsibility on the agency to address the concerns. The facilitator then brainstormed action steps to rectify the situation. The action steps became part of the written service plan, holding all parties accountable.		*the age of 18 yet family group conferences occur at younger ages.*				
Establishing a personal connection - remembering and celebrating goals - A consistent theme in the youth interviews was the personal connection (or lack of connection) youth experienced with the facilitator. Youth felt positively engaged in the conference when they perceived the facilitator to take a genuine interest in them. One mechanism mentioned by youth to determine whether the facilitator took an interest in them was their knowledge about the case. For first time facilitators, it meant being familiar with the case history and permanency planning goals. For repeat facilitators, it meant remembering the case history, permanency	1	**Minor concerns** *Unclear why the participants selected were the most appropriate to provide access to the type of knowledge sought by the study. All were over the age of 18 yet family group conferences occur at younger ages.*	**No concerns**	**Serious concerns** Only 1 study contributed to this theme.	**Minor concerns** Study was from the USA	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
planning goals and checking in with participants on the progress from the previous conference as illustrated in one conference when the facilitator began with a round of applause for the youth for meeting her goal of graduating from high school. In the post-observation interview, the youth reported feeling "like a star" because the facilitator remembered and publicly acknowledged her goal from the previous conference of finishing high school. The youth perceived the facilitator to be proud of her.						
Establishing a personal connection - continuity of facilitators - not retelling story - While the family team conference model does not call for continuity of facilitators several participants mentioned it as a factor in being able to establish a personal connection. From the facilitator perspective, it was helpful to be familiar with the individuals involved in the case, the case history and the case planning goals. By facilitating multiple conferences the facilitator became an "insider" to the case. Youth reported feeling more engaged in the conference when they had previous exposure to the facilitator. They discussed the importance of not having to re-tell their story. They also discussed the importance of already established trust and rapport.	1	**Minor concerns** *Unclear why the participants selected were the most appropriate to provide access to the type of knowledge sought by the study. All were over the age of 18 yet family group conferences occur at younger ages.*	**No concerns**	**Serious concerns** Only 1 study contributed to this theme.	**Minor concerns** Study was from the USA	Very Low
Limitations of a personal connection with the facilitator - Although youth responded positively to facilitators who established personal connections, some facilitators did not perceive this to be their role. They saw their role as a neutral "outside" party to the case. One such facilitator discussed the importance of maintaining professional boundaries with the youth. She saw the case planner as the appropriate person to establish a connection with the youth, since the case planner works closely with the youth. The perspective of the facilitator as the outside	1	**Minor concerns** *Unclear why the participants selected were the most appropriate to provide access to the type of knowledge sought by the study. All were over the age of 18 yet family group conferences occur at younger ages.*	**Minor concerns** Theme somewhat contradicted the theme before, but was coherent.	**Serious concerns** Only 1 study contributed to this theme.	**Minor concerns** Study was from the USA	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
neutral party was contradictory to the preference of youth to have a personal connection with the facilitator. In fact, youth expressed reluctance to open up and share information with facilitator they did not know well. Given that youth are asked to share sensitive information and make important decisions that impact their life in the context of the conference, relational concerns were important to them.						

