National Institute for Health and Care Excellence

Final

Looked-After Children and Young People

[L] Interventions to support looked-after children and young people transitioning out of care to living with adoptive or birth parents or special guardians, or into connected care

NICE guideline NG205

Evidence reviews underpinning recommendations 1.3.19 to 1.3.20, 1.7.1, 1.7.5 to 1.7.9, 1.7.12 to 1.7.19, and 1.7.21

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Final

These evidence reviews were developed by NICE Guideline Updates Team

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Review question

5.1a: What is the effectiveness of interventions and approaches to support looked-after children and young people transitioning out of care to living with their adoptive or birth parents or special guardians, or into connected care?

5.1b: Are interventions to support looked-after children and young people transitioning out of care to living with their adoptive or birth parents or special guardians, or into connected care 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?

Introduction

Once a child enters care, a home placement will be sought which is the right placement for the child or young person. However, placement moves are common. On 31st March 2019 3% of looked after children (2,190) were placed for adoption. Two thirds (68%) of all looked after children had one placement in the year ending 31 March 2019, 22% of all looked after children had up to two placements, and 10% - a small but substantial number of children - experienced three or more placements. Sometimes it is important that a child or young person moves placement e.g. if their needs are no longer being met at their current placement, or concerns about their safety may mean they need to move out of their local area. A shortage of placements, and the high cost of residential or more therapeutic settings, may mean that children whose needs are best met in a children's home or specialist placement often have to experience many placement breakdowns in foster care before they can access the right kind of placement for them. Likewise, a child or young person in highly restrictive settings may benefit from a move to less restrictive settings such as foster or connected care. Finally, looked after children may leave care to be reunited with their birth parents, to be adopted, or to move into special guardianship. Unfortunately, as of December 2019, while the number of children entering care has been rising year after year, the number of children ceasing to be looked after during the year due to adoption has been falling down to 3,570 from a peak of 5,360 in 2015.

Moves out of care or between care settings may require special supports to ensure the long-term success of these placements. Indeed, good support for looked after children and young people in their movement out of care into adoption could have the dual effect of ensuring long term stability for the child and encouraging other potential adopters. However, it is currently unclear what specific interventions are effective for improving permanency outcomes after transition. This review will consider interventions to support looked-after

children and young people transitioning out of care to living with their adoptive or birth parents or special guardians, or into connected care. Achieving permanence is associated with better outcomes for looked after children and young people.

Summary of protocol

PICO table

Table 1: PICO for review on interventions to support looked after children and young people transitioning out of care to living with their adoptive or birth parents or special guardians, or into connected care

Population	Looked after children and young people, aged <18, who are transitioning out of care to living with their adoptive or birth parents or special guardians, or into connected care. Including: • Children and young people who are looked after on a planned, temporary basis for short breaks or respite care purposes, only if the Children Act 1989 (section 20) applies and the child or young person is temporarily classed as looked after. • 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 looked-after children and young people transitioning out of care to living with their adoptive or birth parents or special guardians, or into connected care. Interventions and approaches of interest may include: • Information, education, advice, and signposting interventions for LACYP and their prospective long-term carers • Continuation of the personal education plan (PEP) beyond care • Counselling and conflict resolution programmes for LACYP and birth parents (including multisystemic therapy) • Family group conferences • Approaches to promote contact, or increasing contact, between LACYP and birth parents or long-term carers prior to transition (including support provided by contact supervisors) • Phased approach to entry into long-term care • Approaches to increase involvement of LACYP or prospective permanent carers in the planning and transition process (e.g. to guide stepping down of support services) • Approaches to stepping down support services (e.g. Phased return-home programmes and extended foster care support programmes) • Continuation of life story work into long-term care

	• Models of multi-agency care to facilitate transition out of care • Training programmes for adoptive, birth parents, special guardians or connected carers prior to and during transition process (e.g. parenting programmes)
Comparator	Quantitative evidence Comparator could include standard care, waiting list, or another approach to support looked-after children and young people transitioning out of care to living with their adoptive or birth parents or special guardians, or into connected care.
Outcomes	Quantitative outcomes Following transition: • Re-entering care system (placement breakdown) • Mental or emotional wellbeing • Quality of life • Health outcomes (e.g. sexual health, nutrition, dentition, health behaviours, or risk-taking behaviours) • Behavioural, educational, and social functioning following transition

SPIDER table

Table 2: SPIDER table for interventions to support looked after children and young people transitioning out of care to living with their adoptive or birth parents or special guardians, or into connected care

Sample	Looked after children and young people, aged <18, who are transitioning out of care to living with their adoptive or birth parents or special guardians, or into connected care. Including: • Children and young people who are looked after on a planned, temporary basis for short breaks or respite care purposes, only if the Children Act 1989 (section 20) applies and the child or young person is temporarily classed as looked after. • 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 looked-after children and young people transitioning out of care to living with their adoptive or birth parents or special guardians, or into connected care.
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 care transitions.
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)

Methods and process

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

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

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

Collected 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, 160 studies were obtained and reviewed against the inclusion criteria as described in the review protocol for interventions to support transition out of care to living with adoptive or birth parents or special guardians, or into connected care (Appendix A). Overall, 32 studies were included (reporting 28 original studies). These included 18 original RCT studies, 3 non-randomised studies, and 7 qualitative studies. The full evidence tables for these studies can be found in Appendix D.

Full references of included studies are given in the reference section of this chapter. These articles considered 20 different interventions to support looked after children and young people transitioning out of care to permanency, which are described below:

Excluded studies

128 studies were excluded because they did not meet the eligibility criteria. See Appendix J for a list of references for excluded studies, with reasons for exclusion.

Summary of interventions included in the effectiveness evidence

Studies for this review involved varied populations and interventions. Generally, studies fall under two categories (these are explained in bold under the LACYP population column in the below table):

1) Interventions with the aim of moving the child from their current placement to a more positive one (such reunifying those children in a foster home with their biological parent(s).
2) Interventions aimed at facilitating children who have recently experienced a positive move (such as improving behaviour and reducing placement breakdowns for children who have recently been adopted or facilitating legal permanency with the child's current caregiver(s)).

Included studies described several complex interventions to support transition out of care into permanence.

The tables below present a summary of the populations, comparisons, sample sizes, and outcomes evaluated in the evidence identified within this review. For further information on the studies summarised, see full evidence tables in Appendix D.

Quantitative Evidence

Table 3: Summary of the quantitative studies contained within this evidence review

Study (country)	LACYP population	Intervention	Comparator	Number of participants who completed study	Outcomes reported (follow up f/u)
		RCT			
Akin 2018a and 2018b (USA)	Children in foster care with serious emotional disturbances **Aim is to reunify with parents**	Parent Management Training Oregon	Services As Usual (SAU)	918	Physical permanency (reunified with parent(s)) - at 12 months
Berzin 2008 (USA)	Children at risk of placement moves or placement in a higher level of care. (participants were primarily either living with a relative or in a foster home) (age 2 – 12 years) **Aim is for child to have a "positive exit" from foster care**	Family Group Decision Making	SAU	50 children	Physical permanency (positive exit from foster care: reunification, adoption. Legal guardianship, kin-GAP/relative placement or family stabilized)
Dakof 2010 (USA)	Mothers and children in substance-involved families **Aim is for stable and safe reunification of mother and child dyads.**	The Engaging Moms Program	Family Drug Court (Intensive Case Management Services)	61	Terminated parental rights, No terminated parental rights Joint or sole custody
DeGarmo 2013 (USA)	Children returning to live with biological parent(s) (aged 5 to 12 years) **Aim is to prevent the breakdown of the child's reunification**	Pathways Home Intervention	SAU	103	Foster care re-entry at 12 months
Feldman 2016 (USA)	In various types of foster care system (see appendix D for further information) (aged under 19.5 years old)	Parent For Every Child	SAU	177	Permanency 1) adoption, legal guardianship or relational

Study (country)	LACYP population	Intervention	Comparator	Number of participants who completed study	Outcomes reported (follow up f/u)
	Aim is to facilitate a permanent placement (adoption or legal guardianship)				permanency (finalized and pending, reported separately) 2) Finalized adoption or legal guardianship 3) Finalized relational permanency At end of study collection (around 1.5 – 3.5 years after recruitment)
Fisher 2005 (USA)	Children expected to remain in foster care for > 3 months (aged 3 – 6 years) **Aim is to reunify with biological parents or adoption**	Early Intervention Foster Care	SAU	90	Permanency (reunification with biological parent(s) or adoption) Breakdown of permanency At 2 years
Landsman 2014 / Boel-Studt 2017 (USA)	Youth in foster care and referred to foster care placement programme (aged up to 17 years old) **Aim is to reunify with parent(s) or adoption**	Family Finding Intervention	SAU	243	Permanency: 1) Relational permanency 2) Physical permanency (reunification with parent, relative adoption, non-relative adoption, reported separately) At point of data collection ending (between 7 months and 3

Study (country)	LACYP population	Intervention	Comparator	Number of participants who completed study	Outcomes reported (follow up f/u)
					years, 4 months following recruitment)
Pasalich 2016 / Spieker 2014 (USA)	Children in state dependency (experienced a court-ordered placement resulting in change in primary caregiver within the 7 weeks prior to enrolment (participants were placed either with foster parents or returned to biological parents (aged 10-24 months). **Aim is to facilitate permanency in the child's current placement**	Promoting First Relationships	Early Educational Support	210	Placement stability Placement permanency (Stability plus legal discharge to study caregiver in the form of reunification with birth parent, adoption by study kin or non-kin caregiver, or legal guardianship by kin caregiver) - At 2 years
Price 2008 (USA)	Children in a new foster care placement (aged 5-12) **Aim is to facilitate a "positive exit" from foster care**	KEEP foster parent training	SAU	700	Permanency (positive exit: reunification or adoption. Negative exit: moved to another foster placement, a more restrictive placement, or child runaways. No change)
Rushton 2010 (UK)	Children recently adopted (aged 3-8 years) **Aim is to improve the child's current placement**	Cognitive behavioural intervention for adopters Educational intervention for adopters	SAU	37	Strengths and difficulties Expression of feelings Post-placement problems Daily hassles
Ryan 2006 (USA)	Children from substance-involved families	Intensive Case	SAU	1417 children from 738	Reunification (with parent(s))

Study (country)	LACYP population	Intervention	Comparator	Number of participants who completed study	Outcomes reported (follow up f/u)
	In temporary state custody **Aim is to reunify with parents**	Management Model		substance-involved families	Use of substance abuse services
Ryan 2016 (USA)	Mothers from substance-involved families with child in temporary state custody **Aim is to reunify with parents**	Recovery Coach	SAU	1623	Reunification
Swenson 2000 (USA)	Children placed into foster care due to abuse or neglect **Aim is to reunify with original caregiver(s) or parent(s), relative or family friend.**	Charleston Collaborative Project Services	SAU	52	Permanency (reunification with original caregiver or parent(s), relative or family friend). Instances of abuse
Taussig 2012 (USA)	Placed in foster care due to maltreatment in the prior year (no age restrictions). **Aim is reunification, adoption, or guardianship)**	Fostering Healthy Futures (FHF)	CAU	110	Incidence of placement change (over 18-month observation period) Negative placement change (over 18-month observation period)
Trout 2013 (USA)	Children returning to home, school and community settings after a staying in a residential setting. **Aim: return to home school and community settings**	On The Way Home Family Consultant	SAU	87	Re-entering foster care School attendance
Trout 2013 (USA - RCT)	Children returning to home, school and community settings after a staying in a residential setting.	On The Way Home Family Consultant	SAU	OTWH = 98 CAU = 89	Caregiver Empowerment at 21 months Caregiver self-efficacy at 21 months

Study (country)	LACYP population	Intervention	Comparator	Number of participants who completed study	Outcomes reported (follow up f/u)
	Aim: return to home school and community settings				Placement stability and school stability at 21 months following reunification
Vandivere 2015 (USA)	Children served by an adoption recruitment programme across several unique geographic regions in the United States. Aim: **increase the amount of children in care moving into adoption.**	Wendy's Wonderful Kids	Usual adoption recruitment programmes	956	Adoption
Vandivere 2017 (USA)	Children and youth with no identified permanent placement resource, and had no plan for reunification, or if they were the younger sibling of such a child and also lacked an identified permanent placement resource or plan for reunification (aged 10-17 years old). **Aim is to facilitate positive move from foster care placement**	Parent for Every Child: In each country	SAU	573	Positive and negative foster care movements compared to baseline Safety Well-being
Non-RCTs					
Biehal 2011 (UK)	Serious/persistent young offenders sentenced to custody or intensive supervision and surveillance programme (ISSP) **Aim: to develop problem-solving skills and help young**	Multidimensional Treatment Foster Care/Intensive fostering	Custodial sentence or ISSP	47	Re-offending Re-entering custody Living situation

Study (country)	LACYP population	Intervention	Comparator	Number of participants who completed study	Outcomes reported (follow up f/u)
	offenders change behaviours, to improve and practise social skills, provide education and training and reduce rates of reoffending.				
Harwin 2018 (UK)	Mothers and children from substance-involved families issued section 31 proceedings on the grounds that the child was subject to actual or likely significant harm. **Aim is for stable and safe reunification of mother and child dyads.**	Family Drug and Alcohol Court	Ordinary Care Proceedings	240 (mothers) 350 (children)	Proportion reunited with families Durability of reunification New proceedings due to harm to children following reunification
Monck 2004 (UK)	Children placed for adoption (under 8 years of age) **Aim: early placement of children in a return to the birth family or by adoption into a new family.**	Concurrent Planning	SAU	68	Strengths and difficulties Number of movements before final placement

Qualitative evidence

Table 4: Summary of the qualitative studies contained within this evidence review

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	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	Practitioners involved with delivering Parent Management Training Oregon (30).

Study (country)	Intervention	LACYP population (age)	Setting and context	Type of analysis	Perspectives (n)
			improve permanency outcomes.	supports. Theoretical thematic analysis was performed using multiple analysts.	
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 care workers and therapeutic specialists. Thematic analysis was used.	Therapeutic foster carers and generalist foster carers, foster care workers and therapeutic specialists (43)
Kenrick 2009/2010 (UK)	Concurrent planning	Children placed for adoption by a concurrent planning project (likely under 2 years old)	A Concurrent Planning Project at Coram (from the website – "Coram's Concurrent Planning places babies and children under two years old with concurrent carers while plans for their future are being decided by the family courts")	Semi-structured interviews with thematic analysis.	Families who had adopted children through the Concurrent Planning Project at Coram (26 families)
Kirton 2011 (UK)	Multidimensional Treatment Foster Care (MTFC)	Looked after children involved with an evaluation of multidimensional	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

Study (country)	Intervention	LACYP population (age)	Setting and context	Type of analysis	Perspectives (n)
		treatment foster care (most were aged 13 or older)			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,

Summary of the evidence

Quantitative Evidence

Table 5: Parent Management Training Oregon Model versus Services as Usual (Akin 2018a/2018b)

Outcome	Sample size	Effect size (95% CI)	Interpretation of effect[a]
Reunification: legal discharge from foster care to a parent, as assessed by administrative data from the Child Welfare Agency.	918	HR 1.16 (0.98, 1.37) HR 1.32 (1.09, 1.60)	Could not differentiate when using intention to treat analysis. **When only including those participants who completed the intervention, reunification was significantly more likely in the intervention group at any point in time.**

Table 6: Family Group Decision Making versus Services as Usual (Berzin 2008)

Outcome	Sample size	Effect size (95% CI)	Interpretation of effect[a]
Positive exit over 5-year observation period: reunification, adoption, legal guardianship, kin-GAP/relative placement or family stabilized as evidenced by change in court status and the case being closed with the child welfare system	50	OR 1.19 (0.35, 4.02)	Could not differentiate

Table 7: Engaging Moms Program versus Family Drug Court (Dakof 2010)

Outcome	Sample size	Effect size (95% CI)	Interpretation of effect[a]
Terminated parental rights (child placed in foster care or placed with relatives): assessed using court records	61	OR 0.35 [0.12, 1.06]	Could not differentiate
No terminated parental rights (child placed with relatives): assessed using court records	61	OR 2.24 [0.51, 9.91]	Could not differentiate
Joint or sole custody: assessed using court records	61	OR 1.68 [0.62, 4.59]	Could not differentiate

Table 8: Family Drug and Alcohol Court vs Ordinary Care Proceedings versus Services as Usual (Harwin 2018)

Outcome	Sample size	Effect size (95% CI)	Interpretation of effect[a]
Positive exit over 5-year observation period: reunification, adoption, legal guardianship, kin-GAP/relative placement or family stabilized as evidenced by change in court status and	50	OR 1.19 (0.35, 4.02)	Could not differentiate

Outcome	Sample size	Effect size (95% CI)	Interpretation of effect[a]
the case being closed with the child welfare system			

Table 9: Pathways Home Intervention versus Services as Usual (DeGarmo 2013)

Outcome	Sample size	Effect size (95% CI)	Interpretation of effect[a]
Re-entered foster care by 12 months follow-up: assessed using administrative data	103	OR 0.49 (0.14, 1.74)	Could not differentiate

Table 10: Parent for Every Child Intervention versus Services as Usual (Feldman 2016)

Outcome	Sample size	Effect size (95% CI)	Interpretation of effect[a]
Finalized permanency: adoption, legal guardianship or relational permanency (written contract between youth and a caring adult, known as either a permanency pact or a commitment contract)	177	OR 5.92 (1.71, 20.48)	**Significantly greater odds of permanency (any type) in the intervention group.**
Finalized permanency: adoption or legal guardianship	177	OR 1.45 (0.44, 4.76)	Could not differentiate
Finalized relational permanency (written contract between youth and a caring adult, known as either a permanency pact or a commitment contract)	177	OR 26.56 (1.54, 458.13)	**Significantly greater odds of relational permanency in the intervention group.**
Pending permanency: adoption, legal guardianship or alternative permanency	177	OR 7.60 (0.92, 63.16)	Could not differentiate

Table 11: Early Intervention Foster Care versus Services as Usual (Fisher 2005)

Outcome	Sample size	Effect size (95% CI)	Interpretation of effect[a]
Legal permanency: Reunification with biological parents or adoption	90	OR 1.16 (0.50, 2.70)	Could not differentiate
Breakdown of permanent placement (only including those participants who secured a permanent placement during study period)	54	OR 0.21 (0.05, 0.87)	**Significantly lower odds of permanent placement breakdown in the intervention group.**

Table 12: Family Finding Intervention versus Services as Usual (Landsman 2014/Boel-Study 2017)

Outcome	Sample size	Effect size (95% CI)	Interpretation of effect[a]
Relational permanency: continued contact and emotional support from at	243	OR 2.47 (1.39, 4.38)	**Significantly greater odds of relational**

Outcome	Sample size	Effect size (95% CI)	Interpretation of effect[a]
least one adult, assessed using case records and administrative data			**permanency in the intervention group**
Physical permanency: Reunification with parents, relative adoption or non-relative adoption	243	OR 1.11 (0.67, 1.85)	Could not differentiate
Physical permanency: Reunification with parents	243	OR 0.82 (0.48, 1.41)	Could not differentiate
Physical permanency: Relative adoption	243	OR 8.51 (1.91, 37.89)	**Significantly greater odds of specifically relative adoption in the intervention group**
Physical permanency: Non-relative adoption	243	OR 0.68 (0.33, 1.37)	Could not differentiate

Table 13: Promoting First Relationships versus Early Educational Support (Pasalich 2016/ Spieker 2014)

Outcome	**Sample size**	**Effect size (95% CI)**	**Interpretation of effect[a]**
Placement stability at 2 years: assessed using child welfare administrative database (remained with the study caregiver with no temporary intermediate moves)	210	OR 1.19 (0.63 to 2.27)	Could not differentiate
Permanency at 2 years (stability plus legal discharge to study caregiver: reunification with birth parent, adoption by study kin or non-kin caregiver, or legal guardianship by kin caregiver)	210	OR 1.72 (0.73 to 4.04)[1]	Could not differentiate

Table 14: KEEP Foster Parent Training versus Services as Usual (Price 2008)

Outcome	**Sample size**	**Effect size (95% CI)**	**Interpretation of effect[a]**
Positive exits from care over 6.5 months: foster-parent reported positive reasons for the child's exit from the foster/kinship programme e.g. reunification or adoption	700	OR 2.09 (1.32, 3.31)	**Significantly greater odds of a positive exit in the intervention group.**
Negative exits from care over 6.5 months: foster-parent reported negative reasons for the child's exit from the foster/kinship programme e.g. moved to another foster placement, a more restrictive placement, or child runaways	700	OR 0.83 (0.54 to 1.29)	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)	Could not differentiate

Table 15: Cognitive or education intervention versus Services as Usual (Rushton 2010)

Outcome	Sample size	Time point	Effect size (95% CI)	Interpretation of effect[a]
Strengths and difficulties questionnaire: Self-report by adopters	37	Immediately following intervention	MD 2.13 (-1.45, 5.72)	Could not differentiate
		6 months following intervention	MD 0.79 (-2.85, 4.45)	Could not differentiate
Expression of feelings: Self-report by adopter	37	Immediately following intervention	MD 10.4 (-2.5, 23.4)	Could not differentiate
		6 months following intervention	MD 6.18 (-4.8, 17.2)	Could not differentiate
Post-placements problems: Self-report by adopters	37	Immediately following intervention	MD -0.08 (-3.0, 3.25)	Could not differentiate
		6 months following intervention	MD 0.91 (-3.99, 2.17)	Could not differentiate
Frequency of daily hassles 6 months: Self-report by adopters	37	Immediately following intervention	MD -1.81 (-6.19, 2.55)	Could not differentiate
		6 months following intervention	MD 0.91 (-3.5, 5.4)	Could not differentiate
Intensity of daily hassles 6 months: Self-report by adopters	37	Immediately following intervention	MD -7.01 (-15.19, 1.16)	Could not differentiate
		6 months following intervention	MD -1.78 (-8.34, 4.7)	Could not differentiate

Table 16: Intensive case management versus Services as Usual (Ryan 2006)

Outcome	Sample size	Effect size (95% CI)	Interpretation of effect[a]
Accessed substance abuse services: assessed using administrative data	331	OR 1.78 [0.98, 3.25]	Could not differentiate
Re-entered foster care by 12 months follow-up: assessed using administrative data	331	OR 1.70 [0.68, 4.26]	Could not differentiate

Table 17: Wendy's Wonderful Kids vs Usual Adoption Recruitment Services (Vandivere 2015)

Outcome	Sample size	Effect size (95% CI)	Interpretation of effect[a]
Unadjusted odds of adoption in experimental group: assessed using administrative data	956	OR 1.77 p <0.01	Significantly greater odds of adoption in the intervention group
Adjusted odds of adoption in experimental group: assessed using administrative data	956	OR 1.81 p<0.01	Significantly greater odds of adoption in the intervention group

Table 18: Recovery coach versus Services as Usual (Ryan 2016)

Outcome	Sample size	Effect size (95% CI)	Interpretation of effect[a]
Physical permanency: reunification with biological parents within 3-year follow-up period	1623	OR 1.32 [1.04, 1.67]	Significantly greater odds of reunification in intervention group
Stable physical permanency: reunification with biological parents within 3-year follow-up period (and did not return to care within 12 months of reunification)	1623	OR 1.47 [1.12, 1.91]	Significantly greater odds of stable reunification in intervention group

Table 19: Charleston Collaborative Project intervention versus Services as Usual (Swenson 2000)

Outcome	Sample size	Effect size (95% CI)	Interpretation of effect[a]
Reunification at 3-months post-intervention: placed with biological parent(s), relative or family friend	71	OR 0.76 [0.28, 2.09]	Could not differentiate
Incidence of abuse at 3-months post-intervention: assessed by caseworker	71	OR 0.15 [0.01, 3.95]	Could not differentiate

Table 20: Family Finding Specialist versus Services as Usual (Vandivere 2017)

Outcome	Sample size	Effect size (95% CI)	Interpretation of effect[a]
Positive foster care placement change compared to baseline: assessed in terms of restrictiveness using administrative data at 1-4 years (depending on time of enrolment) (see Appendix D for further information on how this outcome was score)	517	OR: 1.00 β (SE): 0.00 (SE 0.29)	No significant difference according to P value reported by paper
Negative foster care placement change compared to baseline: assessed using administrative data at 1-4 years (depending on time of enrolment) (see Appendix D for further information on how this outcome was score)	517	OR: 1.26 β (SE): 0.23 (SE 0.27)	No significant difference according to P value reported by paper
Permanency (Reunification with biological parents, adoption or guardianship): assessed using administrative data at 1-4 years (depending on time of enrolment)	564	OR: 0.88 β (SE): -0.13 (SE 0.25)	No significant difference according to P value reported by paper
Permanency (Reunification with biological parents): assessed using administrative data at 1-4 years (depending on time of enrolment)	548	OR: 0.98 β (SE): -0.02 (SE 0.39)	No significant difference according to P value reported by paper
Discharged from foster care: assessed using administrative data at 1-4 years (depending on time of enrolment)	548	OR: 1.08 β (SE): 0.08 (SE 0.29)	No significant difference according to P value reported by paper

Outcome	Sample size	Effect size (95% CI)	Interpretation of effect[a]
Re-allegation of abuse or neglect: assessed using administrative data at 1-4 years (depending on time of enrolment)	542	OR: 0.90 β (SE): -0.10 (SE 0.26)	No significant difference according to P value reported by paper
Substantiated claim of re-allegation of abuse or neglect: assessed using administrative data at 1-4 years (depending on time of enrolment)	537	OR: 0.36 β (SE): -1.01 (SE 0.50)	**Significantly fewer (P<.05) substantiated abuse or neglect re-allegations in the intervention group.**
Discharged from foster care to a relative: assessed using administrative data at 1-4 years (depending on time of enrolment)	558	OR: 0.91 β (SE): -0.10 (SE 0.32)	No significant difference according to P value reported by paper
Re-entry into care (among those discharged during study period): assessed using administrative data at 1-4 years (depending on time of enrolment)	349	OR: 1.00 β (SE): 0.00 (SE 0.29)	No significant difference according to P value reported by paper

Table 21: Intensive Fostering versus Standard Judicial Services (Biehal 2011)

Outcome	Sample size	Effect size (95% CI)	Interpretation of effect[a]
Reconvicted at time 1 (year following entry to intervention compared to year following release from custodial sentence): Assessed using administrative data.	47	OR 0.21 (0.06, 0.75)	**Significantly lower odds of reoffending in the intervention arm**
Reconvicted at time 2 (year following exit from intervention compared to year following release from custodial sentence): Assessed using administrative data.	47	OR 0.94 (0.25, 3.51)	Could not differentiate
Re-entered custody at time 1 (year following entry to intervention compared to year following release from custodial sentence): Assessed using administrative data.	47	OR 0.28 (0,08, 0.99)	**Significantly lower odds of re-entering custody in the intervention arm**
Re-entered custody at time 2 (year following exit from intervention compared to year following release from custodial sentence): Assessed using administrative data.	47	OR 0.64 (0.20, 2.05)	Could not differentiate
Living with parent or relative at time 1 (year following entry to intervention compared to year following release from	43	3.16 [0.95, 10.54]	Could not differentiate

Outcome	Sample size	Effect size (95% CI)	Interpretation of effect[a]
custodial sentence): Assessed by self-report			

Table 22: On The Way Home vs Services as Usual (Trout 2013)

Outcome	Sample size	Effect size (95% CI)	Interpretation of effect[a]
Not maintaining placement in school: defined as not maintaining enrolment in the community school setting at 1 year follow up	87	OR 0.30 (0.12 to 0.75)	**Children in the intervention group were significantly more likely to maintain their place in school following returning home out of care**
Re-entry into foster care at 1 year follow up	87	OR 0.18 (0.05 to 0.65))	**Children in the intervention group were significantly less likely to re-enter foster care**
Family-reported home stability at 12 months: measured using School & Home Placement Change Questionnaire	196	OR 1.00 P value 0.99	No association was observed
Family-reported home stability at 21 months: measured using School & Home Placement Change Questionnaire	196	**OR 3.05 P-value 0.03**	**Intervention was associated with improvement however unclear if greater than MID**
School-reported school stability at 12 months: measured using School & Home Placement Change Questionnaire	196	OR 0.94 P value 0.86	No association was observed
School-reported school stability at 21 months follow up: measured using School & Home Placement Change Questionnaire	196	OR 2.02 P-value 0.14	No association was observed

Table 23: Fostering Healthy Futures vs Care as Usual (Taussig 2012)

Outcome	Sample size	Effect size (95% CI)	Interpretation of effect[a]
Whether a child had attained permanency by 1 year post intervention	110	OR 1.67 (95%CI 0.78 to 3.54)	Could not differentiate effect
Association between being in the intervention group and permanency Adjusted for 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	110	OR 1.81 (95%CI 0.77 to 4.22)	Could not differentiate effect

Table 24: Concurrent planning versus Standard Adoptive Services (Monck 2004)

Outcome	Sample size	Effect size (95% CI)	Interpretation of effect[a]
Children experiencing only one move before permanent setting or final interview (the two control groups were combined for this outcome)	68	OR 7.14 (1.93, 26.46)	**Children in the intervention group were significantly more likely to find a permanent place or reach the end of the study in a single move.**
Mean number of months spent in impermanent care (control group 1 only: Manchester Adoption Society)	47	MD -11.76 (-8.89, -14.63)	**Children in the intervention group spent significantly fewer months in impermanent care than the control group**
Mean number of months spent in impermanent care (control group 2 only: Trafford Adoption and Permanency Team)	45	MD -9.32 (-7.06, -11.58)	**Children in the intervention group spent significantly fewer months in impermanent care than the control group**

Qualitative evidence

Table 25: 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-	*"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*	**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.

reflection and continual professional growth. This training process, however, changed these participants' practice style and revealed areas for growth.	*had direction and structure than I 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	*"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*	**1** Akin 2014	ML: No concerns C: No concerns A: Serious concerns R: Minor concerns **Overall:**	Only 1 study contributed to this theme. Study from outside of the UK.

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.	*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 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."*		**Very Low**	
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	*"…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.

issues are indirectly addressed by PMTO; families who faced multiple contextual factors required harder work.				
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 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.	*: "…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." "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."*	**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 facilitators to the effectiveness of PMTO.
Organisational Barriers (practitioners)	*"I think there wasn't as much, there wasn't as much communication to the case*	**1** Akin 2014	ML: No concerns C: Minor concerns	Only 1 study contributed to this theme. Study from

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 accommodating climate and improved the implementation.	*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."*		A: Serious concerns R: Minor concerns **Overall:** **Very Low**	outside of the UK. Theme covered several different organisational barriers to the effectiveness of PMTO.

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 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.	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 multiple important stakeholders.
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,	*"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:**	Only 1 study contributed to this theme. Study from outside of the UK.

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.			**Very Low**	

Table 26: 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, 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	No supportive quotes were reported for this theme	**1** Ausberger 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. 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.

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.				
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	No supportive quotes were reported for this theme	**1** Ausberger 2014	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. Recruitment strategy and selection of participants was unclear. All

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.			**Overall:** **Very Low**	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 the youth had to say. Facilitators used everyday language to communicate with the youth in the conference. Child	*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. One facilitator noted that although it's not a topic addressed in*	**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.

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.	*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	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

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.				happens at younger ages too.
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	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.

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.	*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*	**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.

	her that much."			
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 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.	No supportive quote was reported for this theme	**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 somewhat contradicted the previous theme but was coherent.

Table 27: ***Summary CERQual table (Experience of carers undertaking Treatment Foster Care)***

Themes	illustrative quotes	Studies	CERQual concerns	CERQual explanation
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	*"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*	**1** Castellanos-Brown 2010	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.

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.	*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*		**Overall:** **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	*"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." – 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. 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

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.	*"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*			what exactly led to the feeling of being rushed.
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	*"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*	**1** Castellanos-Brown 2010	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. There was a distinction between the ideas that foster carers would have preferred more information and the

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 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.	*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 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*		**Very Low**	suspicion that information was deliberately being withheld.

	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*			
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	*"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*	**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.

so substantially in a youth newly-placed in their home.	*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 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*	**1** Castellanos-Brown 2010	ML: No concerns C: Minor concerns A: Serious concerns	Only 1 study contributed to this theme. Study from outside of the UK. Unclear why some

	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*		R: Minor concerns **Overall:** **Very Low**	carers experienced problems while others did not.
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 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**.**	*"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*	**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.
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	*"I have an excellent worker, the intake lady was excellent," – TF Carer* *"Lately, I've been having some*	**1** Castellanos-Brown 2010	ML: No concerns C: Minor concerns A: Serious concerns	Only 1 study contributed to this theme. Study from outside of the UK. Several distinct aspects of the support that foster

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.	*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*		R: Minor concerns **Overall:** **Very Low**	carers found to be helpful was outlined here.
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.	*"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.
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	*"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*	**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.

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 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*			
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* *""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*	**2** Castellanos-Brown 2010 McMillen 2015	ML: Minor concerns C: Minor concerns A: Serious concerns R: Minor concerns **Overall:** **Very Low**	Only 2 studies 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.

	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*			
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 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	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.

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.	*'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 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	*"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 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.*	**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.

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.	*Breaking things. And it was for a month straight." – Life Coach*			
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 psychoeducation about their mental health problems from a nurse, others greatly appreciated it, explaining that it changed how they monitored their symptoms and how	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.

they approached their psychiatric providers.				
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	*"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*	**1** McMillen 2015	ML: Minor concerns C: Moderate 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. Several changes to the

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. 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.	*sort of DBT training themselves? So that they're at least speaking the same language to remind them to use their skills."* – Life coach		**Overall:** **Very Low**	intervention were described however it was unclear where qualitative data were coming from for these changes and if participants were all in agreement.

Table 28: 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. (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.
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*	**1** Kirton 2011	ML: Serious concerns C: No concerns A: Serious concerns R: Minor concerns	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

	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)"		**Overall:** **Very Low**	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	*"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*	**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.

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.	*might be totally different and what I accept in my house is different to what somebody else accepts in theirs." (Foster carer)"*			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	*"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*	**1** Kirton 2011	ML: Serious concerns C: Minor concerns A: Serious concerns R: Minor concerns	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

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.	*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)		**Overall:** **Very Low**	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 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*	**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.

	member)			
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	No supportive quote was reported for this theme	**1** Kirton 2011	ML: Serious concerns C: No concerns	Only 1 study contributed to this theme. Data was likely collected prior to

reportedly given rise to some variations or changes of practice, for example, on televisions in bedrooms or consumption of fizzy drinks.			A: Serious concerns R: Minor concerns **Overall:** **Very Low**	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.
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	'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	**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 triangulation, respondent

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.	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)"		**Very Low**	validation, or the use of more than one analyst.
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	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

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 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.				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.
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	*"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.

reassurance on medical issues and dealing with difficult behaviours.				
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:** **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 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 communication as very effective, while foster carers were generally positive about their participation:	*"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.
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 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	*"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.

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)* *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)"*	**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.

Table 29: Summary CERQual table (Experience of carers undertaking concurrent planning)

Themes	illustrative quotes	Studies*	CERQual concerns	CERQual explanation
Children becoming distressed during contact: particular difficulties, at around 6 months, in separating from the primary caregiver. This is something that is seen in most children, in most families, as a normal if difficult developmental stage, when there is tension in the child between dependence, separation and individuation.	*"After two months of three-times-weekly contact at approximately the age of five and-a-half months, Joe began to become much more distressed during the contact visits. Paula could hear him getting more worked up and crying in quite a different way to any that she had ever heard, different in quality. Increasingly his distress could be seen to start as she left the room. She saw birth mother trying to comfort Joe by jiggling him, she thought much too vigorously, and being unsuccessful. It became the practice, after ten minutes of inconsolable crying, that she would return to the contact room and comfort Joe until he was more relaxed. Then she would leave the room again. When Joe again became more distressed she would have to return. She described her anguish while listening to him crying, wanting to be with him to help him and knowing that she could not go until the agreed time."* – Foster Carer	**1** Kenrick 2009/2010	ML: Serious concerns C: No concerns A: Serious concerns R: No concerns **Overall: Very Low**	Only 1 study contributed to this theme. Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method and thematic analysis methods were not explicitly described.

Concurrent planning concerns regarding frequency and timing of contact The CP carers complained that if contact was very frequent – three or five times a week – there was not time for recovery. Contact could lead to disruption for establishing routines. Several CP carers noticed that children were more clingy after contact. They might need a very quiet time for the next 24 hours to settle. The CP carers complained that if contact was very frequent – three or five times a week – there was not time for recovery: they had to be on the road again the next day. They felt the children needed to have more of the quiet time at home which most babies can have when very young. Behavioural issues were also found to occur before and after contact. Nearly all the CP carers, although accepting the timeframe, felt that the infants needed more opportunity than had been given to settle with them and in homes where everything was new and different. The infant might be placed on a Friday and contact would begin on the following Monday. Some reported contact starting the next day, before either infant or CP carer had found or settled into basic care routines and rhythms. It would seem that the peace and quiet the CP carers asked for initially could make sense for these vulnerable children, all of whom had experienced at least one previous move. Disruptive frequency of contact: journeys and scheduling could actively disrupt routines – getting up, feeding, bathing, and so on. Furthermore, it meant there was little time just to 'be', as is possible for most infants. some comments on how attending contact sessions three or more times a week made it difficult to access the community resources to which most new mothers turn, for example, mother and toddler groups or health visitor sessions at local health clinics.	*"Tony's CP carer, Vince, felt that Tony, placed at four weeks after withdrawal from methadone, took the five-times weekly contact with his loving birth mother well. Rather, he suffered from the lack of interaction with his carers during the long car journeys, up to two hours each way. By the time they got home it was bedtime; the only quiet times together were at weekends. He felt strongly that a child who has been withdrawn from drugs needed calm for his optimum development."* *"Paula felt that after contact, when he was reunited with her, Joe was pleased to see her. During the return on public transport he often slept after contact visits, or cried on the journey, but his feeding and sleeping were never disrupted. Once home he became relaxed quite quickly. However, she had noticed that when he found himself in a new place or new situation, he could become more anxious than she would expect. She reflected that in contrast to the very strong relationship that she and Joe now have, she felt quite cut off in her mind from him during the times of the early contact visits."*	**1** Kenrick 2009/2010	ML: Serious concerns C: Minor concerns A: Serious concerns R: No concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method and thematic analysis methods were not explicitly described. Some aspects of this theme related to the disruption of contact on behaviour, routines, accessing community resources and the need for recovery and quiet time.

Arranging handovers so that parents were not upset if infants showed a preference to be with the carers. Many CP carers paid special attention to arranging handovers so that parents were not upset if the infants showed a preference to be with the carers, for example by sitting next to parents so it was not so obvious that the child held out his arms to the returning carer. But some were very aware of a child's need to establish eye or physical contact with the carer. These CP carers knew that this linked to their own need to re-establish contact with the child they had left in uncertain circumstances.	*"Ruth, CP carer of Joanna, placed at six weeks, wondered if the way that Joanna often cried as they arrived at Coram was because of her own stress communicating to her, or whether there was something, especially as time went on, that Joanna really did not enjoy about the contact. She said that for herself it was difficult because she was handing Joanna over to a homeless, ill-looking mother. During one contact at four-anda- half months Joanna cried inconsolably for an hour and a half. Coram then phoned Ruth to come back to look after her. She found Joanna almost on the edge of fitting and everybody was very worried about her. The birth mother did not come to the next few contacts."*	**1** Kenrick 2009/2010	ML: Serious concerns C: No concerns A: Serious concerns R: No concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method and thematic analysis methods were not explicitly described.
Comments from the contact supervisor: how difficult it was for some birth parents when the infant showed a preference for the CP carers and would offer suggestions on how they might help the child (particularly 5 to 8 months). She observed how difficult it was for some birth parents when the infant showed a preference for the CP carers and would offer suggestions on how they might help the child. She might tell them that that is what babies are like at that age, as she had noticed how the infants had more difficulty in spending time with birth parents from five to eight months, depending on the particular child, a time when they could show that they	*"Richard seemed to show no emotion when handed to his mother and then seemed overjoyed when Lila, his CP carer, came to collect him. Lila was worried about the impact of this exchange on birth mother. She also noticed that as he got a bit older, Richard was quite difficult to manage in the taxi on the return journey and would throw himself around. From the age of about six*	**1** Kenrick 2009/2010	ML: Serious concerns C: No concerns A: Serious concerns R: No concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method and thematic analysis methods were not explicitly described.

realised something was different from their usual experience with the CP carer. She was aware of their relief when reunited with their CP carers.	*months, she said that he would not look at her at all on the way back in the taxi or for at least an hour, or sometimes longer, after they returned home."*			
Concerns about the experience of the child during contact sessions. A number of CP carers wondered about the experience of children during contact with their birth parents. One said the birth mother changed the baby more often than was necessary; another thought the mother did not know how to feed the baby her bottle, which must be why she was always so hungry and tearful after contact. Another carer reported that the birth mother, having heard the child loved her bath, had given her one but the child had screamed. It must have been such a different experience from the bath at home. Comments from contact supervisor: The supervisor felt that what can confuse the children is when the birth parents do things with them differently from the carers; even more so when they do the same things but differently**.** For example, feeding and bathing. When the child refuses a bottle given to it in a different way from normal, she might have to call the carer back so the child is not left hungry.	*She thought that during the early contacts Millie seemed to be searching around everywhere with her eyes. The contact supervisor had seen Millie as being very alert and lively as a baby and had praised this. However, Zeta felt that this was a sign of Millie's anxiety. After contact she noticed that Millie seemed very restless, cried more and wouldn't sleep that night. She did not feel that at the point of separation from her Millie showed very much difficulty. However, on reunion she herself could see Millie's anxiety. Sometimes she would just fall asleep when returned to her, not having slept at all during the contact session.*	**1** Kenrick 2009/2010	ML: Serious concerns C: No concerns A: Serious concerns R: No concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method and thematic analysis methods were not explicitly described.
Importance of foster carers in easing the transition to prospective adoptive parents, for continuity of routines. Many of the CP carers were able to give graphic descriptions of the children in the first 24 hours or few days after moving from foster carers, namely the infants' responses to the disruption of their previous attachments. Several were very explicit about how helpful they had found the foster carers' understanding of the infants, and	No quote to support this theme was reported	**1** Kenrick 2009/2010	ML: Serious concerns C: No concerns A: Serious concerns R: No concerns	Only 1 study contributed to this theme. Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview

the feeding and sleeping regimes they had set up, and how these had eased the transitions for children and carers at the time of placement. Some also felt that the security of the rhythms and of the known routines, which they were trying to continue, had been abruptly broken once contact started. For infants placed straight from hospital there was no time to establish routines before contact began. Reliance on foster parents: parents relied on information provided by the foster carers, several of whom had met the birth parents and had photos of them that would be passed onto the children. Because the foster carers held information about the birth parents, some CP carers maintained contact with them and hoped that they would be the ones able to talk to the children later about their families of origin.			**Overall:** **Very Low**	method and thematic analysis methods were not explicitly described.
Realisation by CP carers of how much the infants were missing the foster carers to whom they were already attached. Several carers gave poignant accounts of their realisation of how much the infants were missing the foster carers to whom they were already attached.	*Albert described how Charlie, placed at six months, although apparently happy in the daytime, became distressed at bedtime. Albert also felt more time had been needed for Charlie to start feeling more settled with them before embarking on regular contact with a mother with whom he had had little previous contact while in foster care, the only such case in the sample. Mandy, placed at nearly six months, cried inconsolably on her first visit to the CP carer's home. Fiona, the CP carer, realised how much it meant to her to lose her foster carer, whom Mandy still sees at least twice a year. When Jill cried all the*	**1** Kenrick 2009/2010	ML: Serious concerns C: No concerns A: Serious concerns R: No concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method and thematic analysis methods were not explicitly described.

	way from the foster carer's to the CP carer's home, Una said it would have been strange if Jill had not minded the change in her life; all the smells and routines would be different in her new home. Tina, placed at seven weeks with Bella, did not feed or sleep for the first 24 hours; she just stared at everything and everyone around her. When newly placed baby Joe seemed to sleep both day and night, his CP carer became so anxious that she called her GP. She later realised that this was the child's response to separation from his attachment to his foster carer, and she thought sleep was his defence, his way of cutting off from the pain of his experience.			
How long children and CP carers should be given to get to know one another and settle following the move from foster carers or hospital before contact starts. Greater period of transition may be helpful. A theme that emerged from a number of narratives is how long children and CP carers should be given to get to know one another and settle following the move from foster carers or hospital before contact starts. While appreciating the philosophy that continuing contact with birth parents will help rehabilitation when that becomes possible, many CP carers felt the babies themselves needed more time. The move from foster carers, where they might have been for some months, was a major separation in their lives. Like CP carer Fiona, a small number spoke specifically of	*"David's carers felt they had to fight for the period of introduction not to be rushed. They realised that the placement at ten months with them was an interruption of his secure and firm attachment to the foster carer, with whom they have continued to be in touch. They have taken care with all changes in his life – to a new house and nursery. They feel his separation at ten months still affects him and shows in his continued sensitivity to change*	**1** Kenrick 2009/2010	ML: Serious concerns C: No concerns A: Serious concerns R: No concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method and thematic analysis methods were not explicitly described.

realising that the babies were mourning the loss of their previous foster carers. Some CP carers felt the children were moved too swiftly from foster care. One couple pressed for more introductory meetings than had been planned by the local authority social worker. They were aware the child was losing his primary attachment. This can be generalised to planning moves for all young children in the care system.	*and separation. But they also see a growing independence."*			
Children born to drug/alcohol misusing parents: When the infant was a long time in hospital, the CP carers expressed great concern for what that experience might have meant to the child e.g. being alone during hospitalised detoxification, concerns regarding development and health fallout. One numerically large group consists of children born to drug and/or alcohol misusing parents: 14 out of 23 in the contact group and all four of those in the non-contact group. Many, but not all, of these children had had to go through a hospitalised detoxification at birth. When the infant was a long time in hospital, the CP carers expressed great concern for what that experience might have meant to the child. Some still detected what they believed to be the sequelae of detoxification and possibly also of pre-natal drug/alcohol exposure, in jerkiness and in states of unexplained distress or slow weight gain.	*'I hate to think of her being alone as she had to go through it.' 'I wish I had known about her earlier so that I could have been with her.' – CP Carer* *"Millie, withdrawing quite quickly from a high level of medication, slept most of the time for the first three months after placement, 'doped out'. Baby Rhiannon spent three-and-a-half months in hospital. The CP carer gave her the last doses of methadone when she was placed and found its effects complicated. The child had constant diarrhoea and was restless and difficult to feed for her first year, and subsequently had recurrent infections. She had also had many falls, tantrums and was constantly on the move and challenging."*	**1** Kenrick 2009/2010	ML: Serious concerns C: Minor concerns A: Serious concerns R: No concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method and thematic analysis methods were not explicitly described. This theme describes a range of health problems as a sequalae to being born to drug/alcohol misusing parents.