Experience of carers undertaking Treatment Foster Care

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
Parent vs. Treatment Provider Several experts commented on the challenges TFC parents face in balancing their role as a caregiver with the expectation to be a professional. In treatment foster care, the experts emphasized how the TFC parent is responsible for creating an environment that provides a therapeutic experience for youth. Although the TFC parent may not have a clinical education or license, several experts expressed that "TFC parents are the ones who create the change." Youth in a treatment foster care placement may also be receiving therapy outside the home, but "the foster family is the agent of treatment, not therapy from the outside." The home setting itself is intended to be transformative. Although many TFC parents have experience and competence with parenting, this is no guarantee that they will be effective as a TFC parent. This tension between being a caregiver and being a treatment provider is not just about different competencies but also about embracing this expanded role.	1	**No concerns**	**No concerns**	**Serious concerns** Only 1 study contributed to this theme.	**Minor concerns** Study was from the USA	Very Low
Teamwork - Parent Expertise vs Worker Expertise	2	**No concerns**	**No concerns**	**Moderate concerns**	**Minor concerns**	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
As TFC parents are empowered to have larger roles as experts of the youth in their home, they may struggle to collaborate effectively with their TFC social worker. One of the workforce dynamics commonly found in TFC agencies is that TFC parents may have more life and parenting experience while TFC social workers may have more formal training and education in treatment approaches. The different types of expertise is not just a problem for the TFC parents. For TFC social workers, playing a supervisory or coaching role with experienced TFC parents can be intimidating. This tension may inhibit the social worker from providing validation to the TFC parent's role as a treatment provider. To manage this tension, the experts offered several ideas. Operating from the perspective of a strengths-based partnership was one suggestion. Recognizing that each type of expertise can have value and contribute towards the family's success is key. TFC foster parents across groups repeatedly emphasized the importance of developing strong care teams founded on relationships built of mutual respect and characterized by consistent, clear communication. Participants who expressed satisfaction with their care team were positive about their roles. They felt included in decision-making around their child and were routinely kept abreast of important information. The importance of respect, engagement, and clear communication was also evident in TFC foster parents' relationships with clinicians, and their belief in the efficacy in mental health treatment overall.		One study was low risk of bias, another was moderate risk of bias.		Only 2 studies contributed to this theme.	Studies were from the USA	
Treatment foster carers need to know how to: • Be advocates – including in education, medical, and behavioral health services. Bringing their unique perspectives.	2	**No concerns** One study was low risk of bias, another was moderate risk of bias.	**No concerns**	**Moderate concerns** Only 2 studies contributed to this theme.	**Minor concerns** Studies were from the USA	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
• Have systems knowledge – of both the child wefare system and behavioural health system so as to know how to navigate this care. • Managing challenging behaviours Parenting youth with emotional and behavioural issues requires specialized skills. The experts noted that TFC parents should have the capacity to identify when a youth may require clinical care						
Preferences for training for TFC Experiential Training - Universally, the experts encouraged hands-on learning opportunities during training for TFC parents. One TFC expert recommended to "do a lot of experiential pieces in the training: practicing and role play. Keep it very behavioural." Another expert suggested, "giving them a skill, having them practice in class, and then work with the kids at home." As summarized by one expert: "the more interactive, the better." The experts seemed to agree that a single training event without follow-up would have little impact. This ongoing skill building could be in the form of a coach that could provide follow-up consultation and refining of skill development.	2	**No concerns** One study was low risk of bias, another was moderate risk of bias.	**No concerns**	**Moderate concerns** Only 2 studies contributed to this theme.	**Minor concerns** Studies were from the USA	Very Low
Peer Support The experts emphasized the value of engaging other TFC parents in training and supporting TFC parents who are newer to the role or struggling. Learning from other parents was viewed as both credible and encouraging for TFC parents. The benefits were attributed to not just the recipient, but also for the experienced TFC parent who is able to exercise this leadership and service.	2	**No concerns** One study was low risk of bias, another was moderate risk of bias.	**No concerns**	**Moderate concerns** Only 2 studies contributed to this theme.	**Minor concerns** Studies were from the USA	Very Low
Destabilising staff turnover Consistent across all groups were reports of frequent and, sometimes, destabilizing transitions in the form of staff turnover or staff changing positions within their agency. As a result, participants widely agreed that strategies for	1	**Minor concerns** Theme was derived from a study at moderate risk of bias	**No concerns**	**Serious concerns** Only 1 study contributed to this theme.	**Minor concerns** Study was from the USA	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
managing transitions should be included as part of staff and foster parent training, and that additional resources—both for children and for treatment foster carers —were needed during periods of change. Concerns about staff transitions focused primarily on the impact of transitions on the mental health of children; "every time you turn around they are changing caseworkers on them … and then they feel like they just tired of them." Participants emphasized the toll repeated transitions could take their children, but most said agencies did not prepare them adequately for changes. More than one participant reported addressing transitions by telling their child to focus more on the stability of their (parent-child) relationship than the one with his/her caseworker. Participants agreed that more structured, consistent communication and support was needed around caseworker transitions—for everyone involved. At the very least, participants wanted to be informed in advance of impending departures, and, if possible, given the opportunity to meet with both workers, to facilitate transitions						
Need for emotional support in times of conflict In most of the groups, TFC foster parents described situations in which they felt staff members did not support them when there was conflict with a child in their care; at times staff were described as siding with the child during such conflicts, and at other times they were described as being absent and unsupportive. TFC foster parents who felt supported by their agency during periods of conflict described the things their agency did to make it easier for them to maintain difficult placements. One TFC foster parent said her agency did "everything" from setting up needed appointments with therapists "right away for the child" to picking up things at school. She reflected: "I feel like they are there for me … it's really important because sometimes you feel overwhelming … some kids, you feel	1	**Minor concerns** Theme was derived from a study at moderate risk of bias	**No concerns**	**Serious concerns** Only 1 study contributed to this theme.	**Minor concerns** Study was from the USA	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
like, 'what am I going to do?' – but you have phone numbers for everything."						
**Trial period, importance of suitability of placements: Getting acquainted - visits to ensure suitability - **Opportunities to become acquainted and begin building a relationship were often valued by TFC parents. The visits were helpful not just to assess the match between the youth and foster parents, but also to observe other family dynamics the youth would be joining. Some TFC parents had to consider how a new foster youth would adjust with other youth in the home. Incorporating the foster youth into the family was mentioned by various TFC parents as being an important consideration when deciding whether to accept a youth into their care.	2	**No concerns**	**No concerns**	**Moderate concerns** Only two studies contributed to this theme	**Minor concerns** Studies took place in the USA	Very Low
Feeling rushed to make a decision, the transition process into the home - Timing. Some TFC parents expressed feeling rushed by the transition process of a youth being placed in their home. There seemed to be a push/pull between child welfare policies that emphasize youth living in family settings and the desire for TFC parents to feel adequately informed and prepared to receive the child. TFC parents recognize the pressures within the system even when there is some lead time for placements. Indeed, there was not a clear relationship between the amount of time involved in the transition and the experience of feeling rushed. Some TFC parents who received youth within hours of first being notified about the youth did not express any concerns about the timing, while other TFC parents who had a week or more to weigh the decision mentioned that the process seemed "real quick." This finding suggests that TFC parents differ on the amount of time they feel is needed to prepare for the transition.	1	**No concerns**	**Minor concerns** There was not a clear relationship between the amount of time on the run up to the placement and how "rushed" the foster parent felt. Therefore, it was unclear what exactly leads to this feeling of being rushed.	**Serious concerns** Only one study contributed to this theme	**Minor concerns** Study took place in the USA	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
The need for information prior to placement. information gathering – feeling that information may be withheld. TFC parents used a variety of methods to gather information for making a decision about whether or not to accept a youth into their home. Some TFC parents reported asking the caseworker many questions about the youth or reading the youth's records, in addition to meeting and visiting. Other respondents seemed to require little information to make the decision to accept a youth. TFC parents also recognized the pitfalls of over-reliance on a youth's records or previous history. When TFC parents were asked what types of information they wanted about a youth they were considering accepting into their home, they mentioned characteristics related to the youth's behaviours, their background, and family experiences. Certain problem behaviours were frequently mentioned as important factors in assessing their willingness to foster a youth. Several TFC parents specifically mentioned they wanted to know whether the child had been a "firesetter," was "violent," and if they acted out sexually. Other less commonly reported issues that were mentioned as important to consider included being pregnant, lying, stealing, running away, and anger management issues. At times, TFC parents reported not receiving information they wanted about the youth. For example, 1 TFC parent reported learning that a child had a bedwetting problem that was not disclosed prior to placement. Another TFC parent said of a youth with attention deficit issues: "I didn't know that he had it or anything about it." Other types of information not received were explanations of why previous placements had disrupted or a youth's involvement in sexual activities. TFC parents had different explanations for why information they wanted was not received. In some situations, the information may not have been available in	3	**No concerns** Two studies were low risk of bias and one moderate risk of bias	**Minor concerns** There was a distinction between the idea that foster carers would have preferred more information and the suspicion that information was deliberately being withheld.	**Minor concerns** Only three studies contributed to this theme	**Minor concerns** Study took place in the USA	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
a youth's record or may not have ever been reported previously. Other TFC parents suspected that the placement social worker purposely withheld information from them because they wanted the child placed.						
Resource needs of youngsters arriving for TFC. clothing and personal items - TFC parents seemed prepared to provide personal care items for youth as needed, but often found that youth also needed new clothes. Suggestions for improving the adequacy of clothing included receiving a clothing grant when a child is placed (N = 5). Several TFC parents commented on how they took ownership of their youth's appearance. Providing for the youth's clothing needs seemed to make a positive impression on the youth. However, TFC parents were sometimes reluctant to invest so substantially in a youth newly-placed in their home.	1	**No concerns**	**No concerns**	**Serious concerns** Only one study contributed to this theme	**Minor concerns** Study took place in the USA	Very Low
Issues transitioning youth to school - Some TFC parents reported issues transitioning youth from their previous school to their new school e.g. difficulties getting registered. Others reported no problems in that transition.	1	**No concerns**	**No concerns**	**Serious concerns** Only one study contributed to this theme	**Minor concerns** Study took place in the USA	Very Low
Straightforward transition to new mental health, dental, and medical providers - mental health services transitions - In this TFC program, all youth were expected to receive weekly outpatient therapy. Transitioning youth to new mental health providers was made easier for most TFC parents because this agency's workers provide referrals to providers near the TFC home. The TFC parents also appreciated being able to choose the therapist they wanted to work with. Medical and dental services seemed equally straightforward. A TFC parent could have their caseworker transfer a youth's files to a provider of the parent's choice or the caseworker would	2	**No concerns** One study was low risk of bias, one was moderate risk of bias.	**No concerns**	**Moderate concerns** Only two studies contributed to this theme	**Minor concerns** Study took place in the USA	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
help identify possible local providers. TFC parents reported few difficulties in logistics regarding securing services for youth in their home. TFC parents who were less experienced reported greater reliance on their caseworkers for help in navigating the process of getting settled, whereas more senior TFC parents knew the ropes well. Overall, TFC parents seemed satisfied with the quality of auxiliary services their youth received.						
Agency support in getting settled – good supportive relationships, training, respite, and referrals. The strengths of the program identified by TFC parents may have facilitated the getting acquainted stage of the transition process. These strengths highlighted various supports that were mentioned as being helpful to TFC parents. Eight TFC parents mentioned they had a good relationship with their TFC worker. Training was mentioned by 5 TFC parents as being a beneficial source of support. Respite was mentioned twice and referrals were mentioned by 1 TFC parent. Six mentioned the staff, counselors, or social workers at this agency were strengths.	2	**No concerns** One study was low risk of bias, one was moderate risk of bias.	**Minor concerns** Several distinct aspects of the support that foster carers found to be helpful was outlined here.	**Moderate concerns** Only two studies contributed to this theme	**Minor concerns** Study took place in the USA	Very Low
Adjustment to the idea of family life. Youth transitioning from group care settings are adjusting not only to their foster family, but also sometimes to family life in general. Some youth seemed to lack experiences that are common in most families. For example, 1 TFC parent recalled having a youth in her home who admitted never before having a set bedtime. Another TFC parent was surprised by a youth's dietary habits. A TFC mother described her efforts to treat her foster youth similarly to how she treated her biological children as a "mainstreaming" process.	1	**No concerns**	**No concerns**	**Serious concerns** Only one study contributed to this theme	**Minor concerns** Study took place in the USA	Very Low
Reasons for breakdown. When youth coming from group care or other settings transition to TFC, struggles in the transition can lead to placement disruptions. More than half of the respondents had experienced at least one	1	**No concerns**	**Minor concerns** Several aspects that could lead to placement	**Serious concerns** Only one study	**Minor concerns** Study took place in the USA	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
disruption of a child leaving their home. Reasons cited for disruptions included lying, running away, skipping school, stealing, and sexual behaviors. From the descriptions provided by TFC parents, disruptions often occurred after an increasing build-up of problems over time. For example, being thrown out of school, or stealing. As youth problems escalated or maintained at high levels of intensity, TFC parents seemed to reach a breaking point.			breakdown were described here. Some of which may require very different responses.	contributed to this theme		
Evidence of positive transition. Although not specifically asked about, many TFC parents shared evidence of a positive transition for youth they fostered, and they were proud and happy to share their success stories. E.g. success at school. Stakeholders perceived qualified clinical successes. One example is from a caseworker who thought that the youth's participation was beneficial even though her stay in an initial foster home placement lasted only a few months. Another qualified success was described by this foster parent, who saw substantial improvements in functioning in a youth she served.	2	**Minor concerns** One study had low risk of bias. One study did not make its methods of coding and thematic analysis explicit.	**Minor concerns** Specific aspects of a positive transition were described here. For example, clinical improvement vs success at school.	**Serious concerns** Only two studies contributed to this theme.	**Minor concerns** Studies took place in the USA	Very Low
Creating relationships with birth families. The Circle Program was felt to be more likely to promote reunification with family or enter kinship care than among children in a generalist foster care placement. Factors contributing to the child's relationship with their family of origin included: valuing the unique knowledge brought by the parents, encouraging the attendance of family, and the usefulness of care team meetings.	1	**Serious concerns** Qualitative methods were not appropriate to evaluate effectiveness of the intervention in terms of likelihood of reunification. Researchers do not discuss how participants were selected for the study, and why these were the most appropriate or why some chose not to take part. Focus group methods were not made explicit. *Thematic analysis*	**No concerns** However, participation of birth families could be encouraged in one of several ways.	**Serious concerns** Only one study contributed to this theme.	**Minor concerns** Study took place in Australia	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
		process was not described explicitly.				
Support that was helpful for retaining foster carers - Focus group data highlighted factors deemed to be influential to carer retention such as support, training, ongoing education and access to flexible funds to obtain services. Comments highlighted the value of participation in regular care team meetings. Carers spoke of their commitment to their role as a Circle carer, highlighting the experience of support, training, and ongoing education.	1	**Serious concerns** Qualitative methods were not appropriate to evaluate effectiveness of the intervention in terms of likelihood of reunification. Researchers do not discuss how participants were selected for the study, and why these were the most appropriate or why some chose not to take part. Focus group methods were not made explicit. *Thematic analysis process was not described explicitly.*	**Minor concerns** Theme covered several distinct aspects of support that could help to retain foster carers.	**Serious concerns** Only one study contributed to this theme.	**Minor concerns** Study took place in Australia	Very Low
Access to flexible brokerage funds - These funds were described by carers as supporting children to participate in normative community activities, for example a dance class or organized sport. Where a child required a specialist assessment (e.g. speech therapy) that was not available through public funding within a reasonable time frame, brokerage funding could be used. A key message from carers was the importance of accessing such discretionary funds to meet a child's needs in a timely way.	1	**Serious concerns** Qualitative methods were not appropriate to evaluate effectiveness of the intervention in terms of likelihood of reunification. Researchers do not discuss how participants were selected for the study, and why these were the most appropriate or why some chose not to take part. Focus group methods were not made explicit. *Thematic analysis*	**No concerns**	**Serious concerns** Only one study contributed to this theme.	**Minor concerns** Study took place in Australia	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
		process was not described explicitly.				
Carers valued and treated as professional equals. The Circle Program was described by some carers as elevating the role of the foster carer to one that is 'equal' to the other professionals on the care team. This, combined with the Circle Program training, professionalized the role of the foster carer, and some carers reported increased levels of confidence in their competence. Carers also commented that the success of the Circle Program was linked to the professional support provided: feeling 'listened to', having their opinions 'valued' and being 'supported' in their role as foster carer. In the focus groups, carers discussed their role and participation in the Circle Program with passion and enthusiasm. The wellbeing of the carer was also a focus of care team meetings with one carer commenting that someone always asked her how she was at care meetings and 'They really want to know how I am'!	1	**Serious concerns** Qualitative methods were not appropriate to evaluate effectiveness of the intervention in terms of likelihood of reunification. Researchers do not discuss how participants were selected for the study, and why these were the most appropriate or why some chose not to take part. Focus group methods were not made explicit. *Thematic analysis process was not described explicitly.*	**No concerns**	**Serious concerns** Only one study contributed to this theme.	**Minor concerns** Study took place in Australia	Very Low
The common purpose of the care team with an equal system of carers - The egalitarian nature and common purpose of the care team were features mentioned by a number of focus group participants as having significance in their experience of TFC.	1	**Serious concerns** Qualitative methods were not appropriate to evaluate effectiveness of the intervention in terms of likelihood of reunification. Researchers do not discuss how participants were selected for the study, and why these were the most appropriate or why some chose not to take part. Focus group methods were not made explicit. *Thematic analysis*	**No concerns**	**Serious concerns** Only one study contributed to this theme.	**Minor concerns** Study took place in Australia	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
		process was not described explicitly.				
Training essential particularly in trauma theory, attachment and self-knowledge. Contents of training - Training in trauma theory, attachment and selfknowledge were also identified as essential components by foster carers and foster care workers alike.	1	**Serious concerns** Qualitative methods were not appropriate to evaluate effectiveness of the intervention in terms of likelihood of reunification. Researchers do not discuss how participants were selected for the study, and why these were the most appropriate or why some chose not to take part. Focus group methods were not made explicit. *Thematic analysis process was not described explicitly.*	**No concerns**	**Serious concerns** Only one study contributed to this theme.	**Minor concerns** Study took place in Australia	Very Low
Key role of the therapeutic specialist (Circle programme). The key role of the therapeutic specialist - Therapeutic specialists were identified by all stakeholders as core to the Circle Program's success. Circle carers and foster care workers highlighted the value of this role in guiding assessment and the care of the child. The availability of the therapeutic specialist was considered a particular strength given their knowledge; and ability to assist carers in understanding the child and their needs. Their role was active in guiding the foster carer in their day to day response to the child and this was experienced as very supportive and was seen to facilitate a more immediate and appropriate response in meeting the child's needs. The therapeutic specialist could also extend their focus to include the child's family of origin as from the commencement of placement the aim is for the	1	**Serious concerns** Qualitative methods were not appropriate to evaluate effectiveness of the intervention in terms of likelihood of reunification. Researchers do not discuss how participants were selected for the study, and why these were the most appropriate or why some chose not to take part. Focus group methods were not made explicit. *Thematic analysis*	**No concerns**	**Serious concerns** Only one study contributed to this theme.	**Minor concerns** Study took place in Australia	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
child to reunify with their family if the family can meet their needs. As many of the families of origin had themselves experienced trauma, it is important that they be assisted to heal and change to be available for the care of their child/young person.		*process was not described explicitly.*				
Building a support network for the child. Feedback from focus groups and the survey highlighted the importance of building a support network for the child/young person. This network included teachers, extended family and others in addition to members of the care team.	1	**Serious concerns** Qualitative methods were not appropriate to evaluate effectiveness of the intervention in terms of likelihood of reunification. Researchers do not discuss how participants were selected for the study, and why these were the most appropriate or why some chose not to take part. Focus group methods were not made explicit. *Thematic analysis process was not described explicitly.*	**No concerns**	**Serious concerns** Only one study contributed to this theme.	**Minor concerns** Study took place in Australia	Very Low
The hard and stressful work of fostering. How would foster parents and staff tolerate the intervention? - a feasibility worry was that the TFC-OY intervention would be difficult for foster parents to tolerate. This was confirmed. In addition, some staff found the work stressful. In weekly meetings and in the qualitative research interviews, foster parents reported that the youth were extremely difficult to parent. Despite training that focused on the needs of youth with psychiatric problems, the foster parents reported being surprised by the amount of emotional volatility in the young people they served, the low levels of what they perceived as emotional maturity, and high needs for monitoring and supervision. No parent	1	**Serious concerns** Qualitative methods were not appropriate to evaluate effectiveness of the intervention in terms of likelihood of reunification. Researchers do not discuss how participants were selected for the study, and why these were the most appropriate or why some chose not to take part.	**No concerns**	**Serious concerns** Only one study contributed to this theme.	**Minor concerns** Study took place in Australia	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
or youth described an extended period of time when life settled into a comfortable routine. It always felt like stressful work to the foster parents. The experience was not easy for the TFC-OY staff either. One Life Coach was surprised by the low level of emotional functioning of youth in an office setting.		Focus group methods were not made explicit. *Thematic analysis process was not described explicitly.*				
Key role of the skills coach (Circle programme). The skills coach component was uniformly appreciated by foster parents, the program supervisor and the youth. When asked about the skills coach component, the youth tended to report things the coach had done for and with them that were related to positive youth development. E.g. helping to find a job, getting a drivers liscence, going to find a place to eat. Multiple stakeholders commented on the positive relationships that youth developed with their skills coaches.	1	**Serious concerns** Qualitative methods were not appropriate to evaluate effectiveness of the intervention in terms of likelihood of reunification. Researchers do not discuss how participants were selected for the study, and why these were the most appropriate or why some chose not to take part. Focus group methods were not made explicit. *Thematic analysis process was not described explicitly.*	**No concerns**	**Serious concerns** Only one study contributed to this theme.	**Minor concerns** Study took place in Australia	Very Low
Key role of the psychiatric nurse (Circle programme). A second component that drew positive comments from stakeholders was that of the psychiatric nurse. Care managers appreciated the medication and diagnostic review provided by the nurse. They provided numerous examples of how they used this review and knowledge in their interactions with mental health providers. While some youth did not understand why they were receiving psychoeducation about their mental health problems from a nurse, others greatly appreciated it, explaining that it changed how they monitored their symptoms and how they approached their psychiatric providers.	1	**Minor concerns** This study did not make its methods regarding coding and thematic analysis explicit.	**No concerns**	**Serious concerns** Only one study contributed to this theme.	**Minor concerns** Study took place in USA	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
Role of the life coach (Circle programme). The role of the life coach was a difficult one to execute. Initially, the role was focused on interpersonal skills the youth needed to succeed in the foster home, but was later supposed to involve life planning and psychoeducation. Two life coaches worked in the program and both found their role frustrating in terms of completing what they felt they were being asked to do.	1	**Minor concerns** This study did not make its methods regarding coding and thematic analysis explicit.	**No concerns**	**Serious concerns** Only one study contributed to this theme.	**Minor concerns** Study took place in USA	Very Low
The family consultant role (Circle programme). The family consultant role was less well received. The family consultant made many unsuccessful efforts to re-engage biological relatives and other nominated individuals into the lives of youth in TFC-OY and executed one successful effort, involving an older sibling. The role was also expensive (using a master's level mental health professional). In the end, the principal investigator concluded that the family consultant role would be eliminated going forward and that needed family work would be conducted by the program supervisor.	1	**Minor concerns** This study did not make its methods regarding coding and thematic analysis explicit.	**No concerns**	**Serious concerns** Only one study contributed to this theme.	**Minor concerns** Study took place in USA	Very Low
Changes suggested for the circle programme. Program changes needed? - Since it was decided that it was permissible to alter the intervention mid-pilot in order to have an intervention worthy of testing at the end of pilot period, two modifications to the protocols were made several months into the intervention: 1) redefined roles for team members; and 2) efforts to address emotional dysregulation. Some of the life coach's responsibilities were offloaded to other team members. The skills coaches became responsible for helping youth plan for more independent living and the psychiatric nurse became responsible for providing psychoeducation about mental health problems. These modifications were considered successful, as viewed by stakeholders in qualitative interviews at the end of the project. Most glaring was the need to develop intervention components to address	1	**Minor concerns** This study did not make its methods regarding coding and thematic analysis explicit.	**Moderate concerns** Several changes to the intervention were described however it was unclear where qualitative data were coming from for these changes and if themes were all in agreement.	**Serious concerns** Only one study contributed to this theme.	**Minor concerns** Study took place in USA	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
youth emotion regulation problems. Six of the foster parents interviewed qualitatively reported that the young people served in their homes experienced severe emotional outbursts; typically youth were seen as quick to become emotional and remaining emotionally volatile for substantial periods of time. During the last six months of the pilot, TFC-OY staff explored the potential of using processes and materials from Dialectical Behaviour Therapy in TFC-OY to address youth emotion regulation problems. Staff received initial DBT training from a certified trainer and a DBT skills group was mounted with the foster youth to teach interpersonal effectiveness and mindfulness skills. The groups were well received by youth who attended them, but attendance was a problem, mostly due to logistics, such as distance from youth placements to the group site, work schedules, and transportation issues. By the end of the pilot, the intervention team concluded that any future trials or implementation of TFC-OY should be delayed until new intervention components were developed to address emotion regulation problems.						