Poor passage of medical information about health issues to the foster carers/CP carers: e.g. hepatitis infections. One of the children has hepatitis C and another child's diagnosis of the same condition was later reversed. Miranda was shocked that the foster carer had not been told that Jade had hepatitis C. Una discovered, as a result of a routine blood test at four months, that Jill had hepatitis C. Una is distressed by the difficulties the condition may pose Jill later in life. Three more children were placed with an uncertainty about hepatitis C. The CP carers did not want to delay placement and were naturally relieved that later tests were negative. They knowingly accepted the risk that is implicit in the placement of very young infants who might later be adopted and whose health and development cannot yet be adequately assessed.	*"Martin, who had four weeks hospital detoxification, seemed to be the easy baby. His fears and sleeping difficulties appeared to start when he moved to nursery school and returned when he entered reception class, ie at times of change and transition. The second child, Joel, was much more restless and cried a lot when placed. He was diagnosed well into his placement as having mild cerebral palsy. For both children, Kathy has had to mobilise resources, including physiotherapy and speech therapy. Joel only started to sleep well from the age of three." – CP Carer*	**1** Kenrick 2009/2010	ML: Serious concerns C: Minor concerns A: Serious concerns R: No concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method and thematic analysis methods were not explicitly described. This theme shows some examples of uncertainty regarding pre-existing medical conditions upon taking on a foster child for adoption.
Continuing sensitivity to separation and change following adoption placements. Continuing sensitivity to separation and change is a factor that emerged in descriptions of some of the children.	*"One adoptive mother said she would look for a particularly nurturing primary school for her son who shows anxiety in new places and situations, and sudden emotional collapses that do not seem to be triggered by anything specific. She wondered how much these states are the sequelae of early detoxification and a rather under-stimulating foster placement."*	**1** Kenrick 2009/2010	ML: Serious concerns C: No concerns A: Serious concerns R: No concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method and thematic analysis methods were not explicitly described.
Comments from the contact supervisor: the need to help the parent to play with the child during contact sessions. She might also have to help the parent to learn	No quote to support this theme was reported	**1** Kenrick 2009/2010	ML: Serious concerns	Only 1 study contributed to this theme. Researchers do not

how to play with the child, not just to offload their own difficulties onto her while leaving the child unstimulated and ignored.			C: No concerns A: Serious concerns R: No concerns **Overall:** **Very Low**	justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method and thematic analysis methods were not explicitly described.
Comments from the contact supervisor: help the parent to recognise the child's gesture towards them and to find ways to help them to respond. The supervisor had a special concern for the children distressed when their attempts to interact with their birth parent were not reciprocated, in which case they might turn to her instead. She saw it as part of her task to help the parent to recognise the child's gesture towards them and to find ways to help them to respond. In this way birth parents who were deemed likely to fail in their child care could be helped to greater success, even though, in this sample, in only one case did such support contribute to the rehabilitation of the child.	No quote to support this theme was reported	**1** Kenrick 2009/2010	ML: Serious concerns C: No concerns A: Serious concerns R: No concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method and thematic analysis methods were not explicitly described.
Continuing contact: CP carers have concerns about these wider contacts when the extended family may still be in touch with birth parents. Only one child still has direct contact with her birth mother. For others there is letterbox contact through Coram. Some children have continuing contact with sibling groups or extended family, although their CP carers have concerns about these wider contacts when the extended family may still be in touch with birth parents. Direct contact does need to be safe for all concerned.	No quote to support this theme was reported	**1** Kenrick 2009/2010	ML: Serious concerns C: Minor concerns A: Serious concerns R: No concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method and thematic analysis methods were not explicitly described. It

				is unclear to what extent this theme was reflected in the whole sample studied.
Uncertainty leading to uncertainty in attachment (of the CP caregiver): CP carers had opted to be part of Coram's Concurrent Planning Project, hoping at the end of the day that they would have the chance of adopting a very young child. They had also chosen to take the risk that the adoption might not happen.	*"One said that if the child had returned to his birth mother, it would have been because the birth mother had made it happen, not because they had failed. Xan, carer of Charlie, saw how good his birth mother could be with him when she was not using drugs and thought that, had it been possible, returning to her would have been the best option for him." – CP carer* *"'I knew I would just have to deal with the loss if it happened later.' One CP carer summed up her feeling about the uncertainties: 'You have to learn to keep a lid on your expectations.' – CP Carer*	**1** Kenrick 2009/2010	ML: Serious concerns C: No concerns A: Serious concerns R: No concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method and thematic analysis methods were not explicitly described.
Difficulties with consent: The CP carers had no part in the legal process of concurrent planning and no parental responsibility. This was an issue in one case, where a child became ill and in need of urgent medical intervention for which the CP carer could not give permission. That responsibility lay with children's services or the birth parents.	No quote to support this theme was reported	**1** Kenrick 2009/2010	ML: Serious concerns C: No concerns A: Serious concerns R: No concerns **Overall:**	Only 1 study contributed to this theme. Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method and thematic

			Very Low	analysis methods were not explicitly described.
Benefits of training: the Coram training had led them not to expect the infants to attach too quickly, helping to ensure that attachments developed at a pace that was right for the infants, who were still totally dependent on others for their survival.	No quote to support this theme was reported	**1** Kenrick 2009/2010	ML: Serious concerns C: No concerns A: Serious concerns R: No concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method and thematic analysis methods were not explicitly described.
Length of time taken on journeys to contact visits: All the CP carers had to live within a 20-mile radius of Coram, later within the boundary of the M25. For some, this could entail a journey of up to two hours by car or public transport.	*"Vince regretted the length of time that Tony, from aged four weeks taken by car to contact five times a week, had to spend travelling and the inevitable lack of interaction between him and his CP carers. He thought that Tony, who had spent the first four weeks of his life being withdrawn from methadone, needed all the calm interaction he could have – which during this period was only possible at weekends. He felt that when contact was later reduced, Tony began to make a huge leap in his development. Albert described taking Chris to contact in a crowded commuter train the*	**1** Kenrick 2009/2010	ML: Serious concerns C: No concerns A: Serious concerns R: No concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method and thematic analysis methods were not explicitly described.

	morning after he was placed. Chris was crying wretchedly and Albert and his wife felt anxious and exposed as novice parents."			
Importance of knowing birth parents for children's identity needs: the CP carers who had the most contact with birth parents seemed to value the relationship most. All felt they would be able to tell the children about the 'real' parents, not ones just described in social work files as interpreted by local authority social workers, who might not themselves have known the people involved. one of the real benefits emerging from concurrent planning: it enables CP carers to give their children a truthful, balanced account of their birth parents as they grow older, incorporating both positives and negatives in age appropriate ways. Not getting to know the birth parents: For the four families where there had been no contact with birth parents, there was a feeling of disappointment after the build-up from the preparatory training groups, together with loss and regret that they could not talk later to the children about parents who were real to them. They felt this would be a lost opportunity for the children. Admittedly, they could see how they had gained from the quiet time they had had to get to know the children without the disruption of the contact visits.	*"CP carer Una had felt she had a bond with the birth mother with whom she had some common interests. She had also been very pleased about the close relationship between the birth parents. She knew it would be important to tell her child about this and that it would make a difference for her to know she had been born to a loving couple."*	**1** Kenrick 2009/2010	ML: Serious concerns C: No concerns A: Serious concerns R: No concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method and thematic analysis methods were not explicitly described.
Concern for the birth parents and uncertainty of the concurrent planning process: As well as respecting them, many CP carers expressed concern for the ordeal to which continuing contact exposed the birth parents. Vince thought it cruel for the birth mother when contact was prolonged for 12 months, just as it was for his wife, both being left on what he called a 'rollercoaster of uncertainty'. Many expressed sadness for the plight of	*"I feel so sad for [birth mother] who is losing the child she so clearly loved . . . and I feel terribly sad that Beth was not able to be with her birth mother."* *"Vince thought it cruel for the birth mother when contact was*	**1** Kenrick 2009/2010	ML: Serious concerns C: No concerns A: Serious concerns R: No concerns	Only 1 study contributed to this theme. Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview

birth parents, especially those struggling with drug problems.	*prolonged for 12 months, just as it was for his wife, both being left on what he called a 'rollercoaster of uncertainty'."*		**Overall:** **Very Low**	method and thematic analysis methods were not explicitly described.
Importance of contact supervisor and social worker oversight, and confidentiality during contact with dysfunctional birth families	*"CP carer Linda thought the needs of the birth parents were put before those of the child. The birth father, who was the parent being assessed in this child's case, had a long history of drug use and violence. Linda was alarmed by his agitated, aggressive states and thought he was 'high' on some substance when she first met him. Thereafter, she was anxious about the child's safety during contact, as she was sure that the birth father did not meet the requirement to be drug free at contact sessions and believed social workers were frightened to challenge him because of his history of violence. 'What is safe enough?' she queried. It was a relief when the children's guardian also questioned the father's state. Before that, she had felt she must be going mad when she objected and no one seemed to take her seriously. Her anxiety about the child's safety during contact was to an extent contained because of her confidence in the contact supervisor."*	**1** Kenrick 2009/2010	ML: Serious concerns C: No concerns A: Serious concerns R: No concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method and thematic analysis methods were not explicitly described.

	"Fiona, another CP carer, was concerned that the child's birth father, with a history of violence and drugs, would follow her or trace where she lived through her car's registration. She took care to park some way away from the community contact centre and did not give details of her family even to staff there. She had found it helpful to discuss her fears with her Coram social worker." *"Several other CP carers had been upset or alarmed by meeting birth parents who were in disturbed states or ill. Two expressed specific concerns about health issues and the dirty state of birth parents at contact; they were anxious about infection being passed on to the infants."*			
Implications for matching and placement if CP carers voice their concerns: A few CP carers were reluctant to venture their criticisms of the process as they were aware of being continually assessed themselves and feared that if they 'failed' in any way, they could lose the child to whom they had become attached. several CP carers felt they had to be careful not to expose too many of their difficulties for fear of being regarded as unsuitable carers, demonstrating the continual effect of the anxiety created by the uncertainties intrinsic to concurrent planning.	*"CP carers need extra support, as described by Linda and Fiona, and opportunities to voice their anxieties about safety without feeling criticised. A few CP carers were reluctant to venture their criticisms of the process as they were aware of being continually assessed themselves and feared that if they 'failed' in any way, they could lose the child to whom they*	**1** Kenrick 2009/2010	ML: Serious concerns C: No concerns A: Serious concerns R: No concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method and thematic

	had become attached."			analysis methods were not explicitly described.
Avoiding problematic continuing direct contact and letter box contact through Coram: one couple were clear that direct contact would only continue while it was in the child's best interest. Letterbox contacts can be problematic, but most are directed through Coram, which can filter or encourage rewriting if the contents are inappropriate or disturbing either to child, CP carers or birth parents. This degree of care, not always taken by other organisations, is enormously helpful to all concerned. Indeed, many of the birth parents regularly seek advice from Coram when writing their annual letter to the adoptive parents of their child.	*"Elizabeth and Fred, carers of Stella, placed at three days, were alone in the study in meeting the birth mother shortly before Stella's birth. They established a strong and respectful relationship with her through a long period of contact and Fred thought that continuing contact should be direct after the adoption order was made. There had subsequently been three annual meetings between Stella and her birth mother. From the description, it also seemed important for the birth mother that she was able to continue her relationship with Elizabeth and Fred, which meant a lot to her. The couple were clear that direct contact would only continue while it was in Stella's best interest. So far, they felt it was helpful for Stella to know her real mother and not just to have a fantasised and idealised picture of her."*	**1** Kenrick 2009/2010	ML: Serious concerns C: No concerns A: Serious concerns R: No concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method and thematic analysis methods were not explicitly described.
Involvement of CP families extended family: Where extended family and friends were involved from the start – for example, the father of CP carer Bella collected the child from contact sessions when Bella had to work – the family relationships became and remained strong. Some	*"When the carers' extended family were elderly or lived far away, some CP carers chose not to tell them too much about the uncertainty implicit in the process.*	**1** Kenrick 2009/2010	ML: Serious concerns C: No concerns A: Serious concerns	Only 1 study contributed to this theme. Researchers do not justify the research

CP carers commented on how the children now adopted were accepted and on a par with biological grandchildren. Involvement of the extended family could be the difference between success and failure.	*Heather described how the process had been difficult for the potential grandparents, aunts and uncles. One grandmother had distanced herself in what seemed quite a defensive way. Heather noticed that the child had a much less close relationship with her now than with family members who had taken the risk of committing to him. CP carer Ruth said they were unable to attend to grandparents' anxieties about how things would turn out and that she and her partner needed to see to their own needs and support each other as a couple through the process. Xan spoke of support from close friends who had become the child's godparents, as they did not want to burden family members with their anxieties. They felt the child's story was his private affair."*		R: No concerns **Overall:** **Very Low**	design. Unclear recruitment strategy and why certain participants were selected. Interview method and thematic analysis methods were not explicitly described.
Extra support from Coram Social Workers: Most parents valued the support from their Coram social workers and from being a continuing part of the Coram 'family', as experienced in outings such as summer picnics. The Coram social worker was usually available to discuss any anxieties or to accompany the CP carer if contact sessions were difficult or in a different setting. The continuity provided by the contact supervisor proved very helpful.	No quote to support this theme was reported	**1** Kenrick 2009/2010	ML: Serious concerns C: Minor concerns A: Serious concerns R: No concerns **Overall:**	Only 1 study contributed to this theme. Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method and thematic

			Very Low	analysis methods were not explicitly described. Unclear that this theme covers the full range of "extra" support available, or how many made use of this support – which seemed varied.
By comparison, undersupport from local authority workers: If at times some CP carers found it difficult to request as much support from Coram as they felt they needed, more were openly critical about the local authority social workers. The majority of these criticisms centred on chaos as they experienced it within the local authority departments, leading to delays in placement and in preparation for court hearings. Where some birth parents presented difficulties, e.g. with aggression, they felt the local authority workers backed off, leaving the carers exposed. Several wondered if the needs of birth parents were being put before those of the child by professionals involved with the process.	No quote to support this theme was reported	**1** Kenrick 2009/2010	ML: Serious concerns C: No concerns A: Serious concerns R: No concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method and thematic analysis methods were not explicitly described.
Helpfulness of children's guardians appointed by the courts: Parents had equally differing views of the helpfulness or otherwise of children's guardians appointed by the courts for the child. One had recommended trial rehabilitation rather late in the process, which had profoundly upset the CP carers. Others had intervened helpfully when there had been difficulties during contact with birth parents, in one case recommending the termination of contact.	No quote to support this theme was reported	**1** Kenrick 2009/2010	ML: Serious concerns C: Minor concerns A: Serious concerns R: No concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method and thematic analysis methods were not explicitly described. Contrasting views over

				the usefulness of the children's guardian. Perhaps this was dependant on who's "side" the guardian had taken during proceedings.
Changes late in the concurrent planning process being especially unsettling: an event that was unsettling for CP carers was when consideration was given to members of the extended birth family to become adopters well into the concurrent planning process. On the other hand, placements could be delayed if such consideration took place before the placement. Similar crises of uncertainty arose when court hearings for care orders or adoption were contested by birth parents.	No quote to support this theme was reported	**1** Kenrick 2009/2010	ML: Serious concerns C: No concerns A: Serious concerns R: No concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method and thematic analysis methods were not explicitly described.
Overcoming drug and alcohol addiction to achieve reunion (birth mother) As she had misused drugs and alcohol over a long period, she only realised she was pregnant when she began to feel nauseous while using. She then stopped and made use of support from Coram and drug and alcohol support services to make radical changes to her lifestyle, a process that had started before her baby's birth. She was able to make and sustain these changes within a period that was consistent with the developing needs of the child. In this way, she stands out from other birth parents in the study who were unable to make or sustain sufficient transformation in themselves for the satisfactory care of their children.	*"More people need to be told about concurrent planning. It gives you a chance but you have to be strong, to really want it, to have your baby."*	**1** Kenrick 2009/2010	ML: Serious concerns C: No concerns A: Serious concerns R: No concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method and thematic analysis methods were not explicitly described.

Support from Coram appreciated (successful birth mother) She contrasted the support from Coram, which is still available, to the social services who she felt did not believe in her. This description seemed to replicate the split between her belief in and lack of confidence in herself. She said that the contact supervisor was crucial.	*"They judged you. Social services have no faith in people like me. Once it's drugs, they give up on you, don't believe you can do it."* *"She would cheer me along.When I said I would never get him back she would make me think about the good things."*	**1** Kenrick 2009/2010	ML: Serious concerns C: No concerns A: Serious concerns R: No concerns **Overall:** **Very Low**	Only 1 study contributed to this theme. Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method and thematic analysis methods were not explicitly described.

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. One study did not meet the inclusion criteria and was excluded, 2 publications were included in 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.

Summary of included cost effectiveness evidence

Lynch 2014

Study	Comparators	Costs[1,2]	Effects[4]	ICER	Uncertainty[5]	Applicability[6]	Limitations[7]
Lynch 2014 117 foster children, aged 3 to 5 years economic analysis conducted alongside RCT US public sector perspective 24-month time horizon	Multidimensional Treatment Foster Care for Pre-schoolers (MTFC-P), n=57	**Mean total costs:** Full sample $27,204 (£23,065) Placement instability sample[3] $29,595 (£25,092)	**Permanent placement:** Full sample 36.84% (21/57) Placement instability sample 48.28% (3/23)	MTFC-P dominates RFC being less expensive and resulting in more permanent placements for both the full sample and placement instability sample	**Mean incremental net monetary benefit** Full sample $4,591 (95% CI −596 to 9,779) £3,892 (95% CI -505 to £8,291) Placement instability sample $8,087 (95% CI 188 to 15,987) £6,857 (95% CI 159 to £13,554) Deterministic sensitivity analysis was not conducted. Cost-effectiveness acceptability curve was not reported.	Partially applicable	Very serious limitations
	Regular foster care (RFC), n=60	**Mean total costs:** Full sample $30,090 (£25,512) p<0.005 Placement instability sample $36,061 (£30,574) p<0.05	**Permanent placement:** Full sample 31.67% (19/60), p=0.787 Placement instability sample 13.04% (14/29) p=0.002				

[1]Mean total public agency costs were statistically significantly different between MTFC-P and RFC groups, adjusted for gender, number of placements prior to start of the study and baseline severity. The sum of the individual cost components incurred by the MTFC-P or RFC populations (Table 1, Lynch 2014) did not match the total costs for MTFC-P and RFC reported by the author. The analyst calculated these to be $27,229 for MTFC-P and $30,002 for RCF, which had no impact in the conclusions of the analysis. The total costs included in the economic evidence tables were those estimated in the original publication.

[2]Converted from 2008 US dollars to 2020 British pounds accounting for inflation, currency conversion and purchasing power parities, conversion ratio 1.179, EPPI Centre cost converter accessed on the 03/03/2020

[3]A subgroup of children had 4 or more placements (placement instability) before inclusion in the study, which included 52 children (29 MTFC-P, 23 RFC)

[4]The primary outcome 'permanent placement' was calculated as the number of attempted permanent placements before a permanent placement was achieved, divided by the total number of cases in each group. A placement was considered permanent if the child was reunited with a biological parent or adopted by a relative/non-relative

[5]The incremental net monetary benefit results presented were calculated based on the assumption that stakeholders would value an additional permanent placement at $10,000 (£8,479). The study considered a range of levels of willingness to pay.

[6]Analysis conducted from the US public sector perspective. No discounting was applied in the second year of the analysis

[7]The authors reported that the study was not powered to detect a difference in the permanent placement outcome in the subpopulation with history of placement instability (Fisher 2009). Complete clinical and services data were available for 69% of participants, missing data were imputed using statistical multiple imputation with chained equations. The time horizon of the analysis is limited to the 24-month duration of the RCT, the long-term effects of the interventions were therefore not explored.

Sharac 2011

Study	Comparators[1,2]	Costs[3]	Effects	ICER	Uncertainty	Applicability[4]	Limitations[5]
Sharac 2011 Economic analysis conducted alongside RCT Adoptive parents of children aged 3 to 8 years NHS and personal social services 6-month time horizon	Cognitive behavioural approach (CBA, n=10) or educational approach (EA, n=9)	**Mean total costs:** £6,069 (SD £3,983)	**Strengths and difficulties questionnaire (SDQ):** Favours SAU, difference 0.79 (SD not reported) **Parental satisfaction questionnaire (PSQ):** Favours combined CBA + EA, difference 4.90 (SD not reported)	SDQ SAU dominates as it was both more effective and less expensive than CBA+EA. PSQ £406/unit improvement in the satisfaction with parenting scale	No sensitivity analyses were conducted.	Partially applicable	Very serious limitations
	Service as usual (SAU, n=18)	**Mean total costs:** £4,066 (SD £6,361)					

[1]The cognitive behavioural approach was adapted from Webster-Stratton (2003), which consists of training carers on how to decrease unacceptable and increase acceptable behaviours by using praise and rewards, logical consequences and problem-solving skills

[2]Adopters under the educational approach were helped to improve their understanding of the meaning of the children's behaviour and its connection with past experiences

[3]Costs inflated to sterling 2020 using the EPPI reviewer cost converter accessed on the 03/03/2020, conversion factor 0.83

[4]Questionnaires' scores used as a measure of the efficacy of the intervention, which may have limited applicability to the NICE decision making context. Perspective of costs was not clearly stated, but costing included NHS and personal social services usage.

[5]Study conducted alongside a small trial with very low quality. Sample size was underpowered to assess a true difference in the primary outcomes and costs between comparators so authors combined costs and effects of CBA and EA, which may have influenced the conclusions about the individual interventions. No analysis of uncertainty was conducted. The analysis was limited to the 6-month duration of the trial and did not explore the long-term effect of the intervention. Resource use was self-reported which may have generated imprecise estimates (recall bias).

Economic model

No economic modelling was undertaken for this review question.

The committee's discussion of the evidence

Interpreting the evidence

The outcomes that matter most

The committee considered the quantitative outcomes reported. The review concerned the successful transition of looked after children and young people out of care into permanency and therefore the committee considered outcomes that reflect longer term success of those placements to be more important. For example, information about the durability of the placements such as any subsequent breakdowns in permanency placement that led to a return to care. Since data on the durability of care placements could be confirmed easily by administrative data this outcome was also more objective. These outcomes varied in follow up time which was between one to three years. Longer term follow-up gave a greater sense of the stability of the placement.

Other outcomes could also give some reflection on the stability of the permanency placement such as behavioural, educational, and social functioning. Of the included evidence, eight studies reported some indication of the durability of the permanent placement. However, only one studied behavioural outcomes following transition out of care.

The committee were also concerned about the long-term health and wellbeing of looked after children following their transition into permanency. Particularly the potential for re-abuse, or neglect. However, few studies reported such outcomes. Three included studies reported data on harm/abuse post permanency, and one on mental health following permanency.

The most commonly reported outcome described whether a person in care had achieved permanency in the first place, usually through adoption, reunification, or permanent kinship placement. This was outcome reported by 16 included studies. Unfortunately, while this measure was useful to show that the process to gain a permanent placement had been successful, the committee considered that it said little about the longer term success of that placement in terms of health, safety, wellbeing, or stability.

The committee also considered the qualitative data, which was useful to provide context to the many multidimensional interventions described. For interventions such as these, the qualitative data could be helpful to draw out the specific components that users and practitioners had found to be most impactful.

The quality of the evidence

The committee considered many of the methodological weaknesses of the evidence base. Randomised controlled trials, though the most robust study design, experienced issues with high attrition rates, lack of information regarding adherence to study interventions, and lack of blinding procedures combined with self-reported outcomes. It was also likely that missing data was a difficulty, particularly with self-reported outcomes, although this was commonly not well described. Difficulties in retaining looked after children over the course of the trial could ultimately result in imbalances in the spread of confounding factors between comparison groups. This was likewise an issue for studies where randomisation techniques had not been used. The committee acknowledged the uncertainty regarding whether observations were due to differences in impact or differences between the composition of comparison groups when interpreting the results.

A lack of clear descriptions regarding the standard of care that interventions were being compared to was also considered an issue. Statistically significant results favouring the intervention group lost meaning where it was not apparent what was the standard of care in the comparison group. The committee considered this problem compounded by the fact that the evidence was largely USA-based. Even more so since standard of care may vary significantly by state, county, and timepoint.

Finally, many studies were underpowered to detect the impact they were measuring. The lack of clear power calculations and defined primary outcomes was apparent in most studies, meaning, in many cases, effect estimates were imprecise and confidence intervals were too wide to allow the committee to make a judgement regarding the impact (or lack of impact) of the intervention under study.

It was recognised that qualitative studies did not report data that could assist the committee in making a judgement regarding the effectiveness of the interventions studied. The qualitative studies did provide useful information to supplement effectiveness data with regard to accessibility, acceptability, and barriers and facilitators to the success of the intervention. However, included qualitative studies themselves frequently had notable limitations. Many were poorly reported in terms of the selection of participants, method of interview, and method of thematic analysis. It was also common not to apply any form of validation e.g. triangulation, respondent validation, or the use of multiple analysts. More commonly, themes were derived from single studies and there were therefore questions regarding adequacy of the data. Similarly, as with the quantitative data, the committee also recognised there was a question of indirectness. Only two studies were UK-based and four of these provided the perspectives of practitioners delivering the intervention, rather than foster youth or carers receiving the intervention.

Benefits and harms

The committee considered parent training interventions. Evidence from two randomised controlled trials suggested that Parent Management Training Oregon and KEEP foster parent training were both associated with significantly greater odds of reunification or positive move into foster care. The committee had also previously considered evidence showing that foster parent training was useful for reducing child behavioural problems and for improving placement stability and had recommended its use for supporting carers (after assessing and understanding the individual needs of the child or young person). Similarly, the committee reviewed RCT evidence showing the benefit of a parent training intervention for looked after youth with clinical scores on the child behaviour checklist, or more severe mental health problems moving out of restrictive care and into the community for maintaining placement in their school and not returning into care. This intervention (On The Way Home) also built up systems of communication between schools and the family consultant to monitor and support school progress. By consensus the committee considered that, in temporary placements where training and development needs had been identified for foster carers, that training should similarly be provided to new carers in the follow on/permanent placements to allow for continuity of behaviour management approaches and attachment-informed, high-support and high-nurturing relational care. Particularly, the committee felt that support should continue following reunification in order to support the durability of permanency, with scheduled follow up. As discussed in previous chapters, the committee extended the need for knowledge of trauma and attachment (and therapeutic approaches) to those providing the training.

In a similar manner, the committee discussed the need for continuity of health care as the looked after person moves from their old to their new placement. The committee suggested that, where regular mental health, physical health, or dental support had been provided in the

old placement, new referrals local to the new placement should be in place prior to the transition out of care, in order to promote continuity of care.

Similarly, the committee discussed the problem of a continuing education plan when a child is moved outside of their local authority area. Children going out of their authority may have no continuity. The committee considered there should be someone who has an overview of the child's educational needs who can help place the child in education that matches their needs. By consensus, it was recommended that this could be assisted by having a transition plan and "handover" from the old to the new school placement as part of the personal education plan.