Experience of carers, youth, and practitioners undertaking Multidimensional Treatment Foster Care

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
A common language and focus and the multidimentional treatment foster care team: One of the main strengths offered by the OSLC model was a degree of focus or 'common language' (seen as crucial in a multi-disciplinary team) and clarity of expectations for young people: "We're all very clear about what we're working towards and it helps in not splitting that group around the child. (Team member)"	1	**Serious concerns** Unclear how participants were recruited and selected. No in-depth description of the analysis process. Unclear if sufficient data presented to support the findings. No apparent triangulation, respondent validation, or	**No concerns**	**Serious concerns** Only one study contributed to this theme	**Minor concerns** Data was likely collected prior to 2010	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
		the use of more than one analyst.				
Crucial emphasis on rewards and punishments: The emphasis on rewards and punishments was generally regarded as crucial, both for its transparency and potential for setting and maintaining boundaries: "If they don't earn it, they can see it, there's something there that they can see, you can hold up in front of them and show them. (Foster carer)"	1	**Serious concerns** Unclear how participants were recruited and selected. No in-depth description of the analysis process. Unclear if sufficient data presented to support the findings. No apparent triangulation, respondent validation, or the use of more than one analyst.	**No concerns**	**Serious concerns** Only one study contributed to this theme	**Minor concerns** Data was likely collected prior to 2010	Very Low
The model takes the emotion out of the situation: Another strength was the perceived capacity for the model, with its relatively neutral and technical language, to 'take the emotion out of the situation' and to avoid escalation in the face of anger and outbursts: "In a way it stops people really feeling too criticised because it's like ... if someone says to you 'off model'that's like, 'Oh well, I can get back on the model.' (Team member)" "You need to be quite calm and not easily fired up, to be able to just walk away when they're ranting and raving and they're in your face and they're shouting at you, and just walk away and let them calm down. (Foster carer)"	1	**Serious concerns** Unclear how participants were recruited and selected. No in-depth description of the analysis process. Unclear if sufficient data presented to support the findings. No apparent triangulation, respondent validation, or the use of more than one analyst.	**No concerns**	**Serious concerns** Only one study contributed to this theme	**Minor concerns** Data was likely collected prior to 2010	Very Low
Limitations of the MTFC model: Limitation 1) certain aspects of it needed to be 'Anglicised': Where they occurred, flexibilities tended to reflect either cultural differences or acquired practice wisdom. Within its UK context, some team members saw the programme being more holistic and less focused on 'breaking the cycle of offending', an emphasis sometimes couched in the language of 'leniency': "Helping that child develop ... in whatever way they need and meeting their	1	**Serious concerns** Unclear how participants were recruited and selected. No in-depth description of the analysis process. Unclear if sufficient data presented to support the findings. No apparent triangulation, respondent validation, or	**Minor concerns** The limitations covered three distinct areas, but there was no contradiction in themes.	**Serious concerns** Only one study contributed to this theme	**Minor concerns** Data was likely collected prior to 2010	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
needs to enable them to move to independence or whatever goes next to it. (Team member)". Limitation 2) it would work for some young people but not others; Limitation 3) the longer-term benefits of the programme were uncertain.		the use of more than one analyst.				
Sticking to the model as a team – adaptions of MDTFC's logic and philosophy. Following the spirit rather than to the letter: A clear majority of interviewees saw themselves and the programme sticking closely to what they understood as 'the model', while often disclaiming any detailed knowledge of it. This partly reflected the routinisation of practice and perhaps the strength of team ethos: I know ... as a team we work towards the model and it's the Oregon model that we follow but it feels much more like we're working to our team model. (Team member) Broad adherence reflected a number of factors. First, the model appeared to 'make sense' to most of those involved, with several foster carers claiming (though with perhaps some oversimplification) that this had been the basis of their own childrearing: It's basically the way I brought my own children up, which is good children get lots of nice things and naughty children get nothing, but I do it with points. Second, the consensus was that, albeit with some flexibility (see below), the model 'worked' but that this required fairly strict adherence: We're very close to the model on most things and whenever we stray I have to say that it kicks us in the teeth. (Team member) A third factor was that of external monitoring and reporting mechanisms, whether from the NIT or OSLC itself. While this sometimes involved elements of 'presentation' to outside audiences that differed from day-to-day realities, it also served to reinforce the programme's logic and philosophy. Much of course, depended on how far the model and its weighty manuals were to be followed 'in spirit' or 'to the letter'. For example, one team member	1	**Serious concerns** Unclear how participants were recruited and selected. No in-depth description of the analysis process. Unclear if sufficient data presented to support the findings. No apparent triangulation, respondent validation, or the use of more than one analyst.	**Minor concerns** Variability in how the model was applied could lead to inconsistent application and standards. However, there was the idea of the model as a philosophy rather than a detailed set of statutes, which could aid adaptability.	**Serious concerns** Only one study contributed to this theme	**Minor concerns** Data was likely collected prior to 2010	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
argued that expectations of young people in terms of healthy eating and eschewing of hip hop or rap music were unnecessarily restrictive and perhaps 'unrealistic'. While most foster carers came to find the award and deduction of points reasonably straightforward, the challenges, such as balancing consistency and individualisation and handling value judgements, should not be underestimated: "My lifestyle to somebody else's might be totally different and what I accept in my house is different to what somebody else accepts in theirs. (Foster carer)" Additional challenges included what constituted 'normal teenage behaviour' and how far the focus for change should rest with 'large' and 'small' behavioural problems respectively. These issues were, however, usually resolved fairly easily, with foster carers happy with their degree of discretion.						
Usefulness of the parental daily report: Parental Daily Reports were sometimes seen as 'a chore' (Westermark et al, 2007), but almost universally valued for their capacity to concentrate minds on behaviours, to ensure daily contact between foster carers and the programme and help 'nip problems in the bud'. "It makes me think about if things have happened, how I can do them better or how we can both do it better. So it's reflection for me. (Foster carer)" The data yielded were seen as useful for identifying trends and one-off or recurrent 'spikes' that might reveal behavioural triggers, such as contact visits or school events and as having a potential 'predictive' value for disruptions and optimal transition timing (Chamberlain et al, 2006). There were concerns that the prescribed list of behaviours was in places too 'Americanised' (eg 'mean talk') and that self-harm (not infrequent within the programme) was not listed separately but under destructiveness, requiring annotation to distinguish it from instances of 'kicking the door in'. Similarly, there was no reference to eating disorders other	1	**Serious concerns** Unclear how participants were recruited and selected. No in-depth description of the analysis process. Unclear if sufficient data presented to support the findings. No apparent triangulation, respondent validation, or the use of more than one analyst.	**Minor concerns** Theme covered several issues with the parental daily report including the burden on caregivers, the overly negative focus on behaviours, Americanisation of the language, and lack of distinction for medical or severe problems. However, spikes in behaviour could be tracked, which were helpful to identify triggers.	**Serious concerns** Only one study contributed to this theme	**Minor concerns** Data was likely collected prior to 2010	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
than 'skipping meals'. The question of whether behaviours were 'stressful' was clearly dependent to a degree on foster carers' tolerance and time of completion: "The next morning or the night time everything's died down and it probably isn't such a big deal ... [do] you give yourself that time just to calm down before you put it in the behaviour or should you do it when it happens? (Foster carer)" Concern was also expressed that the Parental Daily Report's focus on negative behaviours was not entirely congruent with the programme's aims of accentuating the positives (see below), a situation that was seen as having a cultural dimension, with one team member commenting, albeit as a generalisation, on how US counterparts in MTFC tended to be 'more upbeat about things' and hence less likely to dwell on negative behaviours.						
Engagement was crucial to outcomes but highly variable and prone to change over time: "She couldn't give a monkey's. It didn't matter what I'd say she was not gonna . . . And she stayed with me for three months and then she decided she'd had enough and went. (Foster carer)" More generally, however, engagement levels were thought to be high, with some respondents indicating surprise at the apparent willingness to accept a restrictive regime with its initial 'boot camp' withdrawal of privileges: "I find it bizarre that they engage with it really quite well ... I kind of think if I was a 13-year-old lad ... would I really want to be negotiating buying my free time, my time out with points? But they do ... and they stick to it. (Team member)"	1	**Serious concerns** Unclear how participants were recruited and selected. No in-depth description of the analysis process. Unclear if sufficient data presented to support the findings. No apparent triangulation, respondent validation, or the use of more than one analyst.	**No concerns**	**Serious concerns** Only one study contributed to this theme	**Minor concerns** Data was likely collected prior to 2010	Very Low
Need for persistence and finding and tailoring the right rewards: Situations were described where young people would rail against restrictions and thwarted demands but ultimately comply. While the motivational value of an identifiable goal (such as return home) was recognised, sustaining interest day-to-day was equally important and required	1	**Serious concerns** Unclear how participants were recruited and selected. No in-depth description of the analysis process. Unclear if sufficient data presented	**No concerns**	**Serious concerns** Only one study contributed to this theme	**Minor concerns** Data was likely collected prior to 2010	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
delicate judgements from foster carers as the following contrasting approaches indicate: "My young man likes to look at his points on a daily basis so we go through them with him and then we sit down and work out how he's gonna use his rewards and what he's aiming for next. I have to say that I don't sit down and discuss points with [young person] every night because she will just rip it up and throw it at me and tell me what a load of bollocks it is" Equally important, however, was finding the right rewards and appropriate means of earning them (although one young person was said to 'just like getting points'), something that might entail individual tailoring: "She needs to score points really, really highly, so whereas one foster carer might give one of the lads ten points for doing what she did, she may need to earn 50 for it to mean something. (Team member)" If this raises questions of 'inconsistency', it was justified in terms of motivation, individual pathways and progression through the programme (Dore and Mullin, 2006). Similar logic had meant 'massaging' points to prevent a drop in levels, where this might provoke running away or placement breakdown: "I think with some young people they ... just wouldn't manage being on level one and therefore it is slightly adapted to sort of manage that. (Team member)"		to support the findings. No apparent triangulation, respondent validation, or the use of more than one analyst.				
Are normal activities privileges? Transfer of placements into the programme also raised questions of how far previously 'normal' activities could be recast as privileges to be earned. Over time, this had reportedly given rise to some variations or changes of practice, for example, on televisions in bedrooms or consumption of fizzy drinks.	1	**Serious concerns** Unclear how participants were recruited and selected. No in-depth description of the analysis process. Unclear if sufficient data presented to support the findings. No apparent triangulation, respondent validation, or the use of more than one analyst.	**No concerns**	**Serious concerns** Only one study contributed to this theme	**Minor concerns** Data was likely collected prior to 2010	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
Need for redemption and engagement with point and level system: A key element of the OSLC philosophy is 'turning it around', allowing loss of points to be redeemed by subsequent good behaviour or positive reaction to the deduction. Although (some) foster carers felt this approach potentially made light of misdemeanours, the overall working of the programme was supportive of it: "Instead of giving her five points that she'd normally have I'll say, 'Well, you did that really well. I'll give you 15 for that today.' (Foster carer) You hear them talking about 'I really turned it around today' ... [or]'I'm working towards my points.' You actually hear the children saying, 'I know I need to be on this programme'. . . they ... have that insight. (Team member)" One young person had reportedly asked his foster carer not to let him out in case he got into trouble and forfeited a much desired holiday, something that was seen as a significant shift in thinking and timescales.	1	**Serious concerns** Unclear how participants were recruited and selected. No in-depth description of the analysis process. Unclear if sufficient data presented to support the findings. No apparent triangulation, respondent validation, or the use of more than one analyst.	**No concerns**	**Serious concerns** Only one study contributed to this theme	**Minor concerns** Data was likely collected prior to 2010	Very Low
A behavioural model or an attachment model? Behavioural programmes are sometimes criticised for lacking depth or concentrating on 'symptoms rather than causes', a debate we explored in interviews. Foster carers tended to focus on their own specific role in dealing with behaviours and saw the addressing of any 'underlying' problems as being the responsibility of others, especially the individual therapist, as in 'I'm just trying to break a pattern but it's not actually solving why they do it.' Also emphasised strongly was the temporal focus on present and future, by comparison with attachment models 'looking backwards'. If in some senses, practice remained firmly within a behavioural framework, this was not seen as precluding consideration of attachment issues, whether at the level of understanding – 'I find it quite hard not to think about things in terms of attachment' – or in outcomes: "I think what's been helpful is people have sort	1	**Serious concerns** Unclear how participants were recruited and selected. No in-depth description of the analysis process. Unclear if sufficient data presented to support the findings. No apparent triangulation, respondent validation, or the use of more than one analyst.	**No concerns** This theme covers the reconciliation of the behavioural and attachment models in MDTFC	**Serious concerns** Only one study contributed to this theme	**Minor concerns** Data was likely collected prior to 2010	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
of said, 'Oh, it's not an attachment model' and I just have been able to say to them, 'What do you think actually putting a containing and caring environment around a child does?' ... It's not the kind of ... Pavlov's dogs type thing that everyone thinks about when they think about behavioural models. (Team member)"						
Importance of appropriate matching: While in principle, behavioural approaches tend to de-emphasise the importance of relationship, the crucial importance of matching (which tended to involve consideration of several young people for one (or two) foster carer vacancies) was widely recognised and seen as a key area of learning within the programme: "I think we're getting it right more often than not and I think that's reflected in the ... reduction of disruptions. When we do get it wrong we get it wrong very spectacularly! (Team member)"	1	**Serious concerns** Unclear how participants were recruited and selected. No in-depth description of the analysis process. Unclear if sufficient data presented to support the findings. No apparent triangulation, respondent validation, or the use of more than one analyst.	**No concerns** However, this theme offered no suggestions as to how matching could be improved	**Serious concerns** Only one study contributed to this theme	**Minor concerns** Data was likely collected prior to 2010	Very Low
Move on placements and step-down placements: Marrying MTFC's twin aims of providing time-limited 'move on' placements while effecting sustainable behavioural change required complex judgements as to the optimal timing of transitions. Opinion was divided on this (national guidance had suggested a shortening of placements from around 18 to nine months) between those emphasising the time needed to deal with 'long-term damage' or the dangers of 'relapse' and those worried about stagnation, disengagement or young people 'outgrowing the programme'. While practice wisdom and programme data were seen as aiding decision-making, follow-on placements remained a significant problem. In some instances, this had been resolved by the young person remaining with their MTFC (respite) carers, although this usually entailed the latter's loss to the programme. Consideration had also been given to the establishment of 'step-down' placements to provide a	1	**Serious concerns** Unclear how participants were recruited and selected. No in-depth description of the analysis process. Unclear if sufficient data presented to support the findings. No apparent triangulation, respondent validation, or the use of more than one analyst.	**Minor concerns** There was a lack of clarity regarding which approach had been most successful for move on or step-down placements.	**Serious concerns** Only one study contributed to this theme	**Minor concerns** Data was likely collected prior to 2010	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