During the process of transition the committee considered it important that there be a professional who is regularly "checking-in" with the child to ensure the process is going well for them and, in this way, to keep the process of transition out of care child-centred. One of the committee members pointed out that for some pre-verbal children the primary caregiver may need to be present during check-in sessions. These check-in sessions should include listening to and recording the perspective of the child which is then shared with the wider team to feed into a shared decision-making process during transition. In some cases, particularly where a child may struggle to communicate, the need for advocacy services should be assessed. The committee drafted a recommendation, outlining these points, to promote child-centred care in the transition process.

Though no quantitative studies had examined the impact of information-giving during transition out of care. Qualitative data had made clear that good clear information prior to transition was something of great importance to new foster carers and prospective adopters. The committee were pressed to describe the types of information that should be given to a new carer during the process of transition between care placements or out of care. The committee decided, by consensus, that the information provided should give to new carers a clear sense of the chronology of the care process for the child: including elements collected from social care records, health records, and school records. This tied in with previous recommendations stating a clear chronology of health care records should be compiled. To avoid this information being handed over in an overwhelming heap, the committee recommended that the information should be clearly summarised, and with an index and references to sections with more detail. Finally, the information should be briefed to the new carer in person, rather than leaving the carer to make sense of it by themselves. Where possible this should be performed by a social care professional who has had continuous oversight of the child or young person's history in care.

In terms of what information should be included in such a briefing, by consensus, the committee outlined the following would be helpful for new carers and prospective adopters, so that the needs of the new placement can be adequately covered: birth family health history (collected for all children entering care, not just during adoption processes); personal medical history including previous exposure to substances (e.g. antenatal); incidences of domestic violence and abuse, neglect; existing significant relationships (e.g. with adults) and history of conflicts in relationships (especially as relates to contact); significant disclosures, placement moves and reasons for these moves; significant adverse events with potential for significant harm to others through behaviour (e.g. sexual, violent, or firesetting). With regard to events with potential for serious harm to others, the committee wished to stress that context should be expounded when describing these events to prospective carers. This could be aided by the inclusion of the looked-after person in giving information about their care history to the new carer, if appropriate, and the child or young person is willing – drawing from life-story work.

The committee were also keen that this shouldn't simply be a record of negative life events, but that the record should simultaneously lend equal weight to protective factors such as strengths, hopes for future, significant positive relationships (peer and adults), interests and activities. These factors could be drawn out of ongoing life story work (recommended elsewhere).

As part of this process, by consensus, the committee recommended that careful consideration in transition planning should be given to matching of carers and the looked after child – moving from assessment of case history to identify suitable placements, to conversation with carers with information giving and honest assessment of family dynamics and carer strengths. The overall aim of this recommendation would be to match more looked after children and young people with suitable placements and carers who are equipped to address their needs.

The committee also considered evidence suggesting that methods of multidimensional treatment foster care (MTFC) and early intervention treatment foster care were associated with significantly lower odds of permanent placement breakdown in a 3 – 6 year old group, and associated with reduced return to custody in a youth offender populations. The committee had previously recommended (as a result of evidence stemming from review questions 2.1 and 3.2) that multidimensional treatment foster care, a highly intensive form of behaviour management intervention, should be considered for adolescents with history of persistent offending behaviour – since this was the population within which most of the evidence supporting MTFC was based. The committee considered that the evidence base was not strong enough to suggest its use in the broader subpopulation of pre-school children. Therefore, no further changes were made to the recommendations concerning MTFC.

Various case management strategies were presented to the committee, for example, Parent for Every Child, Family Finding Intervention, and the use of a Family Finding Specialist were methods of family searching, recruiting and engagement, and fast tracking movements from care into permanency. Two of these research reports showed improvements in rates of finalised permanency, relational permanency, or contractual "relational" permanency. The committee stated that many of the components of the interventions described were already a part of UK practice in engaging families in permanency planning. The committee sought to draw out core principles of practice that would fit in UK settings.

Concurrent planning was also discussed as something that was already practiced, with success, in certain parts of the UK. In one non-randomised study this was found to result in significantly reduced likelihood of multiple moves prior to finding permanency and of fewer months to finding a permanent placement. Qualitative data was also considered which showed two particular issues arising with concurrent planning in that prospective adopters and birth parents taking part in the system found that late changes in the care plan could be particularly distressing for the carers or parents, in addition, prospective adoptive parents found that the intensive contact arrangements could be taxing for both themselves and the child (in terms of frequency and distance travelled while establishing new routines and building relationships). Given the positive results reported, the committee recommended that concurrent planning should be considered as a strategy to improve time to permanency. However, that carers and birth parents should be well informed of the inherent difficulties of such a strategy and the possibility of late changes to the care plan meaning that adoption or reunification may not occur as anticipated.

For substance-involved families, the committee considered two interventions: a recovery coach intervention and the Family Drug and Alcohol Court (FDAC). Both of these

interventions sought to provide additional drug and alcohol abstinence support to substance involved families concurrently to court processes in order to address the underlying cause of the breakdown in family in line with the requirements of the court, and to promote reunification wherever possible. The recovery coach assisted parents by obtaining and supporting engagement in treatment services, likewise the FDAC provided intensive supervision of families through a multidisciplinary team independent of the court and provides tighter co-ordination of service inputs such as local community substance misuse and family support services. One randomised study showed that recovery coaching was associated with greater odds of reunification and durable permanency. One UK-based non-randomised study found FDAC was associated with improvements in reunification and durability of reunification. The committee therefore considered the importance of independent support for substance-involved families concurrent to child welfare court processes. Drawing on broader principles of care, the committee recommended that substance and alcohol abuse support for birth parents, with a view to support reunification, should be considered alongside court processes, and that this should be offered by staff trained in approaches to support drug and alcohol abstinence. Particularly, the committee felt that support should continue following reunification in order to support the durability of permanency, with clear plans for follow up. To support this recommendation the committee also cross-referred to existing NICE guidelines on managing substance misuse. The committee, similarly, recommended that mental health support also be ongoing alongside court processes, based on their own experience.

Cost effectiveness and resource use

The committee did not make any recommendations specifically based on the economic evidence presented on MTFC-P (Lynch 2014) and the Cognitive behavioural approach or Educational approach (Sharac 2011). Both studies had serious limitations and were considered only partially applicable with results unable to allow comparison with other health and social care interventions. The committee noted that MTFC had already been discussed and recommended for a different population (adolescents with a history of persistent offending behaviour) and that the evidence presented would not change the existing recommendation made.

The committee did not discuss any recommendations that would be particularly resource intensive, generally focusing on continuity of health care and education, parent/carer training, and the detailed chronology of care process for the individual. The committee noted that many of the recommendations considered were focusing on ensuring continuity of existing processes, or on processes that are already in place. The qualitative evidence and the committee discussion (particularly the lay-members) indicated that continuity and stability in relationships would be beneficial to LACYP. These recommendations may have small administrative or organisational costs to implement, but the committee felt that the benefits would outweigh these costs.

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Appendices

Appendix A – Review protocols

Review protocol interventions and approaches to support looked-after children and young people transitioning out of care to living with their adoptive or birth parents or special guardians, or into connected care

ID	Field	Content
1.	Review title	Interventions and approaches to support looked-after children and young people transitioning out of care to living with their adoptive or birth parents or special guardians, or into connected care
2.	Review question	5.1a: What is the effectiveness of interventions and approaches to support looked-after children and young people transitioning out of care to living with their adoptive or birth parents or special guardians, or into connected care? 5.1b: Are interventions to support looked-after children and young people transitioning out of care to living with their adoptive or birth parents or special guardians, or into connected care 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?
3.	Objective	Quantitative To determine the effectiveness, harms and cost-effectiveness of interventions and approaches to support looked-after children and young people transitioning out of care to living with their adoptive or birth parents or special guardians, or into connected care.

		<u>Qualitative</u> To determine if interventions to support looked-after children and young people transitioning out of care to living with their adoptive or birth parents or special guardians, or into connected care 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 looked-after children and young people in transitioning out of care to living with their adoptive or birth parents or special guardians, or into connected care
6.	Population	Looked after children and young people, aged <18, who are transitioning out of care to living with their adoptive or birth parents or special guardians, or into connected care. Including: • Children and young people who are looked after on a planned, temporary basis for short breaks or respite care purposes, only if the Children Act 1989 (section 20) applies and the child or young person is temporarily classed as looked after. • 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 looked-after children and young people transitioning out of care to living with their adoptive or birth parents or special guardians, or into connected care. Interventions and approaches of interest may include: • Information, education, advice, and signposting interventions for LACYP and their prospective long-term carers • Continuation of the personal education plan (PEP) beyond care • Counselling and conflict resolution programmes for LACYP and birth parents (including multisystemic therapy) • Family group conferences • Approaches to promote contact, or increasing contact, between LACYP and birth parents or long-term carers prior to transition (including support provided by contact supervisors) • Phased approach to entry into long-term care • Approaches to increase involvement of LACYP or prospective permanent carers in the planning and transition process (e.g. to guide stepping down of support services) • Approaches to stepping down support services (e.g. Phased return-home programmes and extended foster care support programmes) • Continuation of life story work into long-term care • Models of multi-agency care to facilitate transition out of care • Training programmes for adoptive, birth parents, special guardians or connected carers prior to and during transition process (e.g. parenting programmes)
8.	Comparator	Quantitative evidence

		Comparator could include standard care, waiting list, or another approach to support looked-after children and young people transitioning out of care to living with their adoptive or birth parents or special guardians, or into connected care. 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) Qualitative evidence • 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 looked-after children and young people transitioning out of care to living with their adoptive or birth parents or special guardians, or into connected care.
10.	Other exclusion criteria	• Studies including mixed populations (i.e. looked after and non-looked after children) without reporting results separately for LACYP • Studies relating to transition from Children's to adult health or social care services • Studies relating to transition out of care into independent living

		• Studies of interventions for specific clinical conditions covered in existing NICE guidelines • Mental health and emotional wellbeing interventions covered in existing NICE guidelines • Health promotion interventions covered in existing NICE guidelines • Strategies, policies, system structure and the delivery of care that is covered in statutory guidance about looked after children and young people <u>Quantitative evidence</u> • 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) <u>Qualitative evidence exclusion</u> • 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 looked-after children and young people transitioning out of care to living with their adoptive or birth parents or special guardians, or into connected care. On 31st March 2019 3% of looked after children (2,190) were placed for adoption. Two thirds (67%) of all looked after children had one placement in the year ending

		31 March 2012, 89% of all looked after children had up to two placements in the year ending 31, March 2012, and 11% - a small but substantial number of children - experienced three or more placements in the year ending 31 March 2012. Achieving permanence is associated with better outcomes for looked after children and young people. While placement breakdown is associated with worse outcomes (e.g. health, relationships, and education). Supporting the transition of looked after children out of care into permanent placements may help to reduce the rate of placement breakdown and support permanency.
12.	Primary outcomes (critical outcomes)	<u>Quantitative outcomes</u> Following transition: • Re-entering care system (placement breakdown) • Mental or emotional wellbeing • Quality of life • Health outcomes (e.g. sexual health, nutrition, dentition, health behaviours, or risk-taking behaviours) • Behavioural, educational, and social functioning following transition <u>Qualitative outcomes</u> Qualitative evidence related to interventions to support transition out of care to living with adoptive or birth parents or special guardians, or into connected care, 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 care transitions.

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. <u>Qualitative data</u> 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	June 2019
22.	Anticipated completion date	September 2021
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** Guideline Updates Team **5b Named contact e-mail** LACYPupdate@nice.org.uk **5c 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: https://www.nice.org.uk/guidance/indevelopment/gid-ng10121
29.	Other registration details	N/ A
30.	Reference/URL for published protocol	
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.
32.	Keywords	Looked after children, looked after young people, children in care, transition out of care, interventions, systematic review, mixed methods, adoption
33.	Details of existing review of same topic by same authors	N/ A
34.	Current review status	☐ Ongoing ☐ Completed but not published ☐ Completed and published ☐ Completed, published and being updated ☐ Discontinued

35..	Additional information	
36.	Details of final publication	www.nice.org.uk

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)

Medline Strategy, searched 10th June 2019 **Database: Ovid MEDLINE(R) 1946 to June 10, 2019** **Search Strategy:**
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)
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)

Medline Strategy, searched 10th June 2019 **Database: Ovid MEDLINE(R) 1946 to June 10, 2019** **Search Strategy:**
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)
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)

Medline Strategy, searched 10th June 2019 **Database: Ovid MEDLINE(R) 1946 to June 10, 2019** **Search Strategy:**
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)
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)

Medline Strategy, searched 10th June 2019 **Database: Ovid MEDLINE(R) 1946 to June 10, 2019** **Search Strategy:**	
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)
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:

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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)

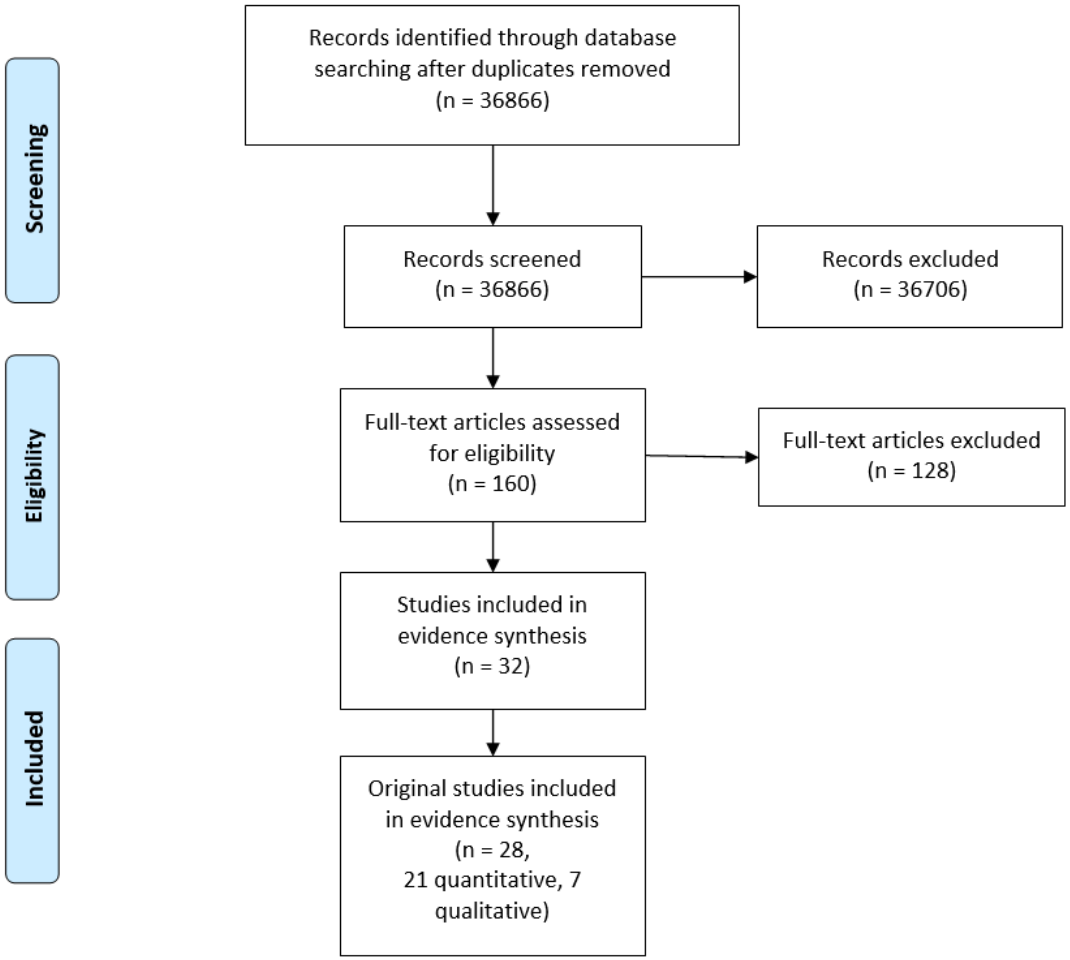
98 (euroqol or euro qol or eq5d or eq 5d).tw. (18036)

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

Effectiveness Evidence

RCTs

Akin 2018a/2018b

Study details

Study type	Post-randomized consent trial Potential participants are randomized, informed of their group assignment and then consent to the study.
Study location	USA
Study setting	Families of children in foster care with serious emotional disturbance
Study dates	September 2012–September 2014
Duration of follow-up	baseline (T1), post-test at 6 months (T2), and follow-up at 12 months from baseline (T3).
Lost to follow-up	Of the 1652 children randomized, 918 were allocated and included in the analysis. Of the intervention group, 101 did not consent, 8 consented to assessment only. 74 received partial intervention only. 22 did not receive an intervention.
Sources of funding	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, under grant number 90-CT-0152.
Inclusion criteria	Age 3-16 years old Foster care entering or re-entering foster care, with a case plan goal of reunification. emotional or behavioral problems identified within 6 months of this removal episode. For children 3-5 years old, a PECFAS score of 50+, or 20+ on a single subscale. For children aged 6-16 years old, a CAFAS score of 60+ or 30+ on a single subscale. Alternatively, children were eligible if they were identified by a Community Mental Health Center as having an SED, had an Individual Education Plan for an emotional or behavioral disorder, had a diagnosed mental disorder, and symptoms of that disorder were contributing to placement instability, a diagnosed mental disorder, a history of outpatient or inpatient mental health treatment, and was currently prescribed psychotropic medications, or had been admitted for inpatient psychiatric care within the last year Family level criteria the child's case plan goal must be reunification, parent must reside in the service area, parent may not be incarcerated for longer than three months; and parent cannot have a court-order of "no contact" with the child. Parents included biological parents, stepparents, adoptive parents, or other adults serving as primary caregiver.
Sample size	1652 were randomized, 918 were allocated treatment and included in the ITT analysis.
Outcome measures	Reunification The state's public child welfare agency provided state administrative data to local evaluators to determine children's reunification status. Reunification was defined as legal discharge from foster care to a parent. The dataset provided the date of entry into foster care; the date of discharge from foster care, if it had occurred; and the reason for discharge, including the three types of permanency and four types of non-permanent exit. Life tables were produced to describe monthly reunification rates for each group. By plotting these data, we showed reunification rates by group during the entire observation period. Next, Cox regression models estimated hazard ratios (HRs) and tested whether the difference in group's reunification rates was statistically significant.

Study arms

Parent Management Training Oregon model intervention (N = 461)
PMTO was delivered in-home to individual families, focusing on parents as the agents of change, and delivered for up six months. The program did not require a specific number of sessions or weeks; rather, practitioners worked with families until they completed the PMTO curriculum. Families who were retained for six months but did not complete the curriculum were discharged from the program at six months. Typically, practitioners met with families twice per week for approximately 60–90 minutes per session plus a mid-week check-in that lasted for 20–30 minutes. These weekly sessions followed a three-step process. First, practitioners met with parents without children present. Second, parents were expected to practice new skills, and practitioners followed-up with the parent by phone or in-person to discuss the weekly 'homework.' Third, practitioners conducted a family session with the parents and children together, during which the parents tried newly learned skills with the practitioner present and acting as a live coach. The PMTO curriculum centered on teaching parents five core parenting practices: 1) positive involvement; 2) skill building; 3) supervision and monitoring; 4) problem-solving; and 5) appropriate discipline. The project requested tailoring of PMTO with regards to trauma. To address pervasive trauma in both children and parents, the project leaders asked that the PMTO training incorporate trauma-specific content. PMTO was delivered by the state's private contractors for foster care services across the state. The frontline staff were master's level practitioners, most of whom were licensed social workers, about one quarter were licensed marriage and family therapists, and the other quarter were licensed counsellors. The PMTO training regimen required practitioners to participate in 8 days of pre-service training followed by 10 additional days of training over approximately 8 months. Practitioners also participated in two full days of in-person coaching. In addition to this initial coaching, they received observation-based coaching twice per month in one of three formats: written feedback, live feedback via video-conference, and/or live feedback via group.

Services as usual (N = 457)
These services comprised case management delivered by staff with bachelor or master's degrees in a variety of fields and with varying levels of training. The state's foster care contracts required case managers to visit children and to arrange for at least one parent-child visit per week.

Characteristics (arm-level)

	Parent Management Training Oregon model intervention (N = 461)	Services as usual (N = 457)
Mean age (SD) *(years)*	11.6 (4.1)	11.9 (4.3)
% Female *(%)*	44.3	58.8
% non-white ethnicity *(%)*	24.1	21.4
Diagnosed disability *(%)*	52.9	54.7
Removal reason *(%)*		
physical abuse	18.9	17.9
sexual abuse	5.9	6.6
neglect	36.9	37.2
parent substance abuse	22.1	20.6
child behaviour	52.3	49.5
Single parent *(%)*	63.5	56.9
Child had prior removals *(%)*	23.2	19.7
Time in care at start of study *(Mean (SD) days)*	54.4 (102)	45.6 (50.8)

	Parent Management Training Oregon model intervention (N = 461)	Services as usual (N = 457)
Child social emotional functioning (*Mean (SD)*	84.2 (41.2)	87.5 (40.7)

Risk of bias

Section	Question	Answer
Domain 1: Bias arising from the randomisation process	1. 1. Was the allocation sequence random?	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)	Some concerns *(Consent to the trial took place following randomization and this likely accentuated the attrition rate. (153 in the control group, 101 in the intervention group). Attrition likely had a disproportionate effect on the intervention arm as those people who did not consent in the control arm did not receive an intervention but were still contained in both the ITT and per protocol analyses. On the other hand, those who did not consent in the intervention arm did not receive the intervention and were included in the ITT but not in the per protocol analysis. This may lead to an imbalance of baseline characteristics (these are not presented) and reflect a risk of bias as the tendency to consent to an RCT may reflect differences to those people who do not consent.)*
Domain 2b: Risk of bias due to deviations from the intended	Risk of bias judgement for deviations from the intended	Some concerns *(the authors noted that there is a lack of information on two potential confounders: parental visitation/contact and other service use.)*

Section	Question	Answer
interventions (effect of adhering to intervention)	interventions (effect of adhering to intervention)	
Domain 3. Bias due to missing outcome data	Risk-of-bias judgement for missing outcome data	Low *(Despite issues with the process for allocation, baseline characteristics were comparable between groups. Additionally, use of the a post-randomization consent trial in which all eligible children were automatically enrolled and then contacted for consent, likely reduced the risk of selection bias (certain children being more likely to consent to an RCT).*
Domain 4. Bias in measurement of the outcome	Risk-of-bias judgement for measurement of the outcome	Low
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	High
	Overall Directness	Partially applicable *(Non-UK study)*

Berzin 2008

Study details

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
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	Physical permanency 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.

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: 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.

(2) preparation and planning: 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.

(3) the FGDM meeting: 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.

(4) follow-up planning and events: 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.

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.

Risk of bias

Section	Question	Answer
Domain 1: Bias arising from the randomisation process	Was the allocation sequence random?	High *(no information regarding randomization process, allocation concealment was not possible and baseline characteristics for each arm are not presented)*
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 2b: Risk of bias due to deviations from the intended interventions (effect of adhering to intervention)	Risk of bias judgement for deviations from the intended interventions (effect of adhering 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	Low
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	High
	Overall Directness	Partially applicable *(Non-UK study)*

Dakof 2010

Study details

Study type	Randomised controlled trial (RCT)
Study location	USA
Study setting	A family-oriented intervention aimed at facilitating treatment entry and retention among mothers of substance-exposed infants in Florida.
Study dates	Not reported
Duration of follow-up	18 months follow up
Sources of funding	National Institute on Drug Abuse
Inclusion criteria	Age Parents 18 years or older Referred for intervention services with potential for family reunification; after consultation with their attorney, to voluntarily enroll in drug court. Family level criteria to have at least one child adjudicated dependent; Substance-involved family have a diagnosis of substance abuse or dependence
Exclusion criteria	Severe physical or learning difficulties Care status of children Have had parental rights previously terminated Mental health problems Severe emotional disorders
Sample size	62
Split between study groups	Mothers were randomly assigned to either ICMS (n = 31) or EMP (n = 31)
Loss to follow-up	Attrition rates after randomization by assessment points were as follows: 3 months, 6%; 6 months, 6%; 9 months, 12%; 12 months, 8%; and 18 months, 8%. "Attrition rates did not differ by treatment condition."
% Female	100% (mothers)

Mean age (SD)	30.2 ± 11.4 years
Condition specific characteristics	History of drug abuse among biological mothers 100% History of being arrested among biological mothers Total lifetime arrests: mean 3.1 ± 9.3 History of family violence among biological mothers Physical abuse (55%); sexual abuse: 36% Ethnicity Black: 42%; Hispanic: 35%; White: 23% Education <high school graduation: 57%; Graduated high school/GED: 37%; Some college: 6% Employment status Employed: 29% Monthly family income 845 ± 939 dollars Mental health history Serious depression: 68%; Serious anxiety: 55%; Hallucinations: 13%; Suicidal ideations: 19% Marital status Married: 10%; Divorced/separated: 24%; Never married: 66%
Outcome measures	Permanency Child welfare status: Information on child welfare status at 18 months was extracted from court records. Child welfare status was defined as follows: (a) sole custody with one or more children, (b) joint custody with one or more children, (c) permanent guardianship with relative without termination of mother's parental rights, (d) permanent guardianship with relative with termination of mother's parental rights, or (e) child placed in foster care with termination of mother's parental rights.