more gradual reduction in structure and support (NIT, 2008). However, such provision is challenging in terms of recruitment. Several young people who had left MTFC had subsequently kept in contact, and interestingly this included some early and late leavers as well as graduates.						
Foster carers satisfaction with the level of support and out of hours service: Foster carers were extremely positive about levels of support in MTFC – 'Just absolutely amazing', 'I have to say brilliant. 100 per cent brilliant' – and some commented on how this had prevented disruptions that might otherwise have occurred. 'Enhanced' (relative to 'mainstream' fostering) features included higher levels of contact with supervising (and assistant) social workers and a structured pattern of short breaks or 'respite care'. In addition to their primary role of granting some relief from pressures, these arrangements sometimes evolved into follow-on placements after disruptions, helping to provide important elements of continuity. Another crucial 'enhanced' feature was a dedicated out-of-hours service staffed by members of the team, which, though used fairly modestly (typically one or two calls per day), was highly valued for its provision of a crucial safety net: "There's nothing more reassuring ... that you can ring someone up and actually hear that person on the end of the phone, it's not some call centre or someone you've never met before. (Foster carer)" Use of the out-of-hours service ranged from serious incidents involving offending, (alleged) sexual assaults, suicide concerns and violence or damage in the foster home, to reassurance on medical issues and dealing with difficult behaviours.	1	**Serious concerns** Unclear how participants were recruited and selected. No in-depth description of the analysis process. Unclear if sufficient data presented to support the findings. No apparent triangulation, respondent validation, or the use of more than one analyst.	**Minor concerns** Enhanced support covered several aspects that foster carers found to be helpful, particularly in comparison to usual fostering.	**Serious concerns** Only one study contributed to this theme	**Minor concerns** Data was likely collected prior to 2010	Very Low
Value of therapists and skills workers While the roles of therapists and skills workers sometimes raised issues of co-ordination with foster carers, their	1	**Serious concerns** Unclear how participants were recruited and selected. No in-depth	**Minor concerns** It is unclear what was meant by	**Serious concerns** Only one study	**Minor concerns**	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
capacity to ease pressures at times of difficulty was valued by carers.		description of the analysis process. Unclear if sufficient data presented to support the findings. No apparent triangulation, respondent validation, or the use of more than one analyst.	"issues of co-ordination"	contributed to this theme	Data was likely collected prior to 2010	
Usefulness of the foster carers' weekly meetings the foster carers' weekly meetings. These served both to ensure fairly prompt attention to issues, but also afforded the opportunity for mutual support and problem-solving	1	**Serious concerns** Unclear how participants were recruited and selected. No in-depth description of the analysis process. Unclear if sufficient data presented to support the findings. No apparent triangulation, respondent validation, or the use of more than one analyst.	No concerns	**Serious concerns** Only one study contributed to this theme	**Minor concerns** Data was likely collected prior to 2010	Very Low
Success of co-ordinated working There has been little research on the operation of teamwork within MTFC or its external relations. Despite significant staff turnover and some reworking of roles, the programme had also benefited from continuity in some key positions and a capacity to fill vacancies relatively quickly. From interviews and observation, internal roles appeared to be fairly clear and well co-ordinated, although the team's relatively small size had inevitably given rise on occasion to questions of flexibility, with tensions between willingness to help out and the maintenance of role boundaries (eg on provision of transport or supervision of contact): "On the whole, given that we have got a bunch of quite disparate professions ... we've got a conjoined CAMHS, education and social care team, there's a lot less conflict than I thought there might be. (Team member)"	1	**Serious concerns** Unclear how participants were recruited and selected. No in-depth description of the analysis process. Unclear if sufficient data presented to support the findings. No apparent triangulation, respondent validation, or the use of more than one analyst.	**Minor concerns** Some sense of difficulty co-ordinating the team and role boundaries despite the overall positive findings.	**Serious concerns** Only one study contributed to this theme	**Minor concerns** Data was likely collected prior to 2010	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
The workings of MTFC both facilitate and require high levels of communication, combining multifarious opportunities for contact with a need to pass on information regarding 'eventful' lives and high levels of activity on the programme. With occasional, and usually fairly specific exceptions, team members regarded communication as very effective, while foster carers were generally positive about their participation: 'They do value your input and they value your knowledge and your sort of past experience.'						
Leadership of programme supervisors The role of Programme Supervisor (PS) as key decision-maker – variously referred to as 'Programme God' or 'the final word'– was crucial within the team. While some team members reported taking time to adapt to this, it was widely acknowledged that the PS and indeed 'the programme' could act as a lightning rod to defuse conflicts involving young people and their foster carers: "Always it's'[PS], says' ... in answer, so my [young person] wishes that [PS] would drop dead at any moment. But that takes a huge amount off of me because it's not me who's saying it. That's absolutely been brilliant. (Foster carer)"	1	**Serious concerns** Unclear how participants were recruited and selected. No in-depth description of the analysis process. Unclear if sufficient data presented to support the findings. No apparent triangulation, respondent validation, or the use of more than one analyst.	**No concerns**	**Serious concerns** Only one study contributed to this theme	**Minor concerns** Data was likely collected prior to 2010	Very Low
Clash with the children's social worker Like any specialist programme, MTFC has faced challenges in its relationships with Children's Social Workers (often exacerbated by turnover among them) regarding the balance between a necessary transfer of responsibility on the part of Children's Social Workers while they continue to hold case accountability. Despite routinely sent information and discussions with the programme supervisors, almost all CSWs interviewed expressed some concerns, usually involving either not knowing of specific incidents (e.g. entry to hospital) or more ongoing matters, such as the content of counselling. For some, the concern was simply about being 'out of the loop', while for others it was the potential for exclusion	1	**Serious concerns** Unclear how participants were recruited and selected. No in-depth description of the analysis process. Unclear if sufficient data presented to support the findings. No apparent triangulation, respondent validation, or the use of more than one analyst.	**Minor Concerns** Theme encompassed several aspects of difficulty in working with Children's Social Workers. Both in relinquishing control and stepping back too much.	**Serious concerns** Only one study contributed to this theme	**Minor concerns** Data was likely collected prior to 2010	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
from decision making and conflict with statutory duties: "It seemed to me that the treatment fostering team pretty much took on responsibility for the case, which is fine, but if anything goes wrong then don't make me accountable." From a programme perspective, there were occasional references to Childrens Social Workers who 'found it hard to let go', or whose misunderstanding caused confusion. As one foster carer put it, 'they start telling these kids all sorts of things and you're thinking "no actually, they can't"', although it should be noted that some Social Workers were viewed very positively. A more common concern, however, was that some Social workers 'opted out' once the young person entered MTFC, although this was often acknowledged (on both sides) as understandable given the workload pressures facing children's social workers: "[. . .] was the sort of child I used to literally wake up worrying about and I don't now because somebody else is doing that worrying. (CSW)" Encouragingly, CSWs also referred to improving communication, with some plaudits for MTFC being approachable and responsive. The programme had attempted to improve liaison by visiting teams and by inviting children's social workers to attend meetings, although these offers had not been taken up, with CSWs reporting diary clashes and imprecise timings to discuss 'their' charges. It was also noted that the very specific workings and language of MTFC were not always well-integrated into Looked After Children (LAC) review processes.						
Social workers were positive about the programme even where placements broke down "He was a really, really difficult young man and they've really supported him and provided him with a stable home environment, really, really firm boundaries which he's really needed . . . I think the placement's been fantastic. She would have met the criteria [for secure	1	**Serious concerns** Unclear how participants were recruited and selected. No in-depth description of the analysis process. Unclear if sufficient data presented	**No concerns**	**Serious concerns** Only one study contributed to this theme	**Minor concerns** Data was likely collected prior to 2010	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
accommodation] in terms of running off ... self-harming ... And now the self-harming is very ... very limited. It changed his life around to be perfectly honest. Yeah, I'd go that far." This is not, of course, to say that time in MTFC represents any form of panacea, but recognition of its impact in often difficult circumstances: "He's only absconded three times in six months or so and it's only ever been running off from school and he's back by nine o'clock ... whereas before he was missing for days on end. (Team member) There are obviously still concerns about her emotional welfare and there will be, but she was a very, very damaged girl for lots and lots of reasons, but there was a time where I thought she just might ... not survive. (CSW)" The idea that even 'failed' placements might nonetheless carry some residual benefit for young people – particularly those in 'multiple disruption mode' was also expressed by some.		to support the findings. No apparent triangulation, respondent validation, or the use of more than one analyst.				
Creating relationships with birth families. The Circle Program was felt to be more likely to promote reunification with family or enter kinship care than among children in a generalist foster care placement. Factors contributing to the child's relationship with their family of origin included: valuing the unique knowledge brought by the parents, encouraging the attendance of family, and the usefulness of care team meetings.	1	**Serious concerns** Qualitative methods were not appropriate to evaluate effectiveness of the intervention in terms of likelihood of reunification. Researchers do not discuss how participants were selected for the study, and why these were the most appropriate or why some chose not to take part. Focus group methods were not made explicit. *Thematic analysis process was not described explicitly.*	**No concerns** However, participation of birth families could be encouraged in one of several ways.	**Serious concerns** Only one study contributed to this theme.	**Minor concerns** Study took place in Australia	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
Support that was helpful for retaining foster carers - Focus group data highlighted factors deemed to be influential to carer retention such as support, training, ongoing education and access to flexible funds to obtain services. Comments highlighted the value of participation in regular care team meetings. Carers spoke of their commitment to their role as a Circle carer, highlighting the experience of support, training, and ongoing education.	1	**Serious concerns** Qualitative methods were not appropriate to evaluate effectiveness of the intervention in terms of likelihood of reunification. Researchers do not discuss how participants were selected for the study, and why these were the most appropriate or why some chose not to take part. Focus group methods were not made explicit. *Thematic analysis process was not described explicitly.*	**Minor concerns** Theme covered several distinct aspects of support that could help to retain foster carers.	**Serious concerns** Only one study contributed to this theme.	**Minor concerns** Study took place in Australia	Very Low
Access to flexible brokerage funds - These funds were described by carers as supporting children to participate in normative community activities, for example a dance class or organized sport. Where a child required a specialist assessment (e.g. speech therapy) that was not available through public funding within a reasonable time frame, brokerage funding could be used. A key message from carers was the importance of accessing such discretionary funds to meet a child's needs in a timely way.	1	**Serious concerns** Qualitative methods were not appropriate to evaluate effectiveness of the intervention in terms of likelihood of reunification. Researchers do not discuss how participants were selected for the study, and why these were the most appropriate or why some chose not to take part. Focus group methods were not made explicit. *Thematic analysis process was not described explicitly.*	**No concerns**	**Serious concerns** Only one study contributed to this theme.	**Minor concerns** Study took place in Australia	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
Carers valued and treated as professional equals. The Circle Program was described by some carers as elevating the role of the foster carer to one that is 'equal' to the other professionals on the care team. This, combined with the Circle Program training, professionalized the role of the foster carer, and some carers reported increased levels of confidence in their competence. Carers also commented that the success of the Circle Program was linked to the professional support provided: feeling 'listened to', having their opinions 'valued' and being 'supported' in their role as foster carer. In the focus groups, carers discussed their role and participation in the Circle Program with passion and enthusiasm. The wellbeing of the carer was also a focus of care team meetings with one carer commenting that someone always asked her how she was at care meetings and 'They really want to know how I am'!	1	**Serious concerns** Qualitative methods were not appropriate to evaluate effectiveness of the intervention in terms of likelihood of reunification. Researchers do not discuss how participants were selected for the study, and why these were the most appropriate or why some chose not to take part. Focus group methods were not made explicit. *Thematic analysis process was not described explicitly.*	**No concerns**	**Serious concerns** Only one study contributed to this theme.	**Minor concerns** Study took place in Australia	Very Low
The common purpose of the care team with an equal system of carers - The egalitarian nature and common purpose of the care team were features mentioned by a number of focus group participants as having significance in their experience of TFC.	1	**Serious concerns** Qualitative methods were not appropriate to evaluate effectiveness of the intervention in terms of likelihood of reunification. Researchers do not discuss how participants were selected for the study, and why these were the most appropriate or why some chose not to take part. Focus group methods were not made explicit. *Thematic analysis process was not described explicitly.*	**No concerns**	**Serious concerns** Only one study contributed to this theme.	**Minor concerns** Study took place in Australia	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
Training essential particularly in trauma theory, attachment and self-knowledge. Contents of training - Training in trauma theory, attachment and selfknowledge were also identified as essential components by foster carers and foster care workers alike.	1	**Serious concerns** Qualitative methods were not appropriate to evaluate effectiveness of the intervention in terms of likelihood of reunification. Researchers do not discuss how participants were selected for the study, and why these were the most appropriate or why some chose not to take part. Focus group methods were not made explicit. *Thematic analysis process was not described explicitly.*	**No concerns**	**Serious concerns** Only one study contributed to this theme.	**Minor concerns** Study took place in Australia	Very Low
Key role of the therapeutic specialist (Circle programme). The key role of the therapeutic specialist - Therapeutic specialists were identified by all stakeholders as core to the Circle Program's success. Circle carers and foster care workers highlighted the value of this role in guiding assessment and the care of the child. The availability of the therapeutic specialist was considered a particular strength given their knowledge; and ability to assist carers in understanding the child and their needs. Their role was active in guiding the foster carer in their day to day response to the child and this was experienced as very supportive and was seen to facilitate a more immediate and appropriate response in meeting the child's needs. The therapeutic specialist could also extend their focus to include the child's family of origin as from the commencement of placement the aim is for the child to reunify with their family if the family can meet their needs. As many of the families of origin had themselves	1	**Serious concerns** Qualitative methods were not appropriate to evaluate effectiveness of the intervention in terms of likelihood of reunification. Researchers do not discuss how participants were selected for the study, and why these were the most appropriate or why some chose not to take part. Focus group methods were not made explicit. *Thematic analysis process was not described explicitly.*	**No concerns**	**Serious concerns** Only one study contributed to this theme.	**Minor concerns** Study took place in Australia	Very Low