Study arms

Family Drug Court (Intensive Case Management Services) (N = 31)

Although family drug courts are based on the adult court model, there are features of family drug court that distinguish it from adult drug court, namely, these courts do not operate in the criminal justice system, most participants are female, and the court addresses dual issues of parental addiction and recovery as well as child safety and permanency. Most drug dependency courts share certain basic features including a nonadversarial relationship among the parties, comprehensive assessment of service needs, frequent court hearings and drug testing, intensive judicial supervision, enrollment in substance abuse treatment and other necessary services, and court-administered rewards and sanctions. To graduate from drug dependency courts, participants must have successfully completed substance abuse treatment, have a specified period of continuous abstinence, show evidence of a safe and stable living situation, spend a substantial period adequately performing the parent role, and have a life plan initiated and in place (e.g., employment, education, vocational

training). Most family drug courts employ court counselors whose job is to refer clients to substance abuse treatment and other court-ordered services, develop a recovery service plan, and monitor and report clients' ongoing progress to the court. The DDC program was a 12 to 15-months program organized into four phases. Progression through the phases was related to the mother's level of substance abuse treatment and compliance with court orders. Mothers were drug tested (urine screens) at each court hearing and in their substance abuse treatment programs. During the first month of drug court, mothers were required to attend weekly drug court hearings. Thereafter, if reports to the court indicated that the mother was progressing well, court hearings were typically reduced to twice monthly. During the second phase of the program, which lasted 3 months, clients continued to attend twice-monthly hearings. In the third phase, which lasted another 3 months, the frequency of hearings was reduced to once per month. In the fourth and final phase, which extended to graduation from the drug court program, clients attended hearings every 6 to 12 weeks. This multiphased process included a collaborative team approach that involved court counselors, child welfare workers, treatment providers, parent educators, and other social and health care service providers, as needed. Drug court counselors had contact with their clients, either in-person or on the telephone, on a weekly basis through Phase 2, reducing to biweekly in Phase 3, and monthly in Phase 4. Workers were available more frequently on an as-needed basis. The caseload for drug court counselors was between 10 and 15 active cases. The only difference between the two groups (EMP and ICMS) was how the drug court counselors worked with the mothers. All other aspects of the programs were the same. ICMS was closely aligned with the drug court case management services recommended by the National Drug Court Institute, the ICMS model provided five key case management functions: assessment, planning, linkage, monitoring, and advocacy within the context of a strong case manager–client therapeutic alliance. The overall objective was to assess needs, engage in collaborative intervention planning, provide referral to suitable drug abuse treatment and other services, coordinate the system of care providing services to the mother, closely supervise and monitor compliance with court orders, advocate for the mother with service providers, and provide emotional support. Case managers in this system served as a liaison between the court, substance abuse treatment providers, child welfare, and the client. The case manager was responsible for referrals to treatment and other court-ordered services, developing a recovery service plan, monitoring and reporting clients' ongoing progress to the court, reducing any barriers to the delivery of treatment and other services, and providing emotional and practical support to the mother.

Duration of follow-up	3, 6, 12, and 18 months follow up
% Female	100% (mothers)
Mean age (SD)	31.2 ± 14.0 years
Condition specific characteristics	History of drug abuse among biological mothers 100% History of being arrested among biological mothers Total lifetime arrests: mean 3.9 ± 12.5 History of family violence among biological mothers Physical abuse (61%); sexual abuse: 32% Ethnicity Black: 39%; Hispanic: 35%; White: 26% Education

	<high school graduation: 61%; Graduated high school/GED: 26%; Some college: 13% Employment status Employed: 32% Monthly family income 1016 ± 1138 dollars Mental health history Serious depression: 68%; Serious anxiety: 55%; Hallucinations: 13%; Suicidal ideations: 13% Marital status Married: 13%; Divorced/separated: 26%; Never married: 61%

The Engaging Moms Program (N = 31)

A family-oriented intervention aimed at facilitating treatment entry and retention among mothers of substance-exposed infants. Mothers who participated in this study were adjudicated in a single drug court with one judge (not the founding family drug court judge) presiding and received the same types of substance abuse treatment, parenting interventions, and other services as ordered by the judge. The judge was blind to study hypotheses and aims. The only difference between the two conditions was the intervention administered by the drug court counselors: EMP versus ICMS. EMP is based on the theory and method of Multidimensional Family Therapy and was adapted for use in family drug court. EMP was designed to help mothers succeed in drug court by complying with all court orders such as attending and benefiting from substance abuse and other intervention programs (e.g., domestic violence counseling, parenting classes), attending court sessions, remaining drug-free, and demonstrating capacity to parent their children. EMP counselors conducted individual and conjoint sessions with the mother and her family, focusing on six core areas of change: (a) mother's motivation and commitment to succeed in drug court and to change her life, (b) the emotional attachment between the mother and her children, (c) relationships between the mother and her family of origin, (d) parenting skills, (e) mother's romantic relationships, and (f) emotional regulation, problem solving, and communication skills. EMP counselors achieve change in the six core areas by conducting a series of integrated individual and family In Stage 1, the counselor is focused on two goals: (a) building a strong therapeutic alliance with the mother and her family and (b) enhancing mother and family motivation to participate in drug court and to change. EMP counselors provide support to both the mother and her family. They empower and validate; highlight strengths and competence; build confidence in the program; and are very compassionate, loving, and nurturing. To enhance motivation, the EMP counselor highlights the pain, guilt, and shame that the mother and her family have experienced and the high stakes involved (e.g., losing child to the child welfare system) while simultaneously creating positive expectations and hope. Stage 2 is focused on behavioral change in both the mother and her family/spouse. EMP has several goals for this stage. First, counselors enhance the emotional attachment between the mother and her children by working individually with the mother to help her explore her maternal role. Mother and children sessions designed to enhance the mother's commitment to her children are also provided. Equally important is enhancement of the attachment between the mother and her family of origin and/or spouse. This is accomplished by helping the family restrain from negativity and offer instrumental and emotional support to the mother. Considerable attention is devoted to repairing the mother's relationship with her family, which frequently has been damaged by past hurts, betrayals, and resentments. Romantic relationships, typically with men, have often been a source of pain and distress for many of the mothers involved in the child welfare system. Hence, the EMP program addresses these relationships by helping the mother conduct a relationship life review, including examining tensions between having a romantic relationship and being a mother. The counselors help the mother examine

the choices she has made and continues to make in terms of romantic relationships and teaches her how to make better decisions for herself and her children. EMP counselors also help the mother deal with slips, mistakes, setbacks, and relapses in a nonpunitive and therapeutic manner (i.e., forward looking). Finally, in Stage 2, the EMP specialist facilitates the mother's relationship with court personnel (judge, child welfare workers, and attorneys) and treatment or other service providers. The EMP counselor conducts “shuttle diplomacy” between the mother and service providers to prevent and resolve problems and helps the mother take full advantage of the services being provided to her. With respect to the court, the drug court counselors facilitate therapeutic jurisprudence in the courtroom by preparing mothers for court appearances and advocating for the mother in front of the judge and at weekly drug court case reviews.

Duration of follow-up	3, 6, 12, and 18 months follow up
Mean age (SD)	29.1 ± 7.6 years
Condition specific characteristics	History of drug abuse among biological mothers 100% History of being arrested among biological mothers Total lifetime arrests: mean 2.3 ± 4.1 History of family violence among biological mothers Physical abuse 48%; sexual abuse: 39% Ethnicity Black: 45%; Hispanic: 36%; White: 19% Education <high school graduation: 52%; Graduated high school/GED: 48%; Some college: 0% Employment status Employed: 26% Monthly family income 674 ± 652 dollars Mental health history Serious depression: 68%; Serious anxiety: 55%; Hallucinations: 13%; Suicidal ideations: 19% Marital status Married: 6%; Divorced/separated: 23%; Never married: 71%

Risk of Bias

Section	Question	Answer
Domain 1: Bias arising from the randomisation process	Was the allocation sequence random?	Low

Section	Question	Answer
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	Low
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	Partially applicable *(Non-UK study)*

DeGarmo 2013

Study details

Study type	Randomised controlled trial (RCT)
Study location	USA

Study setting	Children returning to live with biological parent(s)
Duration of follow-up	Timeline corresponded roughly to a baseline assessment (shortly before the child left their foster care placement), an assessment shortly after the 16 week intervention (roughly 6 months after baseline) and an intervention 6 months after that (roughly 12 months after baseline).
Sources of funding	not reported
Inclusion criteria	Age eligible families must include a child age between 5 and 12 years old Returning to live with at least one biological parent reunifying for the first time after foster care placement and will be living within 25 miles of the research centre
Sample size	103 families and 103 children
% Female	Children: 49.5% female Parents: 54% were single parents, among these there were 2 single fathers and the rest were single mothers.
Mean age (SD)	Children: 8.28 years (range: 5.36 to 11.74) Mothers: 31.86 (range: 22.81 to 49.12) Fathers: 36.62 (range: 20.10 to 49.32)
Condition specific characteristics	History of drug abuse among biological mothers 92% History of being arrested among biological mothers 55%

	History of family violence among biological mothers 47% Child below expected grade-level performance 41%
Outcome measures	Foster care re-entry Collected from CWS records at 12 months

Study arms

Pathways Home Intervention (N = 50)
The structured and manualized curriculum included strategies to enhance parenting skills, encourage cooperation, teach new behaviors, set effective limits, keep track of children's behavior and whereabouts, and help children to succeed at school. Pathways Home was delivered in two main phases during individual sessions with a trained professional family consultant. Phase 1 began just prior to reunification and included 16 weeks of parent management training and healthy self-care strategies.

Curriculum sessions included the following:

• getting started

• daily schedules

• encouragement and cooperation

• tracking cooperation/requests and directions

• teaching new behaviours

• behaviour contracts

• limit setting

• balance between encouragement and discipline

• promoting school success

• promoting positive peer and sibling relationships

• anticipation and pre-teaching

• avoiding power struggles

• problem solving

• stress and coping

• social support

• parenting plans

Stress and coping focused on ongoing substance use issues for parents. Each weekly session included review, home practice assignments, and roleplays. After an eight-week break, Phase 2 continued for an additional eight weeks and included booster session fi ne-tuning of parent management skills, assessed level of risk for future harm to family members, and developed a family protection plan to address those risks. Regarding intent to treat, the mean and median percentage of coverage of the Phase 1 16-week intervention was 80% for the intervention families, meaning half of the families received less than 80% and half of the families received 80% or more of Phase 1.

Services as usual (N = 53)
Families in this group had access to services as usual.

Risk of bias

Section	Question	Answer
Domain 1: Bias arising from the randomisation process	Risk of bias judgement for the randomisation process	Some concerns *(Study was randomize and allocation was concealed from the investigators. However, there was limited reporting of baseline characteristics, so it is unclear whether these procedures were successful)*
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 2b: Risk of bias due to deviations from the intended interventions (effect of adhering to intervention)	Risk of bias judgement for deviations from the intended interventions (effect of adhering to intervention)	Some concerns *(It is noted that 50% of participants received less that 80% of the 16-week intervention. It is unclear whether this is reflective of real-life or a result of the experimental context. Additionally, there is no information regarding co-interventions accessed by either group.)*
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 *(Use of self-report poses a risk of bias due to demand characteristics.)*
Domain 5. Bias in selection of the reported result	Risk-of-bias judgement for selection of the reported result	Low

Section	Question	Answer
Overall bias and Directness	Risk of bias judgement	High
	Overall Directness	Partially applicable *(non-UK study)*

Feldman 2016

Study details

Study type	Randomised controlled trial (RCT)
Study location	USA
Study setting	Children in the legal custody of New York State foster care system and either 1) in the physical care of a facility licensed or operated by the New York State Office of Mental Health 2) resided in facilities licensed or operated by the New York State Office for People with Developmental Disabilities. 3) in the physical care of a facility licensed or operated by the Division of Juvenile Justice and Opportunities for Youth. or 4) resided in congregate care settings such as group homes or group residences or in long-term institutional settings and had a permanency goal other than adoption.
Study dates	recruited between November 2009 and October 2011
Duration of follow-up	All participants were followed through to April 15, 2013 or until they exited the foster care system.

Sources of funding	The Parent for Every Child (PFEC) project was one of several Diligent Recruitment projects supported by the U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau, through the Adoptions Opportunities program. PFEC's five year funding cycle began in 2008 and ended in 2013.
Inclusion criteria	Age Under 19.5 years old Congregate care See 'study setting' for more detail on the four types of congregate care settings included in the study
Sample size	177
Outcome measures	Permanency Used an expanded definition of permanency (to include both legal and relational permanence, with the former culminating as either a finalized legal guardianship or adoption and the latter as a written contract between the youth and a caring adult, known as a permanency pact or a commitment contract). Multiple logistic regressions were conducted to test the relationship between key characteristics of study participants (age, years freed for adoption, system with physical custody, intervention/control group assignment, study cohort) and permanency. Two separate models were run: one with the dependent variable “any permanency” (relational or legal permanency) and one with the dependent variable “legal permanency” (adoption or legal guardianship).

Study arms

Parent for Every Child (PFEC) intervention (N = 88) Intends to identify effective recruitment strategies for matching caring adults with youth in need of permanence and improve permanency outcomes for youth in the target population, inclusive of both legal and relational permanence. Relational permanence was operationalized through the establishment of what is referred to as either a “commitment contract” or “permanency pact.” The program also emphasized individualized casework, with a focus on helping youth and families develop sustainable relationships. With respect to diligent recruitment, PFEC caseworkers used a variety of strategies, the choice of which was based on an individualized assessment of the youth and included family search and engagement (this was given priority), posting personalized videos, photos and information of each child to the adoption site, targeted

recruitment of individuals with experience with special needs youth, adoption panels and exchanges (where caseworkers can share information and resources) and general recruitment efforts (such as agency-based events). Youth were assigned a “Permanency Specialist”, who has received approximately 20 h of additional training, largely related to foster parent recruitment techniques, casework skills related to challenging youth, and use of the PFEC-specific database.

Services as usual (N = 89)
All youth (control and intervention) had a caseworker prior to the study and contact with the person continued during the study.

Characteristics (arm-level)

	Parent for Every Child (PFEC) intervention (N = 88)	**Services as usual (N = 89)**
% Female *(%)*	25	39
% non-white ethnicity *(%)*	74	78
Age *(%)*		
Less than 13 years	5	7
13-18 years	61	59
Over 18 years	34	34
Care system at enrolment *(%)*		
Child welfare	42	47

	Parent for Every Child (PFEC) intervention (N = 88)	Services as usual (N = 89)
Mental health	37	34
Developmental disabilities	18	16
Juvenile justice	3	3
Years in care *(%)*		
0-6 years	27	27
7-14 years	56	51
15-17 years	10	15
over 17 years	7	7
Years freed for adoption *(%)*		
0-5 years	47	46
6-14 years	51	52
15-17 years	2	2

Risk of bias

Section	Question	Answer
Domain 1: Bias arising from the randomisation process	Risk of bias judgement for the randomisation process	Some concerns *(Unclear whether attempts were made to conceal allocation)*
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 2b: Risk of bias due to deviations from the intended interventions (effect of adhering to intervention)	Risk of bias judgement for deviations from the intended interventions (effect of adhering to intervention)	Some concerns *(The study allowed for a tailored approach in which the caseworker decided on the recruitment activities for each child. This is likely reflective of real world practice how it allows for researcher bias when choosing the activities. Only a small proportion of children participated in each activity (for both study groups) and there was a similar degree of participation between study groups for several activities. This brings into question how rigorously the intervention was applied and also suggests issues of heterogeneity in how the intervention was carried out.)*
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	Low
Domain 5. Bias in selection of the reported result	Risk-of-bias judgement for selection of the reported result	Low

Section	Question	Answer
Overall bias and Directness	Risk of bias judgement	Some concerns
	Overall Directness	Indirectly applicable *(Non-UK study. Also included children from a range of disparate settings (such as those specializing in mental health, developmental disabilities, juvenile justice, or child welfare))*

Fisher 2005

Study details

Study type	Randomised controlled trial (RCT)
Study location	USA
Study setting	Children in foster care (and expected to remain there for at least 3 months)
Study dates	Not reported
Duration of follow-up	2 years (children were assessed at 3-6 month intervals over this study period)
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 Foster care; expected to remain in care for more than 3 months
Sample size	90
Loss to follow-up	None reported
% Female	Not reported for total sample
Mean age (SD)	Not reported for total sample
Outcome measures	Permanency Entering permanent placement: Permanent placements were defined as the final non-foster care placement for the child. Recommendations about permanent placements are made by the child's caseworker and are ultimately determined by the court. There were three types of permanent placements: reunification with biological parent, relative adoption, and non-relative adoption. Return to care from permanency Failure of permanent placements: A placement was considered to have failed if the child returned to foster care.

Study arms

Early Intervention Foster Care (N = 47) The EIFC intervention is delivered via a team approach to the child, foster care provider, and permanent placement resource (birth parents and adoptive relatives or nonrelatives). Before receiving a foster child, the foster parents complete intensive training. After placement, the foster parents work with a foster parent consultant and are given extensive support and supervision through daily telephone contacts, weekly foster parent support group meetings, and 24-hour on-call crisis intervention. The children receive services from a behavioral specialist working in preschool or day care and home-based settings. In addition, the children attend weekly therapeutic playgroup sessions where behavioral, social,

and developmental progress is monitored and addressed. The program staff is largely composed of clinicians with bachelor's and master's degrees and a licensed psychologist as the clinical supervisor. Group supervision occurs weekly, with consultation provided as needed. A consulting psychiatrist provides necessary medication management to address symptoms of ADHD, anxiety, and other disorders. Whenever a child is being entered in a permanent placement, a family therapist works to train the parents (birth parents, adoptive relative, or adoptive nonrelative) in the same parenting skills used by the foster parents in the program to facilitate consistency between the home environments and to facilitate a successful transition. Children typically receive services for 6 to 9 months, including the period of transition to a permanent placement. Foster families and permanent placement resources receive the same services. In general, compliance with treatment is high for foster parents and permanent placement resources. It is not uncommon for birth parents to be mandated to substance abuse treatment. In the case of inpatient treatment, the EIFC family therapy does not begin until after the parent completes such treatment. In the case of outpatient treatment, family therapy runs concurrently with the substance abuse treatment.

Usual Foster Care (N = 43)
a services-as-usual condition in which children were placed in state foster homes and were provided services in accordance with standard policies and procedures. These services often involve individual mental health therapy and medical and/or dental treatment. Some of the children in RFC also received developmental screening and referral for services if found to be delayed. Birth families and relative or non-relative adoptive families also typically receive social service support, substance abuse and/or mental health treatment, and parent training (although not through the study centre).

Study characteristics

	Early intervention foster care (N = 47)	**Services as usual (N = 43)**
Female *(%)*	34	40
Age *(Mean/SD years)*	4.50 (0.86)	4.22 (0.74)
Non-White *(%)*	21	8

	Early intervention foster care (N = 47)	Services as usual (N = 43)
History of maltreatment *(%)*		
Sexual abuse	17	8
Physical abuse	24	4
Neglect	55	84
Emotional abuse	4	4

Risk of bias

Section	Question	Answer
Domain 1: Bias arising from the randomisation process	Was the allocation sequence random?	High *(considerable differences between groups in the types of maltreatment leading to the child being placed in foster care)*
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

Section	Question	Answer
Domain 2b: Risk of bias due to deviations from the intended interventions (effect of adhering to intervention)	Risk of bias judgement for deviations from the intended interventions (effect of adhering 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	Low
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
	Overall Directness	Partially applicable *(Non-UK study)*

Landsman 2014 / Boel-Studt 2017

Study details

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	Data collection ended in September 2012, therefore length of follow-up depended on time of enrolment
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 referred to the state's centralized foster care placement matching program managed by Four Oaks
Sample size	243
Loss to follow-up	Intervention = 10 Control = 5
Outcome measures	***Notes on how data were obtained*** *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 Placement changes. authors calculated the number of placement disruptions from the date of random assignment through case closure or the end of the study.

	Permanency 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. Maltreatment child maltreatment data provided by DHS to identify whether each child had a confirmed maltreatment report following the date of random assignment. Relational Permanency Relational permanency was measured 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 = 125)
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.

Standard Child Welfare Services (N = 118)
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.

Characteristics (arm-level)

	Family finding intervention (N = 125)	**Services as usual (N = 118)**
Female *(%)* child-level baseline characteristic	53.6	39.8
Mean age (SD) *(years)*	9.41 (5.24)	10.24 (5.71)
History of maltreatment *(%)*		
Physical abuse	16.7	16.5
Psychological abuse	1.8	0
Sexual abuse	6.1	7.8
Neglect	67.5	72.8

	Family finding intervention (N = 125)	Services as usual (N = 118)
Non-white *(%)*	30.4	32.5
Prior placement changes (Mean/SD)	2.40 (3.13)	2.40 (2.83)

Risk of bias

Section	Question	Answer
Domain 1: Bias arising from the randomisation process	Was the allocation sequence random?	Some concerns (*perfect randomization was not possible to achieve due to the sibling group exception)*
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 2b: Risk of bias due to deviations from the intended interventions (effect of adhering to intervention)	Risk of bias judgement for deviations from the intended interventions (effect of adhering 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 *(The experimental group had a database*

Section	Question	Answer
		specifically designed to capture process and outcome measures, whereas data for the control group were extracted manually from case records)
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
	Overall Directness	Partially applicable *(Non-UK study)*

Pasalich 2016 / Spieker 2014

Study details

Study type	Randomised controlled trial (RCT)
Study location	USA
Study setting	Children in a court-ordered placement that resulted in a change in primary caregiver (mixed population including those with foster parents, biological parents, or adult kin).
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 enrolment. Eligible caregivers spoke English and included foster parents (n = 89), biological parents (n = 56), or adult kin (n = 65).
Sample size	210
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	Placement stability 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 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

Study arms

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.
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.

Characteristics (arm-level)

	Promoting First Relationships (N = 105)	**Early education support (N = 105)**
Female *(%)*	40	47.6
Mean age (SD) *(months)*	17.96 (4.97) months	18.06 (4.49) months
Mean number of placement changes (SD)	2.67 (1.66)	2.70 (1.51)
Non-white (%)	51.4%	38.1%

Risk of bias

Section	**Question**	**Answer**
Domain 1: Bias arising from the randomisation process	Was the allocation sequence random?	Some concerns *(unclear if allocation was concealed. Participants in the PFR intervention group were more likely to have been removed from birthparents' home more than once compared to early support group.)*

Section	Question	Answer
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 2b: Risk of bias due to deviations from the intended interventions (effect of adhering to intervention)	Risk of bias judgement for deviations from the intended interventions (effect of adhering to intervention)	Low
Domain 3. Bias due to missing outcome data	Risk-of-bias judgement for missing outcome data	Some concerns *(attrition rates were high and a significant proportion of attrition was as a result of change in caregiver, which may be directly related to outcomes and not be reflective of real-world practice. However, attrition rates were comparable between groups.)*
Domain 4. Bias in measurement of the outcome	Risk-of-bias judgement for measurement of the outcome	Some concerns *(use of self-report poses risk of bias as participants were aware of assigned condition and likely the purpose of the experiment.*
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

Section	Question	Answer
	Overall Directness	Partially applicable *(Non-UK study)*

Price 2008

Study details

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 or with kinship parent
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:

(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

(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.

Services as usual (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.