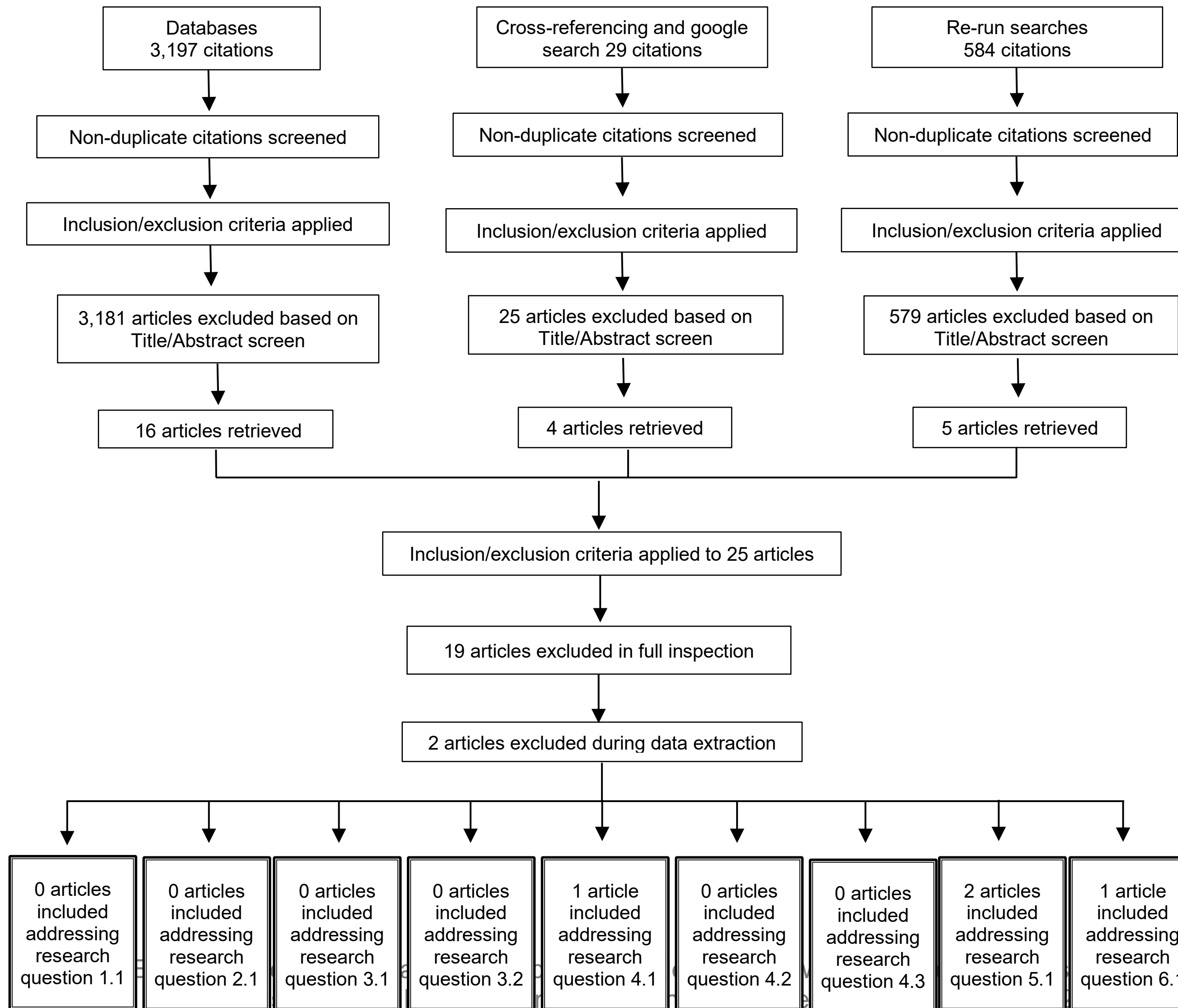
Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
experienced trauma, it is important that they be assisted to heal and change to be available for the care of their child/young person.						
Building a support network for the child. Feedback from focus groups and the survey highlighted the importance of building a support network for the child/young person. This network included teachers, extended family and others in addition to members of the care team.	1	**Serious concerns** Qualitative methods were not appropriate to evaluate effectiveness of the intervention in terms of likelihood of reunification. Researchers do not discuss how participants were selected for the study, and why these were the most appropriate or why some chose not to take part. Focus group methods were not made explicit. *Thematic analysis process was not described explicitly.*	**No concerns**	**Serious concerns** Only one study contributed to this theme.	**Minor concerns** Study took place in Australia	Very Low
The hard and stressful work of fostering. How would foster parents and staff tolerate the intervention? - a feasibility worry was that the TFC-OY intervention would be difficult for foster parents to tolerate. This was confirmed. In addition, some staff found the work stressful. In weekly meetings and in the qualitative research interviews, foster parents reported that the youth were extremely difficult to parent. Despite training that focused on the needs of youth with psychiatric problems, the foster parents reported being surprised by the amount of emotional volatility in the young people they served, the low levels of what they perceived as emotional maturity, and high needs for monitoring and supervision. No parent or youth described an extended period of time when life settled into a comfortable routine. It always felt like	1	**Serious concerns** Qualitative methods were not appropriate to evaluate effectiveness of the intervention in terms of likelihood of reunification. Researchers do not discuss how participants were selected for the study, and why these were the most appropriate or why some chose not to take part. Focus group methods were not made explicit.	**No concerns**	**Serious concerns** Only one study contributed to this theme.	**Minor concerns** Study took place in Australia	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
stressful work to the foster parents. The experience was not easy for the TFC-OY staff either. One Life Coach was surprised by the low level of emotional functioning of youth in an office setting.		*Thematic analysis process was not described explicitly.*				
Key role of the skills coach (Circle programme). The skills coach component was uniformly appreciated by foster parents, the program supervisor and the youth. When asked about the skills coach component, the youth tended to report things the coach had done for and with them that were related to positive youth development. E.g. helping to find a job, getting a drivers liscence, going to find a place to eat. Multiple stakeholders commented on the positive relationships that youth developed with their skills coaches.	1	**Serious concerns** Qualitative methods were not appropriate to evaluate effectiveness of the intervention in terms of likelihood of reunification. Researchers do not discuss how participants were selected for the study, and why these were the most appropriate or why some chose not to take part. Focus group methods were not made explicit. *Thematic analysis process was not described explicitly.*	**No concerns**	**Serious concerns** Only one study contributed to this theme.	**Minor concerns** Study took place in Australia	Very Low
Key role of the psychiatric nurse (Circle programme). A second component that drew positive comments from stakeholders was that of the psychiatric nurse. Care managers appreciated the medication and diagnostic review provided by the nurse. They provided numerous examples of how they used this review and knowledge in their interactions with mental health providers. While some youth did not understand why they were receiving psychoeducation about their mental health problems from a nurse, others greatly appreciated it, explaining that it changed how they monitored their symptoms and how they approached their psychiatric providers.	1	**Minor concerns** This study did not make its methods regarding coding and thematic analysis explicit.	**No concerns**	**Serious concerns** Only one study contributed to this theme.	**Minor concerns** Study took place in USA	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
Role of the life coach (Circle programme). The role of the life coach was a difficult one to execute. Initially, the role was focused on interpersonal skills the youth needed to succeed in the foster home, but was later supposed to involve life planning and psychoeducation. Two life coaches worked in the program and both found their role frustrating in terms of completing what they felt they were being asked to do.	1	**Minor concerns** This study did not make its methods regarding coding and thematic analysis explicit.	**No concerns**	**Serious concerns** Only one study contributed to this theme.	**Minor concerns** Study took place in USA	Very Low
The family consultant role (Circle programme). The family consultant role was less well received. The family consultant made many unsuccessful efforts to re-engage biological relatives and other nominated individuals into the lives of youth in TFC-OY and executed one successful effort, involving an older sibling. The role was also expensive (using a master's level mental health professional). In the end, the principal investigator concluded that the family consultant role would be eliminated going forward and that needed family work would be conducted by the program supervisor.	1	**Minor concerns** This study did not make its methods regarding coding and thematic analysis explicit.	**No concerns**	**Serious concerns** Only one study contributed to this theme.	**Minor concerns** Study took place in USA	Very Low
Changes suggested for the circle programme. Program changes needed? - Since it was decided that it was permissible to alter the intervention mid-pilot in order to have an intervention worthy of testing at the end of pilot period, two modifications to the protocols were made several months into the intervention: 1) redefined roles for team members; and 2) efforts to address emotional dysregulation. Some of the life coach's responsibilities were offloaded to other team members. The skills coaches became responsible for helping youth plan for more independent living and the psychiatric nurse became responsible for providing psychoeducation about mental health problems. These modifications were considered successful, as viewed by stakeholders in qualitative interviews at the end of the project. Most glaring was the need to develop intervention components to address	1	**Minor concerns** This study did not make its methods regarding coding and thematic analysis explicit.	**Moderate concerns** Several changes to the intervention were described however it was unclear where qualitative data were coming from for these changes and if themes were all in agreement.	**Serious concerns** Only one study contributed to this theme.	**Minor concerns** Study took place in USA	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
youth emotion regulation problems. Six of the foster parents interviewed qualitatively reported that the young people served in their homes experienced severe emotional outbursts; typically youth were seen as quick to become emotional and remaining emotionally volatile for substantial periods of time. During the last six months of the pilot, TFC-OY staff explored the potential of using processes and materials from Dialectical Behaviour Therapy in TFC-OY to address youth emotion regulation problems. Staff received initial DBT training from a certified trainer and a DBT skills group was mounted with the foster youth to teach interpersonal effectiveness and mindfulness skills. The groups were well received by youth who attended them, but attendance was a problem, mostly due to logistics, such as distance from youth placements to the group site, work schedules, and transportation issues. By the end of the pilot, the intervention team concluded that any future trials or implementation of TFC-OY should be delayed until new intervention components were developed to address emotion regulation problems.						

Appendix G – Economic evidence study selection



Appendix H – Economic evidence tables

No economic evidence was identified for this review question.

Appendix I – Health economic model

No economic modelling was undertaken for this review question.