Characteristics (arm-level)

	KEEP foster parenting training (N = 359)	**Services as usual (N = 341)**
Female *(%)*	50	54
Mean age *(years)*	8.88	8.72
Non-white (%)	80%	75%

Risk of bias

Section	Question	Answer
Domain 1: Bias arising from the randomisation process	Was the allocation sequence random?	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)	Risk of bias for deviations from the intended interventions (effect of assignment to intervention)	Some concerns *(Unclear if significant deviations between intervention groups.)*
Domain 2b: Risk of bias due to deviations from the intended interventions (effect of adhering to intervention)	Risk of bias judgement for deviations from the intended interventions (effect of adhering to intervention)	Low
Domain 3. Bias due to missing outcome data	Risk-of-bias judgement for 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.)*

Section	Question	Answer
Domain 4. Bias in measurement of the outcome	Risk-of-bias judgement for 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	Risk-of-bias judgement for 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	Risk of bias judgement	High
	Overall Directness	Partially applicable *(Non-UK study)*

Rushton 2010

Study details

Study type	Randomised controlled trial (RCT)

Study location	UK - Local authorities in England with high rates of adoption were contacted and asked to identify eligible adoptive families.
Study setting	Recently (in last 3-18 months) adopted children.
Duration of follow-up	First interview was held prior to randomization, the second was held within two weeks of completing the intervention (or around 12 weeks for control group) and the final was held 9 months after the first interview.
Sources of funding	This study was funded by the UK Department of Health (subsequently the Department for Children, Schools and Families) and the Nuffield Foundation and we appreciate their support.
Inclusion criteria	Age Between 3 and 8 years of age Recently adopted Child must have been placed for non-relative adoption within the last 3-18 months
Exclusion criteria	Severe physical or learning difficulties Placed with relative or existing foster parents
Sample size	37
Outcome measures	Strengths and difficulties Using 25-item strengths and difficulties questionnaire to measure the child's psycho-social problems (with 5 items covering each of emotions, behaviour, restlessness and concentration, peer relationships and pro-social behaviour (helping and caring). The first four of which are combined in this study for total difficulties). Expression of feelings 50 item questionnaire (using a 5-point scale) completed by adopters to capture nature and progress of relationship with the new carers, focusing on the child's ability to show feelings and seek comfort and affection appropriately. It covers distorted ways of expressing emotions as in the “bottling up” of feelings or over-expressiveness or exhibiting affection lacking “genuineness” Post-placement problems 9-item (rated on a 0-4 scale) questionnaire completed by adopters to identify common problems of maltreated children when placed in a new home (such as rejecting parents) in areas not covered by the EFQ or SDQ.

	Daily hassles A 20-item questionnaire complete by the parents to assess frequency and impact (on parents) of common parenting difficulties such as mealtime difficulties and sibling arguments. There is no cut-off point, but scores above 50 on the frequency scale or above 70 on the impact scale indicate significant problems.

Study arms

Cognitive behavioral intervention (N = 10) Both interventions were designed to help adopter(s) better control difficult behaviour and to provide the child with a consistent, responsive, parenting environment. This intervention focuses on increasing acceptable behaviours through the use of praise and reward (and what to do if the child rejects praise/reward), ignoring unacceptable behaviour, limit setting and using logical consequences and problem solving. In addition, there is focus on ensuring daily play sessions with the child,
Educational intervention (N = 9) Both interventions were designed to help adopter(s) better control difficult behaviour and to provide the child with a consistent, responsive, parenting environment. This intervention focuses on helping the adopter(s) understanding the meaning of the child's current behaviour and better manage it by anticipating events (such as by identifying triggers for angers or distress). The educational programme includes sessions on understanding insecurity, the role of the parent's reactions to the behaviour in facilitating future behaviour, understanding how past events (such as bad experiences and relationships) can influence behaviour, learning and development, understanding 'survival strategies and defensive reactions', emotional expression and how children develop new relationships.
Services as usual (N = 18) The author noted that "Some of the “service as usual” group received support, but it was far less intensive than the individualized parenting advice provided in the trial."

Characteristics (arm-level)

	Cognitive and Educational intervention groups combined (N = 19)	Services as usual (N = 18)
Female *(%)*	53	55
% non-white ethnicity *(%)*	16	12
Mean age at first admission to care (SD) *(months)*	37 (14)	27 (17)
Mean (SD) number of placement changes *(number)*	6 (2.9)	6 (3.7)
Reason(s) for first admission to care *(%)*		
neglect	89	89
sexual abuse	21	22
physical abuse	58	44
emotional abuse	57	33
Carer's mental illness	47	39
carer's addiction	42	72
concern about siblings	56	43

	Cognitive and Educational intervention groups combined (N = 19)	Services as usual (N = 18)
schedule I offender in household	16	22
domestic violence	63	55
Perinatal problems *(%)*	22	11
Mother's addiction during pregancy *(%)*	6	33
Broken attachments *(%)*	84	44
Prematurity *(%)*	16	22
Parental conflict *(%)*	47	55
Severe economic deprivation *(%)*	52	61
Adopting parent has experience with a child's major health problem *(%)*	16	33
Adopted parent's mean (SD) number of adversities on file *(number)*	8.21 (3)	7.22 (2.4)

Risk of bias

Section	Question	Answer
Domain 1: Bias arising from the randomisation process	Risk of bias judgement for the randomisation process	High *(Unclear whether allocation was concealed from investigators. Groups were reasonably well balanced although some slight differences in baseline characteristics are also noted (for example, children in the control group were much more likely to have first been admittted to care due to their carer's problem with addiction [72% vs. 42%] and were less likely to report broken attachments [44% vs. 84%], when compared to the intervention group) and the baseline characteristics for each intervention group is not presented.)*
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 2b: Risk of bias due to deviations from the intended interventions (effect of adhering to intervention)	Risk of bias judgement for deviations from the intended interventions (effect of adhering to intervention)	Low
Domain 3. Bias due to missing outcome data	Risk-of-bias judgement for missing outcome data	High *(outcome data is pooled for the two intervention groups, individual arm level data is not presented).*
Domain 4. Bias in measurement of the outcome	Risk-of-bias judgement for measurement of the outcome	High *(Outcomes relied on the adopter's self-report. The parents in this study rated their children as having severe difficulties and among these parents, only around have agreed to participate in the study. It is very likely that the unblinded nature of the intervention (and the potential for demand*

Section	Question	Answer
		characteristics) influenced the parents' responses to the outcome measures). It is unclear whether mean differences at T3 were calculated using same method as T2. There are discrepancies in the findings tables and as the means for each group are not provided, it is not possible to reconcile this.
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	High
	Overall Directness	Directly applicable

Ryan 2006

Study details

Study type	Randomised controlled trial (RCT)
Study location	USA
Study setting	Parents in substance-involved families that were referred to the Juvenile Court Assessment Program at the time of the temporary custody hearing (or in subsequent 90 days).
Study dates	April 2000- March 31, 2003

Duration of follow-up	1-year
Sources of funding	not reported
Inclusion criteria	Foster care families eligible for the study must be foster care cases opened on or after April 28, 2000, in Chicago and suburban Cook County, Illinois. Parents in substance-involved families that were referred to the Juvenile Court Assessment Program at the time of the temporary custody hearing (or in subsequent 90 days).
Sample size	738 families and 1,417 children
Outcome measures	Reunification Use of substance abuse services Looked at the number of caregivers who signed up for substance abuse services, only including those caregivers who had completed substance abuse screening by March 31, 2003.

Study arms

Intensive case management model (N = 986)
Number of families in experimental group: 521 Uses recovery coaches to increase access to substance abuse services, improve substance abuse treatment outcomes, shorten length of time in substitute care placement, and affect child welfare outcomes, including increasing rates of family reunification. Recovery coaches engage in a variety of activities, including comprehensive clinical assessments, advocacy (assisting parents in obtaining benefits and ensures associated responsibilities are met), service planning, outreach, and case management. The clinical assessments focus on a variety of problem areas, such as housing, domestic violence, parenting, mental health, and family support needs. Recovery coaches visit the family home (including home visits with child welfare case workers) and the AODA treatment provider agencies. Coaches have access to "outreach or tracker" staff who specialize in identifying and managing hard-to-reach or -locate parents. Coaches participate in IDCFS and Division of Alcoholism and Substance Abuse training that covers a variety of topics, including addiction, relapse prevention, DSM-IV, American Society of Addiction Medicine, fundamentals of assessment, ethics, service hours, client tracking systems, service planning, case management, and counselling.

Services as usual (N = 431)
Number of families in experimental group: 217. Families in the control group received referrals substance abuse services that were available before the introduction of the intervention (intensive case management model). Child welfare caseworkers monitored compliance and encouraged participation in treatment programmes.

Characteristics (arm-level)

	Intensive case management model (N = 986)	**Services as usual (N = 431)**
Female *(%)* child-level baseline characteristic	48	48
Non-white *(%)*	89	88
Age of youngest care giver in family *(years)* family-level baseline characteristic	32.4	32
unemployed parent *(%)*	70	65
Prior-substance exposed infant *(%)*	63	64

Section	**Question**	**Answer**
Domain 1: Bias arising from the randomisation process	Risk of bias judgement for the randomisation process	Some concerns *(randomization was done at the agency level and it is unclear whether allocation sequence was concealed. However, baseline characteristics were comparable between groups.)*

Section	Question	Answer
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 2b: Risk of bias due to deviations from the intended interventions (effect of adhering to intervention)	Risk of bias judgement for deviations from the intended interventions (effect of adhering to intervention)	Some concerns *(There is limited data on the exact services provided by the recovery coach, and information regarding other services accessed by families. However, it is likely that this is reflective of what would happen in the real-world)*
Domain 3. Bias due to missing outcome data	Risk-of-bias judgement for missing outcome data	Some concerns *(Only applicable to accessed services outcome. Data for this outcome were only available for families who signed the informed consent letter. <50% of families gave consent and more participants in the intervention group gave consent (48%) than the control group (37%).)*
Domain 4. Bias in measurement of the outcome	Risk-of-bias judgement for measurement of the outcome	High *(Accessed substance abuse services outcome was limited to whether or not the parent(s) used services but it does not provide data on the level of involvement, services accessed or persistence.)*
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

Section	Question	Answer
	Overall Directness	Partially applicable *(non-UK study)*

Ryan 2016

Study details

Study type	Randomised controlled trial (RCT)
Study location	USA
Study setting	Parents in substance-involved families (one parent(s) meeting criteria for substance abuse disorder) that were referred to the Juvenile Court Assessment Program at the time of the temporary custody hearing (or in subsequent 90 days).
Study dates	Enrolment cut-off was December 31, 2011, with the study lasting until December 31, 2015.
Duration of follow-up	3 year follow-up to achieve reunification and a subsequent twelve-month window to observe re-entry.
Sources of funding	supported by a grant from the Redlich Horwitz Foundation.
Inclusion criteria	Foster care Following Juvenile Court Assessment Program assessment, temporary custody of the child must have been granted to IDCFS. Substance-involved family

	Parent(s) must meet criteria for substance abuse disorder and meet criteria for referral to treatment provider. Must have been assessed at JCAP within 90 days of temporary custody hearing. Female parent "For the current study, we selected only the mothers associated with each family case."
Sample size	1623
Outcome measures	reunification Reunification stability rated as 0 (child not returned to biological family home within 3 years, 1 (reunified within 3 years but subsequently returned to a substitute care placement setting (foster care or other group setting) within 12 months), or 2 (reunified and able to sustain the reunification for the 12 months observation period.

Study arms

Services as usual (N = 511) traditional child welfare and substance abuse services were available to parents in this group.
Recovery coach (N = 1112) traditional child welfare and substance abuse services plus a recovery coach. The recovery coach assisted parents with obtaining needed treatment services, provided outreach efforts to support treatment engagement and negotiate departmental and judicial requirements associated with drug recovery, and helped with concurrent permanency planning.

Characteristics (arm-level)

	Services as usual (N = 511)	**Recovery coach (N = 1112)**
Mother characteristics		

	Services as usual (N = 511)	Recovery coach (N = 1112)
Non-white ethnicity *(%)*	78	80
unemployed *(%)*	88	86
high school education/GED *(%)*	45	41
Homeless *(%)*	14	14
Neglect as additional placement issue *(%)*	80	82
Married *(%)*	10	11
Prior substance-exposed infant *(%)*	66	67
Primary alcohol *(%)*	16	19
Primary marijuana *(%)*	22	18
Primary cocaine *(%)*	35	39
Primary opioids *(%)*	30	26
2+ children *(%)*	36	40

Risk of bias

Section	Question	Answer
Domain 1: Bias arising from the randomisation process	Risk of bias judgement for the randomisation process	Some concerns *(Limited information on the randomization process and whether allocation was concealed.)*
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 2b: Risk of bias due to deviations from the intended interventions (effect of adhering to intervention)	Risk of bias judgement for deviations from the intended interventions (effect of adhering to intervention)	Some concerns *(Study did not capture use of co-interventions. Additionally, it did not capture differences in how the intervention was applied, although such differences would likely occur in real-world practice.)*
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	Low
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	Partially applicable

Section	Question	Answer
		(non-UK study)

Swenson 2000

Study details

Study type	Randomised controlled trial (RCT)
Study location	USA
Study setting	all families of children taken into custody by the Charleston County Department of Social Services (DSS)
Study dates	Recruited between November 18, 1996 and July 31,1997
Duration of follow-up	Follow-up took place at baseline, at the end of the intervention (90 days) and 3 months following the end of the intervention.
Sources of funding	Funding for study not reported
Inclusion criteria	Foster care children taken into custody by the Charleston County Department of Social Services and placed in foster care due to abuse or neglect (i.e., the placement was not voluntary)
Exclusion criteria	Already receiving treatment through a research project

Sample size	72 children in 45 families
Mean age (SD)	Child: 8 years (range = 1 day to 16 years) Caregiver: 35 years (range = 16 to 39 years)
% female	53%
% non-white ethnicity	68%
Living situation at time of referral	33% single care-giver households 45% two-adult households 22% households with three or more adults Average number of children in placement households: 3 (range: 1 to 6) Annual income <$10,000: 58%
Lost to -follow-up	Three of the 45 families and three of the 72 children were lost by the final follow-up
Outcome measures	Reunification With parent, relative or family friend. Incidences of abuse To assess abuse reincidence, DSS caseworkers were interviewed at T2 and T3. Data were gathered on new reports of abuse and characteristics of the new case.

Study arms

Charleston Collaborative Project (N = 48)

Structure
All personnel held master's degrees, except one service coordinator who had a bachelor's degree and one supervisor who held a doctoral degree.

Initially, the team assured that the child was placed in a foster home or with a relative, if possible. Within 72 hr, the CCP team transported (if needed) the child and both maltreating and nonmaltreating caregivers to the host agency to participate in comprehensive and separate child and family trauma assessments. Following the assessments, the child was evaluated at the site by a physician specializing in child maltreatment examinations. After completion of the comprehensive assessments, the CCP team conducted a family meeting with the maltreating caregiver and other pertinent family members to discuss the results of the assessments, complete the risk assessment and develop a total service plan incorporating the noted risks.

When the overall goal of the family was reunification, the purpose of the family meeting was to engage the family in a collaboration with the team to work toward reducing risks and expediting the timely return of the child to the family.
When the goal of the family was not reunification, the team worked with family members to rapidly identify other relatives or friends who might serve as a kinship placement for the child. When no appropriate family resource could be identified, all kinship options were exhausted, and reunification was not an option, the team contacted adoption services to proceed with permanency planning.

Following the family meeting, an interagency staffing was conducted for each child to develop a specified plan for meeting the treatment goals and overcoming any barriers to the child's safety in the home and return to the family. Thus, the focus
of the staffing was on identification of resources that supported the treatment goals. After the interagency staffing, the CCP intensive family-based interventions began and continued for 90 days. The intervention model was developed by the host agency and is specified in a manual (Ralston & Swenson, 1998). The interventions were conducted in the family home or community and in the foster home for 90 days.

Single point of entry
The CCP service team provided the family with a DSS assessment, coordination of care, and direct treatment under one rubric (in the control condition, the DSS worker had to refer the family to other agencies to access services, except for those provided directly by DSS, which could result in long waits and difficulties in communications).
Trauma and risk assessment

Conducted to elicit information pertinent to the investigation and determine child and family clinical needs. A service plan was developed in collaboration with the caregivers. (trauma and mental health assessments in the control group were less comprehensive, recommended services might or might not have been linked specifically with observed risk factors, and recommended services were limited to a predetermined array available in the community. Moreover, the DSS professional developing the intervention plan did not provide the treatment, and families were again referred to multiple agencies may have had to contend with multiple and uncoordinated treatment plans).

Medical examinations
Comprehensive medical examinations were conducted on all children by a physician specializing in maltreatment assessments, to better document maltreatment and allow for early treatment. (in the control group, children received a less intensive general medical examination – similar to a well-child check-up – and comprehensive medical exams were provided only if sexual abuse had occurred or if the child had marks suggesting physical abuse).

Abuse and protection clarification procedure
The purpose of this procedure is to open communication about the abuse and for the parent to acknowledge responsibility for the maltreatment and removal of the child from the home, and to absolve the children of responsibility for a caregiver's inappropriate behaviour and help children understand that abusive behaviour is not the norm. (Clarification is not a feature of control group).

Service coordination and treatment
Treatment sessions included parents, children, caregivers, and foster parents and focused on caregiver risk reduction and child psychosocial functioning. The service coordinator and therapist worked together with the family to meet concrete needs such as housing and to assure that the family had rapid access to services not provided by the CCP (e.g., inpatient substance abuse treatment). (the control group did not always receive service coordination or treatment. Some families were referred for treatment but did not engage with the provider or faced barriers to attending (e.g., lack of transportation)).

Services as usual (N = 24)
See intervention group for more detail on how services compared.

The control group followed state guidelines. A DSS assessment worker began the investigation and placed the child in a foster home or other placement, and a DSS caseworker was assigned to the family.

Within 24 hr, a mental health assessment was completed on children 4 years and older. This assessment focused on the child's current functioning, including presenting problems; medical, mental health, and family history; and a mental status examination.

Within 48 hr of placement, an internal DSS placement staffing was held to discuss the specifics of the case, the circumstances leading to out-of-home care, and whether the current placement was appropriate.

Within 72 hr of placement, physically abused children with marks from the abuse and sexually abused children were scheduled for a ftill medical evaluation, and all other children were scheduled for a general medical screening (i.e., well-child checkup). In addition, an interagency staffing was held to develop a treatment plan for the child, discuss initial service delivery, decide what services were needed, and assign a service team.

Referrals for treatment of the child then were made to providers in the community.

Risk of bias

Section	Question	Answer
Domain 1: Bias arising from the randomisation process	Risk of bias judgement for the randomisation process	Some concerns *(Randomization was done by the researcher who assessed inclusion criteria, using a table of random numbers. Allocation was therefore not concealed. Baseline characteristics for each group are not reported and the author highlights that participants in the intervention group performed significantly worse on the Denver II score than the control group at baseline.)*
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

Section	Question	Answer
Domain 2b: Risk of bias due to deviations from the intended interventions (effect of adhering to intervention)	Risk of bias judgement for deviations from the intended interventions (effect of adhering to intervention)	Some concerns (“*data indicate that the implementation of the planned procedures was modest to low. In fact, the majority of services billed for pertained to coordination and management of the case. Although case management certainly helps children and families meet concrete needs and gain access to placements and other services, case management might be insufficient for improving behavioral and emotional functioning (Bums, Farmer, Angold, Costello, & Behar, 1996). Further, compromised implementation might have been due to providing less intense and frequent treatment than originally planned. In the CCP, families received an average of 1.7 treatment sessions per week, much less than planned.”)*
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 *(Assessments for maltreatment were more rigorous, as part of the study design, in the intervention group.)*
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	High
	Overall Directness	Partially applicable

Section	Question	Answer
		(non-UK study)

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 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	**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)

Trout 2013

Study details

Study type	Randomised controlled trial (RCT)
Study location	USA
Study setting	Youth returning to home, school and community settings are living in a residential programme. The majority (69%) of discharging youth return to their home setting following departure).
Study dates	Not reported
Duration of follow-up	1 year
Inclusion criteria	Foster care returning to home, school, and community settings within a 60-mile radius of the residential campus or university after discharging from a large residential program which used a modified Teaching Family Model where youth live with up to seven other same-sex youth in a home with a married couple and full-time assistant. Age In school grades 8 – 11 Disabilities identified with (i.e., IEP) or at risk of a high incidence disability. At-risk criteria included either a clinical cut-off score on the Child Behavior Checklist , Axis I diagnosis on a psychological/psychiatric assessment, or a DISC diagnosis.
Sample size	87
Mean age (SD)	15.74 (SD 1.23)

% female	47%
% non-white ethnicity	40%
Details on foster care, discharge plan and education	-93% returned to high school and most (63.1%) enrolled in schools that they had not previously attended. -28% received special education services. - Most (88.2%) discharged as planned from care after spending an average of 14.1 months (*SD* =8.53) in the residential setting. - 14% of families were living in extreme poverty and 58% were at or below the median level of income for their region.
Lost to -follow-up	Data are missing for four youth in the treatment group and two youth in the control group as they returned to a school not participating in the study, retuned to a non-English speaking home, or ultimately did not discharge from care.
Outcome measures	Maintaining placement in school Staying in school was defined as maintaining enrolment in the community school setting. Re-entry to foster care

Study arms

On The Way Home (OTWH) Family Consultant (N = 47) Participants received 12 months of OTWH services, which were developed to address the transition needs of youth with or at-risk of disabilities reintegrating into the home and community school settings following a stay in out-of-home care. OTWH integrates three interventions: **Check & Connect:** a dropout prevention program that uses frequent monitoring of high-risk educational behaviours to prevent school failure and build communication between the schools, students, and families. Implemented by both the Family Consultant and a program identified school mentor who serves as the liaison between the consultant and the teachers. The consultant monitors tardies, suspensions, and detentions on a weekly basis, and works with the mentor, teachers, family, and youth to implement an intervention when the data reaches a predetermined

risk criteria. The consultant engages in weekly communication with the youth, parents, and mentor to ensure that the youth is engaged in the academic environment and on his or her educational goals, and to help problem solve when challenges arise.

Common Sense Parenting.
Improves family functioning through parent training of the critical skills necessary to successfully support adolescents' academic and behavioral success. The parent training is provided by the Family Consultant in the youth's home on a one-on-one basis and is used to teach parents skills in a series of 6 one-on-one sessions that include the areas of effective consequences, praise, staying calm, and problem solving among others. Sessions include direct instruction of key skills, observations of video-taped live modelling of the skills in use with children, and role playing. Parents are assigned readings and homework activities to practice the use of the newly taught skills which are reviewed weekly with the Family Consultant to further problem-solve and reinforce the developing skills.

Homework support. This strategy pairs parent monitoring with several self-management techniques. The primary features include establishing a homework environment and structure (e.g., setting, rules, materials) and developing a homework tracking and monitoring system. Students are taught methods to track homework assignments and check for completion with their teachers and parents. For students requiring additional assistance, secondary support such as connecting the youth with a tutor is provided.

Family Consultants. Four Family Consultants participated in the study. Consultant criteria included completion or working towards a bachelor's degree in a social service field and previous experience working with youth in the child welfare system. Consultants completed approximately 82 hours of training prior to working with youth and families. Nearly 40 hours were spent on mastery of CSP, 14 hours on C&C, seven hours on the homework strategy, and 21 hours on model overview, roles, implementation procedures, and service and study related data collection and entry. During direct care services, Family Consultants participated in multiple levels of supervision. First, consultants participated in weekly two-hour group supervision sessions which covered: reviews of active individual cases; reviews of eligibility and consent status of discharging youth still in care; and reviews of the research project procedures, documentation, and data collection. Second, individual supervision sessions were available weekly and as needed with the research and implementation supervisors to address cases in crisis or concerns with the overall research project. Finally, each quarter, individual supervision sessions were conducted to evaluate Family Consultant skills, determine additional training needs, and address any concerns with service documentation. Although services varied by the needs of the families and youth, at a minimum, consultants were expected to make weekly contact with the parents, youth, and school mentor to work on family and youth objectives using the CSP materials, collect C&C risk indicator data to monitor youth school

functioning and engagement and evaluate homework completion. On average, over the 12-month period, consultants spend 138 hours per case, with 102 of those hours including direct care services.

Services as usual (N = 41)
Participants in the control condition received the traditional transition supports provided by the residential agency which included a departure planning meeting with the parents, youth, case worker (if assigned), direct care providers, supervisor, and therapists to review youth progress, continuing treatment needs (e.g., therapy, substance abuse treatment), safety and monitoring concerns, medical needs and upcoming doctor and dentist appointments, medication needs, and updated school information. As part of the discharging process, the agency school also worked with the community school to coordinate the release of all information needed for the youth's return to school. Finally, youth and their family were provided with information on the Boys Town National Hotline—a free service designed to provide information on resources as well as ongoing and crisis support, with trained counsellors for help with a broad range of youth and family problems and mental health needs.