Appendix J – Excluded studies

Effectiveness studies

Study	Code [Reason]
AKIN Becci A. and et al (2018) Randomized study of PMTO in foster care. Research on Social Work Practice 28(8): 810-826	- No outcomes of interest under this review question
Akin, Becci A, Yan, Yueqi, McDonald, Thomas et al. (2017) Changes in parenting practices during Parent Management Training Oregon model with parents of children in foster care. Children and Youth Services Review 76: 181-191	- No outcome of interest reported *[Only carer-specific outcomes reported]*
Armour, Marilyn P and Schwab, James (2005) Reintegrating Children into the System of Substitute Care: Evaluation of the Exceptional Care Pilot Project. Research on Social Work Practice 15(5): 404-417	- Non-UK - Uncontrolled before and after study
Banerjee, Leena and Castro, Lorraine E (2005) Intensive day treatment for very young traumatized children in residential care. The handbook of training and practice in infant and preschool mental health.: 233-255	- Intervention description/practice report
Barth, Richard P, Greeson, Johanna K P, Guo, Shenyang et al. (2007) Outcomes for youth receiving intensive in-home therapy or residential care: a comparison using propensity scores. The American journal of orthopsychiatry 77(4): 497-505	- Unclear that population are LACYP *[Services to treat behaviourally troubled but not necessarily looked after children. Only a third had maltreatment as a presenting problem. Study compared residential treatment with parent involved and intensive in-home services]*

Study	Code [Reason]
BARTLETT Jessica Dym and RUSHOVICH Berenice (2018) Implementation of Trauma Systems Therapy-Foster Care in child welfare. Children and Youth Services Review 91: 30-38	- Non-UK - non-randomised controlled study
Barto B., Bartlett J.D., Von Ende A. et al. (2018) The impact of a statewide trauma-informed child welfare initiative on children's permanency and maltreatment outcomes. Child Abuse and Neglect 81: 149-160	- non-randomised controlled study - non-UK
Belanger, Kathleen and Stone, Warren (2008) The social service divide: service availability and accessibility in rural versus urban counties and impact on child welfare outcomes. Child welfare 87(4): 101-24	- No outcome of interest to this review question
Benesh, Andrew S and Cui, Ming (2017) Foster parent training programmes for foster youth: A content review. Child & Family Social Work 22(1): 548-559	- Systematic review considered for relevant references
BERGSTROM, Martin and et, al (2020) Interventions in foster family care: a systematic review. Research on Social Work Practice 30(1): 3-18	- Systematic review considered for relevant references
BERRY Marianne and et al (2000) Intensive family preservation services: an examination of critical service components. Child and Family Social Work 5(3): 191-203	- Unclear that population are LACYP *[Families who are served by the Intensive Family Preservation programme who are believed to be at imminent risk of having the child removed from the home.]*
Biehal, Nina (2005) Working with adolescents at risk of out of home care: The effectiveness of specialist teams. Children and Youth Services Review 27(9): 1045-1059	- Unclear that population are LACYP *[at risk of out of home placement]*

Study	Code [Reason]
Biehal, Nina, Ellison, Sarah, Sinclair, Ian et al. (2011) Intensive fostering: An independent evaluation of MTFC in an English setting. Children and Youth Services Review 33(10): 2043-2049	- No outcome of interest to this review question
Boel-Studt, Shamra Marie (2017) A quasi-experimental study of trauma-informed psychiatric residential treatment for children and adolescents. Research on Social Work Practice 27(3): 273-282	- No outcome of interest to this review question
Brook, Jody and McDonald, Thomas P (2007) Evaluating the effects of comprehensive substance abuse intervention on successful reunification. Research on Social Work Practice 17(6): 664-673	- No outcome of interest to this review question
Brown, Adam D, McCauley, Kelly, Navalta, Carryl P et al. (2013) Trauma Systems Therapy in residential settings: Improving emotion regulation and the social environment of traumatized children and youth in congregate care. Journal of Family Violence 28(7): 693-703	- Non-UK - Uncontrolled before and after study
BULLOCK Roger (2016) Can we plan services for children in foster care? Or do we just have to cope with what comes through the door?. Social Work and Society: International Online Journal 14(2)	- Intervention description/practice report - Case study
Chamberlain, Patricia (2003) Antisocial behavior and delinquency in girls. Treating chronic juvenile offenders: Advances made through the Oregon multidimensional treatment foster care model.: 109-127	- Book
Chamberlain, Patricia, Brown, C Hendricks, Saldana, Lisa et al. (2008) Engaging and recruiting counties in an experiment on implementing	- No outcome of interest reported *[meta-research]*

Study	Code [Reason]
evidence-based practice in California. Administration and policy in mental health 35(4): 250-60	
Chamberlain, Patricia and Smith, Dana K (2003) Antisocial behavior in children and adolescents: The Oregon Multidimensional Treatment Foster Care model. Evidence-based psychotherapies for children and adolescents.: 282-300	- Review article but not a systematic review
Chamberlain, Patricia and Smith, Dana K (2005) Multidimensional Treatment Foster Care: A Community Solution for Boys and Girls Referred From Juvenile Justice. Psychosocial treatments for child and adolescent disorders: Empirically based strategies for clinical practice., 2nd ed.: 557-573	- Book
CHAN Ko, Ling and et, al (2019) The effectiveness of interventions for grandparents raising grandchildren: a meta-analysis. Research on Social Work Practice 29(6): 607-617	- Systematic review
Chinitz, Susan, Guzman, Hazel, Amstutz, Ellen et al. (2017) Improving outcomes for babies and toddlers in child welfare: A model for infant mental health intervention and collaboration. Child abuse & neglect 70: 190-198	- non-UK - uncontrolled before and after study
Chor, Ka Ho Brian, McClelland, Gary M, Weiner, Dana A et al. (2013) Patterns of out-of-home placement decision-making in child welfare. Child abuse & neglect 37(10): 871-82	- No outcome of interest reported
Christenson, Brian L and McMurtry, Jerry (2009) A longitudinal evaluation of the preservice training and retention of kinship and nonkinship foster/adoptive families one and a half years after training. Child welfare 88(4): 5-22	- No outcome of interest reported *[Caregiver knowledge test following training]* - Non-UK setting

Study	Code [Reason]
Christenson, Brian and McMurtry, Jerry (2007) A comparative evaluation of preservice training of kinship and nonkinship foster/adoptive families. Child welfare 86(2): 125-40	- No outcome of interest reported *[Caregiver knowledge test following training]* - Non-UK setting
Christiansen, Oivin, Havik, Toril, Anderssen, Norman et al. (2010) Arranging stability for children in long-term out-of-home care. Children and Youth Services Review 32(7): 913-921	- non-UK - for consideration under RQ1.2
Clark, Hewitt B, Crosland, Kimberly A, Geller, David et al. (2008) A functional approach to reducing runaway behavior and stabilizing placements for adolescents in foster care. Research on Social Work Practice 18(5): 429-441	- non-UK - non-randomised controlled study
Cole, Susan A and Hernandez, Pedro M (2011) Crisis nursery effects on child placement after foster care. Children and Youth Services Review 33(8): 1445-1453	- No outcome of interest reported
COOLEY Morgan, E. and et, al (2019) A systematic review of foster parent preservice training. Children and Youth Services Review 107: 104552	- systematic review
Critelli, Filomena M (2008) Labor of love: foster mothers, caregiving, and welfare reform. Child welfare 87(4): 5-34	- Not an intervention of interest *[Open ended survey questions regarding foster mother's views of welfare reform in America.]*
Cross, Theodore P, Leavey, Joseph, Mosley, Peggy R et al. (2004) Outcomes of specialized foster care in a managed child welfare services network. Child welfare 83(6): 533-64	- No outcome of interest reported

Study	Code [Reason]
D'Andrade, Amy, Frame, Laura, Berrick, Jill Duerr et al. (2006) Concurrent planning in public child welfare agencies: Oxymoron or work in progress?. Children and Youth Services Review 28(1): 78-95	- non-UK - for consideration under RQ1.2
Davies, Philippa, Webber, Martin, Briskman, Jacqueline A et al. (2015) Evaluation of a training programme for foster carers in an independent fostering agency. Practice: Social Work in Action 27(1): 35-49	- No outcome of interest reported
Davis, Cynthia W, O'Brien, Kirk, Rogg, Carla S et al. (2013) 24-month update on the impact of roundtables on permanency for youth in foster care. Children and Youth Services Review 35(12): 2128-2134	- No outcome of interest reported *[prediction of the success of an intervention, plus descriptive outcomes (non-comparative)]*
DeGarmo, David S, Chamberlain, Patricia, Leve, Leslie D et al. (2009) Foster parent intervention engagement moderating child behavior problems and placement disruption. Research on Social Work Practice 19(4): 423-433	- Not an investigation of an intervention *[analysis of factors predicting success of an intervention]*
Denby, Ramona W (2011) Kinship liaisons: A peer-to-peer approach to supporting kinship caregivers. Children and Youth Services Review 33(2): 217-225	- No outcome of interest to this review question
DeSena, Allen D, Murphy, Robert A, Douglas-Palumberi, Heather et al. (2005) SAFE Homes: is it worth the cost? An evaluation of a group home permanency planning program for children who first enter out-of-home care. Child abuse & neglect 29(6): 627-43	- non-UK - NRCT
Eddy, J. Mark, Whaley, Rachel Bridges, Chamberlain, Patricia et al. (2004) The Prevention of Violent Behavior by Chronic and Serious Male Juvenile Offenders: A 2-Year Follow-up of a Randomized Clinical Trial. Journal of Emotional and Behavioral Disorders 12(1): 2-8	- No outcome of interest to this review question

Study	Code [Reason]
Edwards, M (2005) Evaluation of the application of the "Incredible Years" programme with foster carers of looked after children in Gwynedd.: 43pp	- controlled trial abstract
Farmer, Elizabeth M. Z, Wagner, H. Ryan, Burns, Barbara J et al. (2003) Treatment foster care in a system of care: Sequences and correlates of residential placements. Journal of Child and Family Studies 12(1): 11-25	- No outcome of interest to this review question
Feldman, Leonard H and Fertig, Amanda (2013) Measuring the impact of enhanced kinship navigator services for informal kinship caregivers using an experimental design. Child welfare 92(6): 41-62	- Unclear that population are LACYP *[informal kinship care excluding children with an open case with the child welfare agency]*
Fisher, Philip A; Burraston, Bert; Pears, Katherine (2005) The early intervention foster care program: permanent placement outcomes from a randomized trial. Child maltreatment 10(1): 61-71	- No outcome of interest to this review question - to be considered under RQ5.1
Fisher, Philip A and Chamberlain, Patricia (2000) Multidimensional treatment foster care: A program for intensive parenting, family support, and skill building. Journal of Emotional and Behavioral Disorders 8(3): 155-164	- Review article but not a systematic review
Fisher, Philip A and Chamberlain, Patricia (2001) Multidimensional treatment foster care: A program for intensive parenting, family support, and skill building. Making schools safer and violence free: Critical issues, solutions, and recommended practices.: 140-149	- Duplicate reference
Fisher, Philip A, Kim, Hyoun K, Pears, Katherine C et al. (2009) Effects of multidimensional treatment foster care for preschoolers (MTFC-P) on reducing permanent placement failures among children with placement instability. Children and Youth Services Review 31(5): 541-546	- No outcome of interest to this review question - to be considered under RQ5.1

Study	Code [Reason]
Frederico, Margarita, Long, Maureen, McNamara, Patricia et al. (2017) Improving outcomes for children in out-of-home care: The role of therapeutic foster care. Child & Family Social Work 22(2): 1064-1074	-non-UK -Non-randomised controlled trial -to be considered under RQ1.2
Gilbertson, Robyn, Richardson, David, Barber, James et al. (2005) The Special Youth Carer Program: An Innovative Program for At-Risk Adolescents in Foster Care. Child & Youth Care Forum 34(1): 75-89	- non-UK - uncontrolled before and after study
Greeno, Elizabeth J, Lee, Bethany R, Uretsky, Mathew C et al. (2016) Effects of a foster parent training intervention on child behavior, caregiver stress, and parenting style. Journal of Child and Family Studies 25(6): 1991-2000	- non-UK - non-randomised controlled trial
Greeno, Elizabeth J, Uretsky, Mathew C, Lee, Bethany R et al. (2016) Replication of the KEEP foster and kinship parent training program for youth with externalizing behaviors. Children and Youth Services Review 61: 75-82	- non-UK - uncontrolled before and after study
Greenwood, Peter W (2004) Cost-effective violence prevention through targeted family interventions. Annals of the New York Academy of Sciences 1036: 201-14	- Review article but not a systematic review
Hahn, Robert A, Lowy, Jessica, Bilukha, Oleg et al. (2004) Therapeutic foster care for the prevention of violence: a report on recommendations of the Task Force on Community Preventive Services. MMWR. Recommendations and reports : Morbidity and mortality weekly report. Recommendations and reports 53(rr10): 1-8	- systematic review checked for relevant citations

Study	Code [Reason]
Hawkins, Catherine A and Bland, Tammy (2002) Program evaluation of the CREST project: empirical support for kinship care as an effective approach to permanency planning. Child welfare 81(2): 271-92	- Comparator in study does not match that specified in protocol *[noncomparative/descriptive data]*
HERBERT Martin and WOOKEY Jenny (2007) The Child Wise Programme: a course to enhance the self-confidence and behaviour management skills of foster carers with challenging children. Adoption and Fostering 31(4): 27-37	- UK study - for consideration under RQ1.2
Hermenau, Katharin, Goessmann, Katharina, Rygaard, Niels Peter et al. (2017) Fostering Child Development by Improving Care Quality: A Systematic Review of the Effectiveness of Structural Interventions and Caregiver Trainings in Institutional Care. Trauma, violence & abuse 18(5): 544-561	- No outcome of interest to this review question
Herrman, Helen, Humphreys, Cathy, Halperin, Stephen et al. (2016) A controlled trial of implementing a complex mental health intervention for carers of vulnerable young people living in out-of-home care: the ripple project. BMC psychiatry 16(1): 436	- No outcome of interest reported *[feasibility outcomes]*
Hine, Kathleen M and Moore, Kevin J (2015) Family Care Treatment for dispersed populations of children with behavioral challenges: The design, implementation, and initial outcomes of an evidence-informed treatment. Children and Youth Services Review 58: 179-186	- No outcome of interest to this review question
Holmes, Lisa, Ward, Harriet, McDermid, Samantha et al. (2012) Calculating and comparing the costs of multidimensional treatment foster care in English local authorities. Children and Youth Services Review 34(11): 2141-2146	- No outcome of interest to this review question
Howard, Jeanne A, Smith, Susan Livingston, Zosky, Diane L et al. (2006) A Comparison of Subsidized Guardianship and Child Welfare Adoptive Families	- Not an intervention of interest *[subsidized guardianship vs adoption]*

Study	Code [Reason]
Served by the Illinois Adoption and Guardianship Preservation Program. Journal of Social Service Research 32(3): 123-134	
ISRCTN16401432 (2007) Efficacy of a multicomponent support programme for caregivers of disabled persons: a randomised controlled study. Http://www.who.int/trialsearch/trial2.aspx? Trialid=isrctn16401432	- Unclear that population are LACYP
ISRCTN19090228 (2017) Confidence in Care Evaluation. Http://www.who.int/trialsearch/trial2.aspx? Trialid=isrctn19090228	- trial registration
ISRCTN80786829 (2016) Supporting looked after children and care leavers in decreasing drugs and alcohol. Http://www.who.int/trialsearch/trial2.aspx? Trialid=isrctn80786829	- trial registration
Izzo, Charles V, Smith, Elliott G, Holden, Martha J et al. (2016) Intervening at the setting level to prevent behavioral incidents in residential child care: Efficacy of the CARE program model. Prevention Science 17(5): 554-564	- non-UK - interrupted time series
Jani, Jayshree S (2017) Reunification is not enough: Assessing the needs of unaccompanied migrant youth. Families in Society 98(2): 127-136	- No outcome of interest to this review question
Jayasekara, Rasika (2013) Kinship care for the safety, permanency, and well-being of children removed from the home for maltreatment. Child health and human development yearbook, 2011.: 269-272	- Not an intervention of interest
Johnson, Kristen and Wagner, Dennis (2005) Evaluation of Michigan's Foster Care Case Management System. Research on Social Work Practice 15(5): 372-380	- No outcome of interest to this review question

Study	Code [Reason]
Jones, Barry (2008) The price of permanency: Cost-benefit analysis of a psychosocial intervention for children and families. Therapeutic Communities 29(2): 142-159	- No outcome of interest to this review question
Jones, Christopher D, Lowe, Laura A, Risler, Edwin A et al. (2004) The Effectiveness of Wilderness Adventure Therapy Programs for Young People Involved in the Juvenile Justice System. Residential Treatment for Children & Youth 22(2): 53-62	- Unclear that population are LACYP *[juvenile offenders]*
Jones, Loring, Landsverk, John, Roberts, Ann et al. (2007) A comparison of two caregiving models in providing continuity of care for youth in residential care. Child & Youth Care Forum 36(23): 99-109	- No outcome of interest to this review question
Jonkman, Caroline S, Schuengel, Carlo, Oosterman, Mirjam et al. (2017) Effects of Multidimensional Treatment Foster Care for Preschoolers (MTFC-P) for young foster children with severe behavioral disturbances. Journal of Child and Family Studies 26(5): 1491-1503	- No outcome of interest to this review question
Kerr, David C R; Leve, Leslie D; Chamberlain, Patricia (2009) Pregnancy rates among juvenile justice girls in two randomized controlled trials of multidimensional treatment foster care. Journal of consulting and clinical psychology 77(3): 588-93	- No outcome of interest to this review question
Kim, Jangmin, Trahan, Mark, Bellamy, Jennifer et al. (2019) Advancing the innovation of family meeting models: The role of teamwork and parent engagement in improving permanency. Children and Youth Services Review 100: 147-155	- No outcome of interest to this review question

Study	Code [Reason]
KIRBY Stuart and MIIDLEHAM Neil (2005) Reducing misery and saving money - how partners can make a difference in reducing the incidence of young runaways. Community Safety Journal 4(4): 10-13	- Intervention description/practice report - Unclear that population are LACYP - Data not reported in an extractable format
Klein, Sacha, Fries, Lauren, Emmons, Mary M et al. (2017) Early care and education arrangements and young children's risk of foster placement: Findings from a National Child Welfare Sample. Children and Youth Services Review 83: 168-178	- No outcome of interest to this review question
Koh, Eun, Rolock, Nancy, Cross, Theodore P et al. (2014) What explains instability in foster care? Comparison of a matched sample of children with stable and unstable placements. Children and Youth Services Review 37: 36-45	- Not an investigation of an intervention
Koh, Eun and Testa, Mark F (2011) Children discharged from kin and non-kin foster homes: Do the risks of foster care re-entry differ?. Children and Youth Services Review 33(9): 1497-1505	- Not an investigation of an intervention
Kohli, Ravi K. S (2006) The comfort of strangers: Social work practice with unaccompanied asylum-seeking children and young people in the UK. Child & Family Social Work 11(1): 1-10	- No outcome of interest to this review question - to be considered under RQ1.2
Koob, Jeffrey J and Love, Susan M (2010) The implementation of solution-focused therapy to increase foster care placement stability. Children and Youth Services Review 32(10): 1346-1350	- non-UK - uncontrolled before and after study

Study	Code [Reason]
Laan N.M.A., Loots G.M.R., Janssen C.G.C. et al. (2001) Foster care for children with mental retardation and challenging behaviour: A follow-up study. British Journal of Developmental Disabilities 47(1): 3-13	- Comparator in study does not match that specified in protocol *[non-comparative]*
Landsman, M J, Groza, V, Tyler, M et al. (2001) Outcomes of family-centered residential treatment. Child welfare 80(3): 351-79	- non-UK - non-randomised controlled trial
Landsman, Miriam J, Thompson, Kathy, Barber, Gail et al. (2003) Using Mediation to Achieve Permanency for Children and Families. Families in Society 84(2): 229-239	- No outcome of interest reported *[descriptive (non-comparative) outcomes reported]*
Lardner, Mark D (2015) Are restrictiveness of care decisions based on youth level of need? A multilevel model analysis of placement levels using the child and adolescent needs and strengths assessment. Residential Treatment for Children & Youth 32(3): 195-207	- No outcome of interest reported *[study reports on the relationship between initial need and restrictiveness of placement]*
LARZELERE Robert E. and et al (2001) Outcomes of residential treatment: a study of the adolescent clients of girls and boys town. Child and Youth Care Forum 30(3): 175-185	- Data not reported in an extractable format *[no measure of spread reported]*
Lawson, Kate and Cann, Robert (2019) State of the nation's foster care: full report.: 42	- No outcome of interest to this review question - to be considered under RQ1.2
Lee, Bethany R and Thompson, Ron (2008) Comparing outcomes for youth in treatment foster care and family-style group care. Children and Youth Services Review 30(7): 746-757	- No outcome of interest to this review question

Study	Code [Reason]
Lee, Linda J (2011) Adult visitation and permanency for children following residential treatment. Children and Youth Services Review 33(7): 1288-1297	- Not an investigation of an intervention
LEHMAN Constance M.; LIANG Shu; O'DELL KIRSTIN (2005) Impact of flexible funds on placement and permanency outcomes for children in child welfare. Research on Social Work Practice 15(5): 381-388	- non-UK - non-randomised controlled trial
Leon, Scott C, Saucedo, Deborah J, Jachymiak, Kristin et al. (2016) Keeping it in the family: The impact of a Family Finding intervention on placement, permanency, and well-being outcomes. Children and Youth Services Review 70: 163-170	- No outcome of interest to this review question
Leve, Leslie D; Chamberlain, Patricia; Reid, John B (2005) Intervention outcomes for girls referred from juvenile justice: effects on delinquency. Journal of consulting and clinical psychology 73(6): 1181-5	- No outcome of interest to this review question
Leve, Leslie D; Fisher, Philip A; Chamberlain, Patricia (2009) Multidimensional treatment foster care as a preventive intervention to promote resiliency among youth in the child welfare system. Journal of personality 77(6): 1869-902	- Review article but not a systematic review - Intervention description/practice report
Littlewood, Kerry (2015) Kinship Services Network Program: Five year evaluation of family support and case management for informal kinship families. Children and Youth Services Review 52: 184-191	- Unclear that population are LACYP *[informal kinship care (not in child welfare system)]*
Littlewood, K.; Cooper, L.; Pandey, A. (2020) Safety and placement stability for the Children's Home Network kinship navigator program. Child Abuse and Neglect 106: 104506	- large proportion were informal kinship care and adoption - "The results suggest that CHN-KN kept children safe and out of the formal child welfare system" 62% had no involvement with child welfare services

Study	Code [Reason]
LITZELFELNER Pat (2000) The effectiveness of CASAs in achieving positive outcomes for children. Child Welfare Journal 79(2): 179-193	- non-UK - non-randomised controlled trial
MADDEN Elissa E. and AGUINIGA Donna M. (2013) An evaluation of permanency outcomes of child protection mediation. Journal of Public Child Welfare 7(1): 98-121	- No outcome of interest to this review question
Mapp, Susan C and Steinberg, Cache (2007) Birthfamilies as permanency resources for children in long-term foster care. Child welfare 86(1): 29-51	- Case series
McDaniel, Benny, Braiden, Hannah Jane, Onyekwelu, June et al. (2011) Investigating the effectiveness of the incredible years basic parenting programme for foster carers in Northern Ireland. Child Care in Practice 17(1): 55-67	- No outcome of interest to this review question
McKee, Jeanne; Storrs, Jodi; Humphrey, Stewart (2007) Creating a continuum of care for chronically underserved children. Joint Commission journal on quality and patient safety 33(4): 200-4	-
Melius, Patience, Swoszowski, Nicole Cain, Siders, Jim et al. (2015) Developing peer led check-in/check-out: A peer-mentoring program for children in residential care. Residential Treatment for Children & Youth 32(1): 58-79	- No outcome of interest to this review question
Mersky, Joshua P, Topitzes, James, Janczewski, Colleen E et al. (2015) Enhancing foster parent training with parent-child interaction therapy: Evidence from a randomized field experiment. Journal of the Society for Social Work and Research 6(4): 591-616	- No outcome of interest to this review question

Study	Code [Reason]
Muela, Alexander, Balluerka, Nekane, Amiano, Nora et al. (2017) Animal-assisted psychotherapy for young people with behavioural problems in residential care. Clinical psychology & psychotherapy 24(6): o1485-o1494	- No outcome of interest to this review question
Murphy, Kelly, Moore, Kristin Anderson, Redd, Zakia et al. (2017) Trauma-informed child welfare systems and children's well-being: A longitudinal evaluation of KVC's bridging the way home initiative. Children and Youth Services Review 75: 23-34	- non-UK - interrupted time series
Nash, Jordanna and Flynn, Robert J (2009) Foster-parent training and foster-child outcomes: An exploratory cross-sectional analysis. Vulnerable Children and Youth Studies 4(2): 128-134	- cross-sectional (association) study
NCT00339365 (2006) Promoting Infant Mental Health in Foster Care. Https://clinicaltrials.gov/show/nct00339365	- trial registration
NCT00701194 (2008) Early Intervention Foster Care: a Prevention Trial. Https://clinicaltrials.gov/show/nct00701194	- trial registration
NCT00810056 (2008) Fostering Healthy Futures Efficacy Trial for Preadolescent Youth in Foster Care. Https://clinicaltrials.gov/show/nct00810056	- trial registration
NCT00980512 (2009) Community Implementation of KEEP: fidelity and Generalization of Parenting. Https://clinicaltrials.gov/show/nct00980512	- trial registration
NCT01726361 (2012) Multidimensional Treatment Foster Care for Adolescents. Https://clinicaltrials.gov/show/nct01726361	- trial registration

Study	Code [Reason]
NCT02220179 (2014) Resilience for Children and Young People in Foster Care and Residential Care in Denmark. Https://clinicaltrials.gov/show/nct02220179	- trial registration
No authorship indicated (2008) Review of Effects of a foster care parent training intervention on placement changes of children in foster care. Journal of Developmental and Behavioral Pediatrics 29(4): 328	- Review article but not a systematic review
NTR4271 (2013) Supporting foster families with a hogh risk on unplanned termination of foster child placements. Http://www.who.int/trialsearch/trial2.aspx? Trialid=ntr4271	- Trial registration
NTR4282 (2013) Supporting foster families with a high risk on unplanned termination. A Randomized Controlled Trial study (RCT) of Parent Management Training Oregon (PMTO). Http://www.who.int/trialsearch/trial2.aspx? Trialid=ntr4282	- Trial registration
NUGENT William Robert and ELY Gretchen (2010) The effects of aggression replacement training on periodicities in antisocial behavior in a residential facility for adolescents. Journal of the Society for Social Work and Research 1(3): 140-2010	- Unclear that population are LACYP *[At-risk youth and their families. 55% were in custody of their parent.]*
Owens-Kane, Sandra (2006) Respite care:outcomes for kinship and non-kinship caregivers. Journal of health & social policy 22(34): 85-99	- non-UK - uncontrolled before and after study
PALLETT Clare and et al (2002) Fostering changes: a cognitive-behavioural approach to help foster carers manage children. Adoption and Fostering 26(1): 39-48	- No outcome of interest to this review question

Study	Code [Reason]
Pelech, William, Badry, Dorothy, Daoust, Gabrielle et al. (2013) It takes a team: Improving placement stability among children and youth with fetal alcohol spectrum disorder in care in Canada. Children and Youth Services Review 35(1): 120-127	- non-UK - mixed methods, non-randomised controlled trial
PEMBERTON Camilla (2010) Kent's foster care scheme makes its point. Community Care 13510: 20-21	- non -UK - Mixed methods - Non-randomised controlled trial - to be considered under RQ1.2
PENNELL Joan; EDWARDS Myles; BURFORD Gale (2010) Expedited family group engagement and child permanency. Children and Youth Services Review 32(7): 1012-1019	- No outcome of interest to this review question
Perry, Deborah F, Dunne, M. Clare, McFadden, LaTanya et al. (2008) Reducing the risk for preschool expulsion: Mental health consultation for young children with challenging behaviors. Journal of Child and Family Studies 17(1): 44-54	- unclear that population are looked after children
PIERPONT John H. and McGINTY Kaye (2004) Using family-oriented treatment to improve placement outcomes for children and youth in residential treatment. Journal of Human Behavior in the Social Environment 9(12): 147-163	- No outcome of interest reported [descriptive outcomes] - Intervention description/practice report
Pithouse, Andrew, Hill-Tout, Jan, Lowe, Kathy et al. (2002) Training foster carers in challenging behaviour: A case study in disappointment?. Child & Family Social Work 7(3): 203-214	- No outcome of interest to this review question