Risk of bias

Section	Question	Answer
Domain 1: Bias arising from the randomisation process	Risk of bias judgement for the randomisation process	High *(Randomization process was unclear. Although the author notes that there are no significant differences in baseline characteristics between groups, these are not reported, and it is unclear which characteristics were compared. As not all participants will be returning to their parent's home it is important that differences between the groups for this variable are compared).*
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

Section	Question	Answer
Domain 2b: Risk of bias due to deviations from the intended interventions (effect of adhering to intervention)	Risk of bias judgement for deviations from the intended interventions (effect of adhering 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	Low
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	Moderate
	Overall Directness	Partially applicable *(non-UK study)*

Trout 2019

Study Details

Study type	Randomised controlled trial (RCT)
Study location	USA
Study setting	Youth returning to home, school and community settings are living in a residential programme. The majority (69%) of discharging youth return to their home setting following departure).

Study dates	2012–2017
Duration of follow-up	21 months post-reunification
Sources of funding	the U.S. Department of Education, Institute for Education Science
Inclusion criteria	Care situation returning to home, school, and community settings within a 90-mile radius of the residential agencies or university mental health or emotional needs identified with (i.e., receiving special education services via an Individualized Education Program; IEP) or at-risk (i.e., Diagnostic Interview Schedule for Children [DISC-IV] mental health diagnosis on file;) of a high-incidence disability. Education enrolled in grades 8–12
Sample size	196 randomised child-caregiver dyads
Split between study groups	OTWH intervention = 98 participants child-caregiver dyads Services as Usual = 89 participants child-caregiver dyads
Loss to follow-up	9 consented/ assented but declined after randomization to the treatment or control condition. Based on the observed data, the overall attrition rates for the three analytic samples (i.e., posttest caregiver outcomes, posttest school and community placement outcomes, and follow-up school and community placement outcomes) were 31.55% (n = 59), 17.11% (n = 32), and 29.41% (n = 55), respectively. The differential attrition rates (between OTWH and SAU) were Δ6.60%, Δ6.93%, and Δ3.91%.
% Female	Not reported for total sample
Mean age (SD)	Not reported for total sample
Outcome measures	Carer outcome 1 Caregiver Empowerment. Caregivers of participating youths completed the Family Empowerment Scale at posttest (i.e., 12-months after youth discharge from residential care). The FES measures the empowerment of a parent or caregiver of a child with emotional disabilities. The 34 items are rated on a 5-point scale (1 = never to 5 = very often) with

	higher scores indicating greater levels of empowerment. Mean scores for the FES are calculated by summing scores for the subscale items and dividing by the number of items in each subscale: Family (12 items; e.g., I feel confident in my ability to help my child grow and develop, I have a good understanding of my child's disorder), Service System (12 items, e.g., I know what services my child needs, I am able to make good decisions about what services my child needs), and Community (10 items, e.g., I help other families get the services they need, I have ideas about the ideal service system for children). Carer outcome 2 Caregivers completed the 25-item Caregiver Self-Efficacy Scale along with the FES at posttest. The CSES measures caregiver perceptions regarding selective parenting skills and their perceived ability to care for their children. Items address behaviour management (e.g., How comfortable are you with your ability to control your child's behaviour?), child advocacy (e.g., How comfortable are you with your ability to advocate for your child's rights?), and management of school-related matters (e.g., How comfortable are you with your ability to participate in school activities with your child?). Rated on a 4-point Likert-type scale (1 = not very comfortable to 4 = very comfortable), the items comprise five subscales (i.e., Behaviour Management, Advocacy, School Issues, Emotional Support, and Provider Issues). A total score can also be calculated which is the sum of the five subscale scores. For the CSES, higher scores indicate greater perceived caregiving self-efficacy. Placement stability Placement stability and school involvement. Youth placement stability and school involvement were collected by trained data collectors from the schools and families at posttest and follow-up (i.e., 21-months following reunification) using the School & Home Placement Change Questionnaire (SHPQ, Author, 2013). The SHPQ was developed and evaluated in the previous RCT of OTWH and consists of two items (1) Where is the study child currently living? and (2) What is the study child's current school placement status? Community placement was defined as living with a parent, primary caregiver, legal guardian, or independent living. School involvement was defined as maintaining enrolment in the community school setting, graduation, or working on a GED. Although youths who return to care or go to jail receive educational support, this involves a placement change, which prevents attendance at the home school.

Study Arms

On The Way Home (OTWH) Family Consultant (N = 98) Participants received 12 months of OTWH services, which were developed to address the transition needs of youth with or at-risk of disabilities reintegrating into the home and community school settings following a stay in out-of-home care. OTWH integrates three interventions: Check & Connect: a dropout prevention program that uses frequent monitoring of high-risk educational behaviours to prevent school failure and build communication between the schools, students, and families. Implemented by both the Family Consultant and a program identified school mentor who serves as the liaison between the consultant and the teachers. The consultant monitors tardies, suspensions, and detentions on a weekly basis, and works with the mentor, teachers, family, and youth to implement an intervention when the data reaches a predetermined risk criteria. The consultant engages in weekly communication with the youth, parents, and mentor to ensure that the youth is engaged in the academic environment and on his or her educational goals, and to help problem solve when challenges arise. Common Sense Parenting. Improves family functioning through parent training of the critical skills necessary to successfully support adolescents' academic and behavioral success. The parent training is provided by the Family Consultant in the youth's home on a one-on-one basis and is

used to teach parents skills in a series of 6 one-on-one sessions that include the areas of effective consequences, praise, staying calm, and problem solving among others. Sessions include direct instruction of key skills, observations of video-taped live modelling of the skills in use with children, and role playing. Parents are assigned readings and homework activities to practice the use of the newly taught skills which are reviewed weekly with the Family Consultant to further problem-solve and reinforce the developing skills. Homework support. This strategy pairs parent monitoring with several self-management techniques. The primary features include stablishing a homework environment and structure (e.g., setting, rules, materials) and developing a homework tracking and monitoring system. Students are taught methods to track homework assignments and check for completion with their teachers and parents. For students requiring additional assistance, secondary support such as connecting the youth with a tutor is provided. Family Consultants. Four Family Consultants participated in the study. Consultant criteria included completion or working towards a bachelor's degree in a social service field and previous experience working with youth in the child welfare system. Consultants completed approximately 82 hours of training prior to working with youth and families. Nearly 40 hours were spent on mastery of CSP, 14 hours on C&C, seven hours on the homework strategy, and 21 hours on model overview, roles, implementation procedures, and service and study related data collection and entry. During direct care services, Family Consultants participated in multiple levels of supervision. First, consultants participated in weekly two-hour group supervision sessions which covered: reviews of active individual cases; reviews of eligibility and consent status of discharging youth still in care; and reviews of the research project procedures, documentation, and data collection. Second, individual supervision sessions were available weekly and as needed with the research and implementation supervisors to address cases in crisis or concerns with the overall research project. Finally, each quarter, individual supervision sessions were conducted to evaluate Family Consultant skills, determine additional training needs, and address any concerns with service documentation. Although services varied by the needs of the families and youth, at a minimum, consultants were expected to make weekly contact with the parents, youth, and school mentor to work on family and youth objectives using the CSP materials, collect C&C risk indicator data to monitor youth school functioning and engagement and evaluate homework completion. On average, over the 12-month period, consultants spend 138 hours per case, with 102 of those hours including direct care services. For those assigned to OTWH, participants were assigned to one of five different interventionists (i.e., Family Consultants [FCs]). Because only participants in OTWH were nested within interventionists (i.e., participants in the SAU were not nested), this was a partially nested RCT rather than a typical RCT with randomization at the individual level.

Split between study groups	OTWH intervention = 98 child-caregiver dyads Services as Usual = 89 child-caregiver dyads
% Female	46.62%
Mean age (SD)	15.39 ± 1.54 years
Condition specific characteristics	Non-white ethnicity

	35.21% time in care time in therapeutic residential care = 12.90 ± 5.32 months

Services as Usual (N = 89)

Participants in the control condition received the traditional transition supports provided by the residential agency which included a departure planning meeting with the parents, youth, case worker (if assigned), direct care providers, supervisor, and therapists to review youth progress, continuing treatment needs (e.g., therapy, substance abuse treatment), safety and monitoring concerns, medical needs and upcoming doctor and dentist appointments, medication needs, and updated school information. As part of the discharging process, the agency school also worked with the community school to coordinate the release of all information needed for the youth's return to school. Finally, youth and their family were provided with information on the Boys Town National Hotline—a free service designed to provide information on resources as well as ongoing and crisis support, with trained counsellors for help with a broad range of youth and family problems and mental health needs.

Sample size	196 randomised
Split between study groups	OTWH intervention = 98 participants Services as Usual = 89 participants
% Female	49.18%
Mean age (SD)	15.23 ± 1.31 years
Condition specific characteristics	Non-white ethnicity 39.33% time in care Length of time in therapeutic residential care = 12.56 ± 5.82 months

Risk of Bias

Section	Question	Answer
Domain 1: Bias arising from the randomisation process	Risk of bias judgement for the randomisation process	Some concerns *(Process of randomisation unclear, unclear if allocation concealment)*
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)	High *(Unclear approach to missing data and loss to follow up. Unclear if intent to treat analysis used. Unclear if deviations between comparison groups.)*
Domain 3. Bias due to missing outcome data	Risk-of-bias judgement for missing outcome data	High *(the overall attrition rates for the three analytic samples (i.e., posttest caregiver outcomes, posttest school and community placement outcomes, and follow-up school and community placement outcomes) were 31.55% (n = 59), 17.11% (n = 32), and 29.41% (n = 55), respectively. Missing data was substantial and could be related to placement stability.)*
Domain 4. Bias in measurement of the outcome	Risk-of-bias judgement for measurement of the outcome	Low
Domain 5. Bias in selection of the reported result	Risk-of-bias judgement for selection of the reported result	Some concerns
Overall bias and Directness	Risk of bias judgement	High
	Overall Directness	Indirectly applicable *(Non-UK based study. In addition, it was unclear if participants were "true" in care subjects i.e. under the principle care of the child welfare system)*

Vandivere 2015

Study details

Study type	Randomised controlled trial (RCT)
Study location	USA
Study setting	All of the agencies served unique geographic regions in the United States (with the exception of two agencies operating during consecutive time periods in the same region). Among the agencies represented in the final analytic sample, six were private, and the remaining 15 were public child welfare agencies.
Study dates	August 2006 through January 2010
Duration of follow-up	Unclear: "Adoption was operationalized as a dichotomous variable because the date that adoptions were finalized was not available for all children discharged to adoption. However, because pairs of children were randomized to control and WWK groups at the same time, the expected amount of time that children in each group were available for adoption was the same, making this specification innocuous."
Sources of funding	the Dave Thomas Foundation for Adoption
Inclusion criteria	Care status a permanency goal of adoption and had no identified adoptive resource In care Children could be in any type of out-of-home care placement setting and could have varying degrees of interest in being adopted
Sample size	956
Split between study groups	Wendy's Wonderful Kids = 708 children Control group = 685 children

Loss to follow-up	Wendy's Wonderful Kids = 193 children Control group = 212 children
% Female	Total = 41.6%
Mean age (SD)	Total = 10.2 years
Condition specific characteristics	Ethnicity Native American 2.4%; Asian 1.6%; African American 53.8%; Pac. Islander 0.5%; White 49.7%; Hispanic 9.3%. Mental health history Learning disability 7.6%; Emotionally disturbed 49.4%; Physical health problems Visually or hearing impaired 2.6%; Physically disabled 4.2%; Other diagnosed condition 24.9% Maltreatment Physical abuse 21.3%; Sexual abuse 8.2%; Neglect 63.0%; Parent abused alcohol or drugs 24.0%; Child abused alcohol 0.2%; Child abused drugs 0.7%; Child has a disability 3.7%; Child's behavior 13.3%; Death of parent 0.5%; Incarceration of parent 6.1%.
Outcome measures	Permanency Adoption: Adoption was operationalized as a dichotomous variable because the date that adoptions were finalized was not available for all children discharged to adoption. However, because pairs of children were randomized to control and WWK groups at the same time, the expected amount of time that children in each group were available for adoption was the same. The dependent variable was adoption, representing the primary goal of the intervention. Children were categorized as having been adopted if the child had been discharged from foster care and the reason for discharge was indicated to be adoption, or if the child had a valid adoption finalization date in the Statewide Automated Child Welfare Information System data.

Study arms

Wendy's Wonderful Kids (N = 515)

The intervention includes eight components specified by Dave Thomas Foundation for Adoption (DTFA), as summarized below: - Initial case referral. Recruiters contact the child's caseworker in the child welfare agency to introduce the role of WWK, gather initial referral information, establish a date to begin review of the child's case file, and schedule an initial meeting with the child - Relationship with child: Recruiters meet with the child at least monthly, preferably in person and one-on-one, to assess the child's adoption readiness, prepare the child for adoption, and develop an appropriate recruitment plan. - Case record review. Recruiters review the existing case file to document the child's case history and identify significant people in the child's life. - Assessment. Recruiters identify and document the child's strengths, challenges, desires, and preparedness for adoption. The recruiter works with the child's caseworker to ensure that any needs that should be addressed before moving forward with the adoption process are met. The assessment is updated quarterly. - Adoption preparation. Recruiters ensure that the child is prepared for adoption. During the matching process, the recruiter also ensures that the prospective adoptive family is prepared to meet the needs of the child. - Network building. Recruiters maintain regular and ongoing contact with individuals including not only the child's caseworker, but also the child's foster parent, attorney, CASA volunteer, teacher, therapist, relatives, and other adults significant to the child. - Recruitment plan. Based on the case file review, interviews with significant adults, and the input of the child, recruiters develop a written recruitment plan. Recruiters customize the plan based on the child's needs; reviewing and updating it at least quarterly. - Diligent search. This component, the active search for and engagement of potential adoptive families, relies on the implementation of the prior components. Two key approaches used in the search include electronic database searches for individuals identified through the case record review, network building, and interviews with the child; and searches for prospective adoptive parents through reviews of existing pools of home studies of prospective adoptive parents who may be a good match for the child but who have no prior connection to the child. The recruiters then tempt to engage identified individuals in discussions about adoption of the child.

Duration of follow-up	Unclear: "Adoption was operationalized as a dichotomous variable because the date that adoptions were finalized was not available for all children discharged to adoption. However, because pairs of children were randomized to control and WWK groups at the same time, the expected amount of time that children in each group were available for adoption was the same, making this specification innocuous."
% Female	Wendy's Wonderful Kids = 41.6%
Mean age (SD)	Wendy's Wonderful Kids = mean age 9.9 years

Condition specific characteristics	Ethnicity Native American 1.2%; Asian 1.4%; African American 52.0%; Pac. Islander 0.6%; White 50.6%; Hispanic 9.4%. Mental health history Learning disability 6.5%; Emotionally disturbed 49.0%; Physical health problems Visually or hearing impaired 2.9%; Physically disabled 3.8%; Other diagnosed condition 21.6% Maltreatment Physical abuse 21.1%; Sexual abuse 9.2%; Neglect 63.3%; Parent abused alcohol or drugs 24.2%; Child abused alcohol 0.5%; Child abused drugs 0.5%; Child has a disability 3.0%; Child's behavior 12.4%; Death of parent 0.2%; Incarceration of parent 6.0%.

Usual care (N = 496)

Once assigned to the control group, children were not eligible for WWK services for the duration of the evaluation. All children were eligible to receive any adoption recruitment services available in the agency or in the community other than the intervention, regardless of experimental group membership.

% Female	Control group = 41.6%
Mean age (SD)	Control group = mean age 10.5 years (significant difference)
Condition specific characteristics	Ethnicity Native American 3.7%; Asian 1.8%; African American 55.6%; Pac. Islander 0.4%; White 48.9%; Hispanic 9.4%. Mental health history Learning disability 8.8%; Emotionally disturbed 49.9%; Physical health problems Visually or hearing impaired 2.3%; Physically disabled 4.6%; Other diagnosed condition 28.4% Maltreatment

	Physical abuse 21.6%; Sexual abuse 7.1%; Neglect 62.6%; Parent abused alcohol or drugs 23.9%; Child abused alcohol 0.9%; Child abused drugs 0.9%; Child has a disability 4.5%; Child's behavior 14.2%; Death of parent 0.7%; Incarceration of parent 6.1%.

Risk of Bias

Section	Question	Answer
Domain 1: Bias arising from the randomisation process	1. 1. Was the allocation sequence random?	Yes
	1. 2. Was the allocation sequence concealed until participants were enrolled and assigned to interventions?	No
	1.3 Did baseline differences between intervention groups suggest a problem with the randomisation process?	Probably no
	Risk of bias judgement for the randomisation process	High *("Either due to confusion or due to a desire to provide intervention services to a particular case, recruiters occasionally entered information about a single case along with information about an apparently invented case into the random assignment application, rather than entering information about two separate cases. (This problem was apparent due to odd formats for names and case numbers, and which we confirmed by asking recruiters directly). Also very occasionally, recruiters entered information about a child who had already been assigned to the control group into the random assignment application, perhaps again due to a desire to serve a particular child and in the hopes that the child would be re-assigned to*

Section	Question	Answer
		the treatment group." Significant differences were observed between groups for age.)
Domain 2a: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention)	2.1. Were participants aware of their assigned intervention during the trial?	Probably no
	2.2. Were carers and people delivering the interventions aware of participants' assigned intervention during the trial?	Probably yes
	2.3. If Y/PY/NI to 2.1 or 2.2: Were there deviations from the intended intervention that arose because of the experimental context?	Yes/Probably yes
	2.4. If Y/PY to 2.3: Were these deviations from intended intervention balanced between groups?	Yes
	2.5 If N/PN/NI to 2.4: Were these deviations likely to have affected the outcome?	No
	2.6 Was an appropriate analysis used to estimate the effect of assignment to intervention?	Yes
	2.7 If N/PN/NI to 2.6: Was there potential for a substantial impact (on the result) of the failure to	Not applicable

Section	Question	Answer
	analyse participants in the group to which they were randomized?	
	Risk of bias for deviations from the intended interventions (effect of assignment to intervention)	Low *("with the exception of 74 older children also involved in in-person interviews,2 children had no contact with research staff and were likely unaware of the evaluation." and "among randomly assigned children for whomwe received SACWIS data, only two children in the treatment group were no-shows, and only four control group children were crossovers. The low rate of crossovers and no shows is largely due to the design of the intervention, which relied on the activities of the WWK recruiter, rather than activities of the child or youth.")*
Domain 3. Bias due to missing outcome data	3.1 Were data for this outcome available for all, or nearly all, participants randomised?	No
	3.2 If N/PN/NI to 3.1: Is there evidence that result was not biased by missing outcome data?	No
	3.3 If N/PN to 3.2: Could missingness in the outcome depend on its true value?	Probably yes
	3.4 If Y/PY/NI to 3.3: Do the proportions of missing outcome data differ between intervention groups?	No
	3.5 If Y/PY/NI to 3.3: Is it likely that missingness in the outcome depended on its true value?	Probably no

Section	Question	Answer
	Risk-of-bias judgement for missing outcome data	Some concerns *(over 10% missing data across both arms)*
Domain 4. Bias in measurement of the outcome	4.1 Was the method of measuring the outcome inappropriate?	No
	4.2 Could measurement or ascertainment of the outcome have differed between intervention groups ?	Probably no
	4.3 If N/PN/NI to 4.1 and 4.2: Were outcome assessors aware of the intervention received by study participants ?	Probably no
	4.4 If Y/PY/NI to 4.3: Could assessment of the outcome have been influenced by knowledge of intervention received?	Probably no
	4.5 If Y/PY/NI to 4.4: Is it likely that assessment of the outcome was influenced by knowledge of intervention received?	Not applicable
	Risk-of-bias judgement for measurement of the outcome	Low *(Outcome was routinely collected data)*
Domain 5. Bias in selection of the reported result	5.1 Was the trial analysed in accordance with a pre-specified plan that was finalised before unblinded outcome data were available for analysis ?	Yes

Section	Question	Answer
	5.2 Is the numerical result being assessed likely to have been selected, on the basis of the results, from multiple outcome measurements (e.g. scales, definitions, time points) within the outcome domain?	No/Probably no
	5.3 Is the numerical result being assessed likely to have been selected, on the basis of the results, from multiple analyses of the data?	No/Probably no
	Risk-of-bias judgement for selection of the reported result	Low
Overall bias and Directness	Risk of bias judgement	High
	Overall Directness	Indirectly applicable *(Study was based in the USA)*

Vandivere 2017

Study details

Study type	Randomised controlled trial (RCT)

Study location	9 counties in North Carolina, USA
Study setting	Children in foster care with no identified placement resource or plan for reunification.
Study dates	Random assignment occurred from June 2008 to May 2011. Outcome data were obtained in October 2012.
Duration of follow-up	Specialists served approximately five to seven cases at a time, with average service periods of 5 months each.
Sources of funding	private foundation paid for both the intervention and corresponding evaluation. Participation in the evaluation by program providers was a prerequisite for receiving the program funds.
Inclusion criteria	Age 10 - 17 years old Foster care no identified permanent placement resource, and had no plan for reunification, or if they were the younger sibling of such a child and also lacked an identified permanent placement resource or plan for reunification. Referred for intervention services
Sample size	573
Loss to follow-up	Administrative data were unavailable for 5 children. 387 children were eligible (at least 13 years of age) for interview. Of these, 82 children did not complete the first survey and 106 did not complete the second.
Outcome measures	Positive/negative foster placement change

	Obtained from administrative data from North Carolina's child welfare information system. The investigators categorized placements settings in the following order from least to most restrictive: (1) discharge to legal permanency, including a finalized adoption, guardianship, or reunification; (2) parents' home; (3) trial home visit; (4) relative's home including relative adoptive home, living in home of relative, and relative family foster home; (5) specialized relative family foster home; (6) nonrelative's home including nonrelative adoptive home, adoptive foster home, home of legal guardian, or family foster care home; (7) specialized nonrelative home including specialized family foster care home, therapeutic home, or emergency shelter; (8) small congregate care setting including residential school, maternity home, small residential group home, and small treatment group home; (9) independent living arrangement; and (10) large congregate care setting including large group residential or treatment facility, hospital, Department of Juvenile Justice and Delinquency Prevention, and jail, lockup, detention facility. Any move from a "higher" category to a "lower" category—when compared with the youth's placement setting at the time of study enrollment—counted as a positive move (i.e., a positive outcome)." This outcome is reported as any positive move and is further segmented into: any positive (any negative also reported) foster care placement change and; positive (negative also reported) change compared to baseline foster care placement. Permanency Obtained from administrative data from North Carolina's child welfare information system.1) discharge to reunification 2) discharge to adoption, guardianship, or reunification. 3) Discharge from foster care Safety Obtained from administrative data from North Carolina's child welfare information system. 1) Reallegation of abuse or neglect. 2) Substantiated reallegation of abuse or neglect Placement breakdown (re-entry into care) Placement restrictiveness Obtained from administrative data from North Carolina's child welfare information system.1) discharged from foster care to relative. 2) discharged from foster care to a relative OR discharged from foster care and last placement setting was with a relative 3) Last placement setting in foster care is/was with a relative.

Study arms

Family finding specialist (N = 295) In each county, a family finding specialist was responsible for implementing the intervention in conjunction with the child's child welfare team. Specialists served approximately five to seven cases at a time, with average service periods of 5 months each. The intervention does not require direct youth participation (although in most cases, youth did actively participate), so all treatment group youth were assigned to the caseload of a family finding specialist.
Services as usual (N = 278)

Characteristics (arm-level)

	Intervention (N = 295)	Services as usual (N = 278)
Female *(%)*	42	43
Age *(%)*		
aged 0-12 years	26	18
aged 13-15 years	38	42
aged 16 or older	36	40
non-white ethnicity ***(%)***	62	57
>1 entry into foster care *(%)*	19	23
Time in foster care prior to study enrollment *(%)*		
<1 year	18	24
1-2 years	27	18
2-5 years	33	35
5+ years	22	23
In foster care living with relatives at time of referral *(%)*	4	1
Emotionally disturbed *(%)*	18	15

	Intervention (N = 295)	Services as usual (N = 278)
Diagnosed disability (excluding emotional disturbtion) *(%)*	15	18

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 2b: Risk of bias due to deviations from the intended interventions (effect of adhering to intervention)	Risk of bias judgement for deviations from the intended interventions (effect of adhering to intervention)	Some concerns *(Unclear whether co-interventions differed between groups.)*
Domain 3. Bias due to missing outcome data	Risk-of-bias judgement for missing outcome data	Low *(Although there was a relatively high level of attrition, this was comparable between groups)*
Domain 4. Bias in measurement of the outcome	Risk-of-bias judgement for measurement of the outcome	Low

Section	Question	Answer
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	Partially applicable *(non-UK study)*

Non-RCTs

Biehal 2011

Study details

Study type	Quasi-experimental study
Study location	UK
Study setting	Serious / persistent offenders at risk of custodial sentence
Duration of follow-up	Time 1: The year following entry to the intervention was compared to the year after participants in the control arm were released from custody. Time 2: The year following exit from the intervention was compared to the year after participants in the control arm were released from custody.