Study	Code [Reason]
Pratt, Megan E, Lipscomb, Shannon T, Schmitt, Sara A et al. (2015) The effect of head start on parenting outcomes for children living in non-parental care. Journal of Child and Family Studies 24(10): 2944-2956	- No outcome of interest to this review question
Price, Joseph M, Chamberlain, Patricia, Landsverk, John et al. (2009) KEEP foster-parent training intervention: Model description and effectiveness. Child & Family Social Work 14(2): 233-242	- Secondary publication of an included study that does not provide any additional relevant information - Intervention description/practice report
Price, Joseph M, Roesch, Scott C, Walsh, Natalia Escobar et al. (2012) Effectiveness of the KEEP foster parent intervention during an implementation trial. Children and Youth Services Review 34(12): 2487-2494	- No outcome of interest to this review question
Price, Joseph M, Roesch, Scott, Walsh, Natalia E et al. (2015) Effects of the KEEP Foster Parent Intervention on Child and Sibling Behavior Problems and Parental Stress During a Randomized Implementation Trial. Prevention science : the official journal of the Society for Prevention Research 16(5): 685-95	- No outcome of interest to this review question
Pritchett, Rachel, Fitzpatrick, Bridie, Watson, Nicholas et al. (2013) A feasibility randomised controlled trial of the New Orleans intervention for infant mental health: a study protocol. TheScientificWorldJournal 2013: 838042	- RCT protocol
Randle, Melanie, Ernst, Dominik, Leisch, Friedrich et al. (2017) What makes foster carers think about quitting? Recommendations for improved retention of foster carers. Child & Family Social Work 22(3): 1175-1186	- No outcome of interest reported
Rast, Jim and Rast, Jessica E (2014) Neighbor to family: Supporting sibling groups in foster care. Families in Society 95(2): 83-91	- non-UK

Study	Code [Reason]
	- Non-randomised controlled trial
Redd, Zakia, Malm, Karin, Moore, Kristin et al. (2017) KVC's Bridging the Way Home: An innovative approach to the application of Trauma Systems Therapy in child welfare. Children and Youth Services Review 76: 170-180	- No outcome of interest reported *[implementation outcomes]*
Ringle, Jay L, Thompson, Ronald W, Way, Mona et al. (2015) Reunifying families after an out-of-home residential stay: Evaluation of a blended intervention. Journal of Child and Family Studies 24(7): 2079-2087	- No outcome of interest reported for this review question
Robst, John, Armstrong, Mary, Dollard, Norin et al. (2011) Comparing outcomes for youth served in treatment foster care and treatment group care. Journal of Child and Family Studies 20(5): 696-705	- Unclear that population are LACYP *[Youth placed in a treatment group care must be diagnosed as having a psychiatric, emotional, or behavioral disorder, be a dependent child, and have serious functional impairment.]* - Non-randomised controlled trial - non-UK
ROBERTS Rosemarie; GLYNN Georgia; WATERMAN Colin (2016) 'We know it works but does it last?' the implementation of the KEEP foster and kinship carer training programme in England. Adoption and Fostering 40(3): 247-263	- placement stability outcomes reported in this study were non-comparative (study arms were from non-comparable populations)
Rock, Stephen, Michelson, Daniel, Thomson, Stacey et al. (2015) Understanding foster placement instability for looked after children: A systematic review and narrative synthesis of quantitative and qualitative evidence. British Journal of Social Work 45(1): 177-203	- Systematic review checked for relevant citations

Study	Code [Reason]
Sasaki, Ginga and Noro, Fumiyuki (2017) Promoting verbal reports and action plans by staff during monthly meetings in a Japanese residential home. Behavioral Interventions 32(4): 445-452	- No outcome of interest reported for this review question
Schoemaker, Nikita K, Wentholt, Wilma G M, Goemans, Anouk et al. (2019) A meta-analytic review of parenting interventions in foster care and adoption. Development and psychopathology: 1-24	- Systematic review
Smith, Carrie Jefferson and Monahan, Deborah J (2006) KinNet:A Demonstration Project for a National Support Network for Kinship Care Providers. Journal of health & social policy 22(34): 215-31	- Unclear that population are LACYP *[mixed population with informal care]* - No outcome of interest reported
Southerland, Dannia G, Burns, Barbara J, Farmer, Elizabeth M. Z et al. (2014) Family involvement in treatment foster care. Residential Treatment for Children & Youth 31(1): 2-16	- Not an investigation of an intervention *[investigation of predictors of family contact]* - Not a relevant study design *[Although evidence is from an RCT, non-randomised data is presented]*
SPIEKER Susan J. and et al (2012) Promoting first relationships: randomized trial of a relationship-based intervention for toddlers in child welfare. Child Maltreatment 17(4): 271-286	- No outcome of interest reported for this review question
Stacks, A.M., Wong, K., Barron, C. et al. (2020) Permanency and well-being outcomes for maltreated infants: Pilot results from an infant-toddler court team. Child Abuse and Neglect 101: 104332	- Non-UK before and after study

Study	Code [Reason]
STRICKLER, Amy and et, al (2019) Examining fostering readiness in treatment parents. Child and Family Social Work 24(2): 183-189	- No outcome of interest reported readiness to foster, willingness to foster - Non-UK setting - Non-randomised study - non-comparative study
Strolin-Goltzman, Jessica; Kollar, Sharon; Trinkle, Joanne (2010) Listening to the voices of children in foster care: youths speak out about child welfare workforce turnover and selection. Social work 55(1): 47-53	- No outcome of interest to this review question - to be considered under RQ1.2
Summersett-Ringgold, Faith, Jordan, Neil, Kisiel, Cassandra et al. (2018) Child strengths and placement stability among racial/ethnic minority youth in the child welfare system. Child abuse & neglect 76: 561-572	- No outcome of interest reported *[no interventions considered]*
Sunseri, Paul A (2005) Children Referred to Residential Care: Reducing Multiple Placements, Managing Costs and Improving Treatment Outcomes. Residential Treatment for Children & Youth 22(3): 55-66	- non-UK - cohort study
Taussig, Heather N, Culhane, Sara E, Garrido, Edward et al. (2012) RCT of a mentoring and skills group program: placement and permanency outcomes for foster youth. Pediatrics 130(1): e33-9	- No outcome of interest to this review question
Testa, Mark F (2002) Subsidized guardianship: Testing an idea whose time has finally come. Social Work Research 26(3): 145-158	- Not an intervention of interest *[subsidized guardianship vs adoption]*

Study	Code [Reason]
Thornton, Jennifer A, Stevens, Gillian, Grant, Jan et al. (2008) Intrafamilial adolescent sex offenders: Family functioning and treatment. Journal of Family Studies 14(23): 362-375	- Unclear that population are LACYP
UNRAU Yvonne; WELLS Michael; HARTNETT Mary Ann (2004) Removing barriers to service delivery: an outcome evaluation of a 'remodelled' foster care programme. Adoption and Fostering 28(2): 20-30	- non-UK - non-randomised controlled trial
Uretsky, Mathew C and Hoffman, Jill A (2017) Evidence for group-based foster parent training programs in reducing externalizing child behaviors: A systematic review and meta-analysis. Journal of Public Child Welfare 11(45): 464-486	- No outcome of interest to this review question
Waid, Jeffrey, Kothari, Brianne H, Bank, Lew et al. (2016) Foster care placement change: The role of family dynamics and household composition. Children and Youth Services Review 68: 44-50	- Not an investigation of an intervention *[association study]*
Waxman, Hersh C, Houston, W Robert, Profilet, Susan M et al. (2009) The long-term effects of the Houston Child Advocates, Inc., program on children and family outcomes. Child welfare 88(6): 23-46	- non-UK - Non-randomised controlled trials
Weiner, Dana A, Leon, Scott C, Stiehl, Michael J et al. (2011) Demographic, clinical, and geographic predictors of placement disruption among foster care youth receiving wraparound services. Journal of Child and Family Studies 20(6): 758-770	- Not an investigation of an intervention
Whitaker, Tia (2011) Administrative case reviews: Improving outcomes for children in out-of-home care. Children and Youth Services Review 33(9): 1683-1708	- non-UK - cohort study

Study	Code [Reason]
White, Catherine Roller, Corwin, Tyler, Buher, Anne L et al. (2015) The Multisite Accelerated Permanency Project: Permanency roundtables as a strategy to help older youth in foster care achieve legal permanency. Journal of Social Service Research 41(3): 364-384	- No outcome of interest to this review question
Whitemore, Erin, Ford, Monica, Sack, William H et al. (2003) Effectiveness of Day Treatment with Proctor Care for Young Children: A Four-Year Follow-Up. Journal of Community Psychology 31(5): 459-468	- non-UK - uncontrolled before and after study
WISE Sarah (2002) An evaluation of a trial of looking after children in the state of Victoria, Australia. Children and Society 17(1): 3-17	- Study does not contain a relevant intervention *[Describes a system of case planning and review which is already statutory care in the UK. This was a Non-UK based uncontrolled before and after study.]*
Zeanah, C H, Larrieu, J A, Heller, S S et al. (2001) Evaluation of a preventive intervention for maltreated infants and toddlers in foster care. Journal of the American Academy of Child and Adolescent Psychiatry 40(2): 214-21	- book
Ziviani, Jenny, Feeney, Rachel, Cuskelly, Monica et al. (2012) Effectiveness of support services for children and young people with challenging behaviours related to or secondary to disability, who are in out-of-home care: A systematic review. Children and Youth Services Review 34(4): 758-770	- Systematic review considered for relevant references

Cost-effectiveness studies

Study	Reason for exclusion
Bennett, C.E.; Wood, J.N.; Scribano, P.V. (2020) Health Care Utilization for Children in Foster Care. Academic Pediatrics 20(3): 341-347	- Exclude - compared LAC with non-LAC - Exclude - non-relevant outcomes
Boyd, K.A.; Balogun, M.O.; Minnis, H.; (2016) Development of a radical foster care intervention in Glasgow, Scotland. Health promotion international 31(3): 665 - 673	- Exclude – costing analysis
DIXON, Jo (2011) How the care system could be improved. Community Care 17211: 16-17	- Exclude - not an economic evaluation
Holmes, L.; Ward, H.; McDermid, S. (2012) Calculating and comparing the costs of multidimensional treatment foster care in English local authorities. Children and Youth Services Review 34(11): 2141 - 2146	- Exclude – costing analysis
Huefner, Jonathan C, Ringle, Jay L, Thompson, Ronald W et al. (2018) Economic evaluation of residential length of stay and long-term outcomes. Residential Treatment for Children & Youth 35(3): 192-208	- Exclude - costs not applicable to the UK perspective
LOFHOLM Cecilia, Andree; OLSSON Tina, M.; SUNDELL, Knut (2020) Effectiveness and costs of a therapeutic residential care program for adolescents with a serious behavior problem (MultifunC). Short-term results of a non-randomized controlled trial. Residential Treatment for Children and Youth 37(3): 226-243	- Exclude - population not specific to LACYP
Lovett, Nicholas and Xue, Yuhan (2020) Family First or the Kindness of Strangers? Foster Care Placements and Adult Outcomes. Labour Economics 65(0)	- Exclude - not an economic evaluation

Study	Reason for exclusion
Sunseri, P. (2005) Children Referred to Residential Care: Reducing Multiple Placements, Managing Costs and Improving Treatment Outcomes. Residential Treatment for Children & Youth 22(3): 55 - 66	- Exclude – costing analysis

Appendix K – Research recommendations – full details

Research recommendation

What is the effectiveness of interventions to promote placement stability among looked-after children and young people in residential care?

Why this is important

Placement break-down is associated with poor outcomes for looked-after children and young people. Interventions that support placement stability in looked-after children could help to improve a wide range of outcomes including educational, relational, and physical, mental, and emotional health and wellbeing. In this review, while evidence was identified for interventions to support looked after children and young people in placements in the community, there was a paucity of evidence found for interventions to support placement stability in residential care.

Rationale for research recommendation

Importance to 'patients' or the population	Placement break-down is associated with poor outcomes for looked-after children and young people. Interventions that support placement stability in looked-after children could help to improve a wide range of outcomes including educational, relational, and physical, mental, and emotional health and wellbeing.
Relevance to NICE guidance	In this review, evidence was identified for interventions to support looked after children and young people in placements in the community, however, there was a paucity of evidence found for interventions to support placement stability in residential care.
Relevance to the NHS, public health, social care and voluntary sectors	Aside from the benefits to the looked after person themselves, placement stability is beneficial to the NHS, public health, social care sectors, as well as to youth justice departments for whom time and resources may be required to assist in the identification of alternative

	placements for those in whom placements have broken down.
National Priorities	High: this research question is relevant to national statutory policy documents such as Children's homes regulations, including quality standards: guide (2015) Department for Education from the Department of Education.
Current evidence base	None of the identified RCT evidence in this review considered interventions to improve placement stability in looked after children and young people in residential care specifically. However, some studies may have included some participants from residential care.
Equality considerations	Research should consider the differences in approaches required for looked after young children, and those who are older, adolescent, or care leavers. Research should include looked after young children, who have mental and emotional health problems, behavioural disorders. Research should consider the differences in approaches required for unaccompanied asylum seekers, those with a history of being trafficked, and high risk of exploitation or going missing. Research should consider the differences in approaches required for those with learning disabilities.

Modified PICO table

Population	Looked after children and young people in long-term residential care.
Intervention	Interventions to promote placement stability, for example: carer training in responsiveness to attachment disorders, trauma, or emotional and behavioural problems; mentoring and

	relationship-building interventions; therapeutic interventions; other outings activities and skills building interventions.
Comparator	Usual residential care, a waiting list, or other commonly used interventions to support placement stability
Outcome	• Completion of care placement • Adverse events such as prematurely dropping out of a care placement, transitioning from one care situation to another, absconding, or re-entering previous (more restrictive) care situation • Indicators of relational permanency and security in residential care • Indicators of emotional and behavioural stability
Study design	Randomised controlled trial or controlled prospective experimental study.
Timeframe	Results should include moderate-term outcomes (e.g. 6-month) and long-term outcomes (1-2 year follow up).
Additional information	None

Appendix L – References

Other references

None

Appendix M – Other appendix

No additional information for this review question.