Inclusion criteria	Serious/persistent young offenders sentenced to custody or intensive supervision and surveillance programme (ISSP) Young people at imminent risk of a custodial sentence (youth were either sentenced to the intervention or to custody/ISSP (control arm)) Severity score of 3+ (out of 4) on subscales of the Asset Assessment tool (AAT) Must score 3+ on the 'family and personal relationships' and 'lifestyle' subscales of the AAT. The AAT is a structured assessment tool used by Youth Offending Teams with all young people who come into contact with the criminal justice system. It is used to identify the factors which may have contributed to an individual's offending behaviour and to inform decisions about intervention and the assessment of the risk that they will reoffend.
Sample size	47
Loss to follow-up	Administrative data were available for all participants. 11 participants did not complete baseline interviews and 10 did not complete T1 interviews (no T2 interviews conducted).
Outcome measures	Reoffending at time 1 and time 2 Entered custody at time 1 and time 2 Days in custody at time 1 and time 2 Accommodation type at time 1

Study arms

Intensive fostering (IF) (N = 23)
The English IF programme closely followed the multi-dimensional treatment foster care (MTFC) programme, which involves:

- the provision of a consistent reinforcing environment in which young people are mentored and encouraged
- a clear structure, with clearly specified boundaries and consequences for behaviour
- close supervision of young people's activities and whereabouts at all times

- diversion from associations with anti-social peers and help to develop positive social skills and promote the formation of relationships with more positive peers.

This daily programme of positive reinforcement is delivered by specially trained foster carers, who are provided with intensive support. Behaviour is closely monitored and positive behaviours are reinforced using a system of points and levels. The intention is that after six to nine months, young people will accumulate sufficient points to move to the highest level on the programme and then return to their families or move to alternative carers.

MTFC teams are led by Programme Supervisors, who act as case managers and coordinate the intervention. Individual therapists work with young people to develop problem-solving skills and help them change identified behaviours. Skills workers help them improve and practise their social skills and try to involve them in positive recreational activities. Birth family therapists undertake work with parents or alternative follow-on carers during the foster placement and a three-month aftercare period, to ensure that desired behaviours continue to be encouraged and reinforced in a positive manner after they complete the programme. The IF teams also aimed to find appropriate education or training for the young people, help them settle into school or college and to encourage regular attendance. The English teams made minor adaptations to programme delivery by creating additional posts for programme managers and family placement social workers, to allow Programme Supervisors to focus on clinical work.

Standard judicial proceedings (N = 24)
Participants in this comparator arm, met all the same inclusion criteria necessary for the IF intervention but were not selected for inclusion due to a limited number of places being available. Instead, these young people were sentenced to custody (N=20) or ISSP (N=4).

Characteristics (arm-level)

	Intensive fostering (N = 23)	**Standard judicial proceedings (N = 24)**
Female *(%)*	17	17
Mean age (SD) *(years)*	14.9	15.5

	Intensive fostering (N = 23)	Standard judicial proceedings (N = 24)
Experience of maltreatment *(%)*	52	63
Mean age at first conviction (SD) *(years)*	12.7	13.1
Mean no. previous recorded offences (SD)	15.26	17.38
Mean no. previous recorded offences in last 12 months (SD)	7.54	7.7
Previous custodial sentence *(%)*	26	33
Mean gravity score for most serious previous offence (SD)	5.22	5.21
Mean gravity score for most serious index offence (SD)	4.7	5
Index offence of 'violence against the person' *(%)*	21	50

Risk of bias

Section	Question	Answer
Domain 1: confounding	Risk of bias judgement for bias due to confounding variables	Some concerns *(It is likely that the young people who were selected for the intervention were perceived as being more likely to benefit from it than those not selected. The control group was over twice as likely to have committed a violent crime as their index offence. However, baseline characteristics are detailed and reasonably comparable between the groups.)*

Section	Question	Answer
Domain 2: Selection of participants into the study	Risk of bias for selection of participants into the study	Some concerns *(Due to the control group undergoing a custodial sentence, outcomes were recorded for the year following release from custody (control arm) and compared to the intervention group during the year following entry to the intervention (time 1) and year following their (time 2). This would be a suitable method however, the duration of placement in the intervention varied considerably (1 week to 17 months), mean 260 days). The length of custodial sentences in the control arm were not reported. These factors were not controlled for in the analysis.*
Domain 3. Classification of interventions	Risk-of-bias due to classification of interventions	Low
Domain 4. Deviations from intended interventions	Risk-of-bias judgement for deviations from intended interventions	Low *(Study was unblinded however the [quantitative] outcomes are not likely to be affected by this.)*
Domain 5. Missing data	Risk-of-bias judgement for incomplete outcome data.	Low
Domain 6. Measurement of outcomes	Risk-of-bias judgement for measurement of outcomes	Low
Domain 7. Selective outcome reporting	Risk-of-bias judgement for selective reporting of outcome data.	Low

Section	Question	Answer
Overall bias and Directness	**Risk of bias judgement**	**Moderate**
	Overall Directness	**Directly applicable**

Harwin 2018

Study details

Study type	Non-randomised controlled trial
Study location	UK
Study setting	Family drug and alcohol treatment court in London
Study dates	January 2008 to August 2012
Duration of follow-up	5 years
Sources of funding	Children's Social Care Innovation Fund
Inclusion criteria	Substance-involved family In all cases parental substance misuse was a key factor in the local authority's decision to issue section 31 care proceedings on the grounds that the child was subject to actual or likely significant harm. Receiving an intervention All cases that entered the London Family Drug and Alcohol Court between January 2008 and August 2012. They were compared with cases from three comparison local authorities which did not provide FDAC. These cases were heard in ordinary care proceedings in the same Family Proceedings Court as FDAC.
Exclusion criteria	Mental health problems cases were excluded from the cohort if the parent was experiencing florid psychosis as informed consent to join the intervention would not be possible History of severe parental physical or sexual abuse

Sample size	240 (Children)
Split between study groups	Family Drug and Alcohol Court sample = 140 mothers, 201 children Comparison sample = 100 mothers, 149 children However, sample size varied depending on the analysis undertaken
Loss to follow-up	No loss to follow up since data were retrospective
% Female	Not reported
Mean age (SD)	Not reported
Outcome measures	Permanency The number of reunification cases who were estimated to experience no disruption to family stability at 3 years follow up: defined as relapse, placement change and return to court as a single composite measure to define a good outcome Safety Number reunified that were estimated to start new proceedings due to actual or likely significant harm in the follow up period. reunification Proportion of families who were reunited and continued to live together at the end of proceedings Post-placement problems Disruption following reunification: defined as combination of no permanent placement change, no subsequent neglect, and no return to court for new proceedings

Study arms

Family Drug and Alcohol Court (N = 201)

FDAC provides parents with an opportunity to demonstrate capacity to change by providing intensive supervision of families and tighter co-ordination of service inputs, coupled with continuity of judicial authority. Local authorities refer cases into FDAC when they issue care proceedings under section 31 of the Children Act 1989, where the main concern of the local authority is that the child is suffering actual or likely significant harm as a result of parental substance misuse. It is important to emphasize that participation in FDAC is voluntary in the belief that this choice will help increase parental engagement. If parents decide they do not wish to have their case heard in FDAC, it is heard in ordinary care proceedings. The London FDAC follows the model of an American 'integrated FDTC' whereby the same judge has jurisdiction for both the care proceedings and FDAC treatment intervention. The main features of FDAC are judicial continuity, fortnightly judge-led review hearings without lawyers present, and a specialist multidisciplinary team (MDT). Independent of the local authority, the MDT advises the court and provides intensive treatment and support to parents as well as close monitoring of their progress. The specialist

team also links families with local community substance misuse and family support services. The non-lawyer review hearings are the court-based therapeutic forum for the problem-solving component of FDAC. Also central to FDAC is the role of the specialist team in problem solving with the Judge, and with families and practitioners outside of the court room.

Split between study groups	Family Drug and Alcohol Court sample = 140 Mothers, 196 Children Comparison sample = 100 mothers, 138 Children However, sample size varied depending on the analysis undertaken
Mean age (SD)	Under 1 year: 38%; 1-4 years: 18%; 5-10 years: 31%; 11 years old: 12%
Condition specific characteristics	Ethnicity Children White: 53%; Black: 9%; Mixed: 34%; Other 4% Mental health history Children Emotional and behavioural difficulties - 25% Living status Mother and father/partner - 10% Mother only - 26% Father only - 3% Residential provision - 5% Family and friends - 12% Hospital - 26% Foster carer - 18% Other - 0% Physical health problems Children Physical health problems - 41% Born affected by drugs - 26% Born premature - 9% Development delay - 9% Maltreatment Children Physical harm - 47% Emotional harm - 66% Neglect harm - 87% Type of placement seeking Children Placement LA seeking No removal from parent - 22% Father only - 1% Residential - 9% Family and friends - 16% Adoption - 3% Foster carer - 49% Other - 1%

Ordinary care proceedings (N = 149)

FDAC is radically different from ordinary care proceedings. In ordinary care proceedings in England there is no independent multidisciplinary team or judge-led review hearings where the judge plays a problem-solving role and actively seeks to motivate parents to change. Nor do parents engage in conversation with the judge. Instead their views are presented by their legal representative to the judge. Unlike some American FDTCs, the main sanction is that if parents do not comply with their FDAC plan, the case reverts to mainstream public law care proceedings where the local authority still has to prove to the court that the child is at unacceptable risk. At this point FDAC ceases to have any further involvement. All planning for alternative care becomes the responsibility of the local authority.

Condition specific characteristics	Ethnicity Children White: 40%; Black: 17%; Mixed: 41%; Other 3% Mental health history Children Emotional and behavioural difficulties - 29% Living status Mother and father/partner - 8% Mother only - 22% Father only - 2% Residential provision - 3% Family and friends - 12% Hospital - 28% Foster carer - 24% Other - 1% Physical health problems Children Physical health problems - 45% Born affected by drugs - 13% Born premature - 9% Development delay - 9% Maltreatment Children Physical harm - 65% Emotional harm - 68% Neglect harm - 87% Type of placement seeking Children Placement LA seeking No removal from parent - 28% Father only - 1% Residential - 9% Family and friends - 11% Adoption - 3% Foster carer - 88% Other - 1%

Risk of Bias

Section	Question	Answer
1. Bias due to confounding	Risk of bias judgement for confounding	Serious *(Although there were many similarities between the comparison cohorts, several points were important. Mothers in the FDAC group were those who had accepted the intervention, while it was unclear if the comparison mothers would have accepted the intervention. This could be a very important difference since the willingness to take part in the intervention may be strongly related to the success of reunification. In addition there were differences between the groups for ethnicity, cases involving the likelihood of harm, babies born withdrawing from drugs, and the higher proportion of FDAC local authorities plans for placement with family and friends while comparison authorities had a higher proportion of placements with foster carers. The study also did not report the differences between groups for the gender of the children.)*
2. Bias in selection of participants into the study	Risk of bias judgement for selection of participants into the study	Low
3. Bias in classification of interventions	Risk of bias judgement for classification of interventions	Low
4. Bias due to deviations from intended interventions	Risk of bias judgement for deviations from intended interventions	Moderate *(While it is unclear how participants or providers of the intervention may have deviated from best practice,*

Section	Question	Answer
		data is real world and therefore gives an indication of how the intervention would be performed in practice.)
5. Bias due to missing data	Risk of bias judgement for missing data	Serious *(The number of participants included in analysis varied significantly by outcome. At times this may be for good reason (e.g. a sub-analysis of reunified mothers) at other times it was unclear how much data was missing and for what reason.)*
6. Bias in measurement of outcomes	Risk of bias judgement for measurement of outcomes	Serious *(Data were taken from different local authorities which may have defined their outcomes differently. No blinding was performed, therefore judges and outcome assessors would likely have been aware of the interventions taken.)*
7. Bias in selection of the reported result	Risk of bias judgement for selection of the reported result	Serious *(The study used composite outcomes and only reported significant results (for data that was usable for the purposes of this review).)*
Overall bias	Risk of bias judgement	Serious
	Directness	Directly applicable *(Recent UK-based study)*

Monck 2004

Study details

Study type	Quasi-experimental study
Study location	UK
Study dates	1998 to End 2001

Study setting	Looked after children seeking adoption
Source of funding	Funding to the Goodman Project from the Department of Health was contingent on an independent evaluation of the outcomes for the children, undertaken by the present authors. Unclear funding for London and Brighton & Hove services.
Duration of follow-up	Until study end (end of 2001)
Inclusion criteria	Under the age of 8 years when coming into care
Sample size	68
Loss to follow-up	None lost to follow-up however various participants were excluded for different analyses (see risk of bias).
Outcome measures	Strengths and Difficulties Questionnaire (For Children aged 4 years and over) Used to assess the child's development. Completed by parents and carers, nursery staff and teachers. The inventory covers conduct problems, hyperactivity, peer problems, emotional symptoms and pro-social behaviour. General Health Questionnaire 28-item questionnaire completed by the Concurrency carers when the child was first placed with them and after 12-15 month. Number of moves before permanent placement (or final interview) found

Study arms

Concurrent planning (N = 24)

Three concurrency projects (based in Manchester, London and Brighton & Hove) were combined to form the intervention group. These projects took referrals from specific local authorities: the Goodman Project from Bury and Salford, the Coram Family Project from Camden and Islington, and the Brighton & Hove team from within that authority.
Concurrent planning (CP) has distinctive features. It requires that a child care team works concurrently on two care plans. Plan A is for rehabilitation to the birth parents (or a member of the wider family), who are strongly supported in addressing the causes of the child's removal. Meanwhile, the child is placed with concurrency carers, who during this period have the legal status of foster parent (see Note 1). If rehabilitation is judged
unsuitable, the child remains with the concurrency carers as an adoptive placement (Plan B). The work
with the birth parents includes a high level of supervised contact with the child to maintain or develop
attachment in the event of the child's return. Finally, acknowledging in full the damage caused by uncertainty, the courts will set tight timescales for the final hearing.

It is important to recognize that the concurrent planning approach was not designed for work with 'easy' cases, but with families in which there were grave, but possibly not insuperable, problems of inadequate care and parenting. But it appears that it was often the presence of these problems that led to delays in permanency decisions, while social workers wondered whether the parents could have 'another chance'. The selection of CP cases emphasizes the importance of there being at least a glimmer of hope
for rehabilitation to the birth family in a timescale that suits the child's needs, which may well not be those of the adults in the family. In the Seattle model, a *differential diagnosis*
is made of the strengths and difficulties within the birth families. If there are strengths that can realistically be encouraged or developed within a timescale that does
not add to the damage already experienced by the child, then the case is suitable for concurrent planning. From the assessment of family difficulties the parents are told which problems must be solved before they can be considered as able to look after the child again.

Standard adoption agencies (N = 44)
children taken into care by Trafford Metropolitan Boroughand referred to that authority's internal Adoption and Permanency Team (Trafford A&P Team); second, children referred to the MAS Adoption Team (i.e. not to the Goodman Project).

Characteristics (arm-level)

	Concurrent planning (N = 24)	Standard adoption agencies (N = 44)
Age at entry *(%)*		
<26 weeks	96%	7%
>26 weeks	4%	93%

Risk of bias

Section	Question	Answer
Domain 1: confounding	Risk of bias judgement for bias due to confounding variables	High *(Only baseline characteristic reported is age (for which the intervention group is considerably younger). Author notes that there was a very limited number of placements available for the intervention and that the eligibility was very restrictive. Therefore, it is likely that the intervention and control cohorts represent distinct populations.)*
Domain 2: Selection of participants into the study	Risk of bias for selection of participants into the study	Some concerns *(Unclear length of follow-up for both the intervention and control arm)*
Domain 3. Classification of interventions	Risk-of-bias due to classification of interventions	Low

Section	Question	Answer
Domain 4. Deviations from intended interventions	Risk-of-bias judgement for deviations from intended interventions	Low
Domain 5. Missing data	Risk-of-bias judgement for incomplete outcome data.	High *(for the outcome of number of movements to final placement of interview, the author notes that only 4 participants were not in final placements. However, it is unclear whether this relates specifically to the intervention group(with an unclear number in the control group) or overall (with an unclear number for each group). For the time to permanency outcomes, two intervention participants with adoption requests still pending were excluded, this would bias the outcome in favour of the intervention.)*
Domain 6. Measurement of outcomes	Risk-of-bias judgement for measurement of outcomes	Some concerns *(Author notes that the main reasons for rejection by concurrency projects are "no suitable carers" and "rehabilitation extremely unlikely". This makes the outcome less likely in the control arm. Analysis does not control for baseline characteristics relevant to this issue. Additionally, self-reported outcomes such as the Strengths in Families checklist, relies on self-report from multiple sources (family, teachers, nursery staff etc.) this has the potential for demand characteristics due to the unblinded nature of the intervention.*
Domain 7. Selective outcome reporting	Risk-of-bias judgement for selective reporting of outcome data.	Low
Overall bias and Directness	**Risk of bias judgement**	**High**

Section	Question	Answer
	Overall Directness	**Directly applicable**

Qualitative Evidence

Akin 2014

Study Characteristics

Study type	Qualitative
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)*
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)*

Section	Question	Answer
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
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)*

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

Castellanos-Brown 2010

Study Characteristics

Study type	Semi structured interviews RQ5.1
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

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 *(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)*
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

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

Frederico 2017

Study Characteristics

Study type	Focus Groups
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

Section	Question	Answer
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.)*
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.)*

Section	Question	Answer
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)*

Kenrick 2009

Study type	Semi structured interviews
Aim of study	To provide the prospective adoptive (concurrent planning) carers with an opportunity to reflect on the impact that contact with their biological parents had on the children. To establish a focus on the experience and needs of the children during the period of supervised contact with their birth parents as part of the placement process of the Concurrent Planning Project based within Coram.
Study location	UK
Study setting	Carers of looked after children placed for adoption by a concurrent planning project

Study methods	An open-ended questionnaire was produced to achieve consistency across the interviews, but in the event, it was used mainly as a prompt. Using modified Grounded Theory (Holloway and Jefferson, 2000), this account extracted common themes from the data from the 27 interviews, each taking between 1.5 and 2.5 hours. It also uses quotations from the narratives. This was a retrospective study. The CP carers were asked to think back to the process of contact as it had happened.
Population	Concurrent planning carers of 27 children who were later adopted and of one who was rehabilitated to birth parents
Study dates	between February 2006 and July 2007
Sources of funding	not reported
Inclusion Criteria	Criteria 1 families who had adopted children through the Concurrent Planning Project at Coram
Exclusion criteria	None reported
Sample characteristics	Sample size 27 children, of 26 families Reason for stopping recruitment not reported Mean age (SD) not reported
Relevant themes	Theme 1 Children becoming distressed during contact: particular difficulties, at around 6 months, in separating from the primary caregiver Theme 2 Concurrent planning concerns regarding frequency of contact: The CP carers complained that if contact was very frequent – three or five times a week – there was not time for recovery, disruption of routines Theme 3

	Arranging handovers so that parents were not upset if infants showed a preference to be with the carers Theme 4 The need of the child to establish and re-establish eye or physical contact with the carer Theme 5 behavioural issues before and after contact Theme 6 Concerns about the experience of the child during contact sessions Theme 7 Importance of foster carers in easing the transition to prospective adoptive parents, for continuity of routines Theme 8 Realisation by CP carers of how much the infants were missing the foster carers to whom they were already attached. Theme 9 how long children and CP carers should be given to get to know one another and settle following the move from foster carers or hospital before contact starts. Theme 10 Children born to drug/alcohol misusing parents: When the infant was a long time in hospital, the CP carers expressed great concern for what that experience might have meant to the child e.g. being alone during hospitalised detoxification, concerns regarding development and health fallout Theme 11 Poor passage of medical information about health issues to the foster carers/CP carers: e.g. hepatitis infections. Theme 12 continuing sensitivity to separation and change following adoption placements Theme 13 Comments from contact supervisor: The supervisor felt that what can confuse the children is when the birth parents do things with them differently from the carers; even more so when they do the same things but differently, for example, feeding and bathing. Theme 14 Comments from the contact supervisor: the need to help the parent to play with the child during contact sessions Theme 15 Comments from the contact supervisor: help the parent to recognise the child's gesture towards them and to find ways to help them to respond Theme 16

	Comments from the contact supervisor: how difficult it was for some birth parents when the infant showed a preference for the CP carers and would offer suggestions on how they might help the child (particularly 5 to 8 months) Theme 17 Continuing contact: CP carers have concerns about these wider contacts when the extended family may still be in touch with birth parents. Feeling that direct contact does need to be safe for all concerned.

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?	No *(researchers do not justify the research design or how they decided which method to use)*
Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Can't tell *(Researchers were not clear about how participants were selected, why those particular participants were selected. There were no discussions around recruitment.)*
Data collection	Was the data collected in a way that addressed the research issue?	Can't tell *(Researchers did not justify the setting for data collection; were not explicit in how interviews were carried out; were not clear about the form the data took; there was no discussion of data saturation)*

	Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Can't tell *(There was no critical examination of the researchers own role, potential bias, or influence)*
	Ethical Issues	Have ethical issues been taken into consideration?	Can't tell *(No discussion of ethics was included)*
	Data analysis	Was the data analysis sufficiently rigorous?	Can't tell *(unclear how thematic analysis was performed and how many researchers were involved. Unclear if researchers took into account contradictory findings; unclear 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?	Can't tell *(evidence for and against researchers' arguments are not discussed; or the credibility of findings (e.g. triangulation, respondent validation, more than one analyst))*
	Research value	How valuable is the research?	The research has some value *(There is no in-depth discussion of how research contributes to current understanding and literature; or new areas where new research was necessary)*
	Overall risk of bias and directness	Overall risk of bias	High
		Directness	Directly applicable

Kenrick 2010

Study type	Semi structured interviews See also Kenrick 2009
Aim of study	To provide the prospective adoptive (concurrent planning) carers with an opportunity to reflect on the impact that contact with their biological parents had on the children. To establish a focus on the experience and needs of the children during the period of supervised contact with their birth parents as part of the placement process of the Concurrent Planning Project based within Coram.
Study location	UK
Study setting	Carers of looked after children placed for adoption by a concurrent planning project
Study methods	An open-ended questionnaire was produced to achieve consistency across the interviews, but in the event, it was used mainly as a prompt. Using modified Grounded Theory (Holloway and Jefferson, 2000), this account extracted common themes from the data from the 27 interviews, each taking between 1.5 and 2.5 hours. It also uses quotations from the narratives. This was a retrospective study. The CP carers were asked to think back to the process of contact as it had happened.
Population	Concurrent planning carers of 27 children who were later adopted and of one who was rehabilitated to birth parents
Study dates	February 2006 and July 2007
Sources of funding	not reported
Inclusion Criteria	Criteria 1 families who had adopted children through the Concurrent Planning Project at Coram

Exclusion criteria	None reported
Sample characteristics	Sample size 27 children, of 26 families Reason for stopping recruitment not reported Mean age (SD) not reported
Relevant themes	Theme 1 Uncertainty leading to uncertainty in attachment (of the CP caregiver): CP carers had opted to be part of Coram's Concurrent Planning Project, hoping at the end of the day that they would have the chance of adopting a very young child. They had also chosen to take the risk that the adoption might not happen. Theme 2 Difficulties with consent: The CP carers had no part in the legal process of concurrent planning and no parental responsibility. This was an issue in one case, where a child became ill and in need of urgent medical intervention for which the CP carer could not give permission. That responsibility lay with children's services or the birth parents. Theme 3 Benefits of training: the Coram training had led them not to expect the infants to attach too quickly, helping to ensure that attachments developed at a pace that was right for the infants, who were still totally dependent on others for their survival. Theme 4 More time needed to settle between placement and start of contact: Nearly all the CP carers, although accepting the timeframe, felt that the infants needed more opportunity than had been given to settle with them and in homes where everything was new and different. The infant might be placed on a Friday and contact would begin on the following Monday. Some reported contact starting the next day, before either infant or CP carer had found or settled into basic care routines and rhythms. It would seem that the peace and quiet the CP carers asked for initially could make sense for these vulnerable children, all of whom had experienced at least one previous move. Those who had been through a hospital detoxification were arguably most in need of a peaceful time; some still had difficulties sleeping and feeding and were physically jittery. Theme 5 Disruptive frequency of contact: journeys and scheduling could actively disrupt routines – getting up, feeding, bathing, and so on. Furthermore, it meant there was little time just to 'be', as is possible for most infants. some comments on how attending contact sessions three or more times a week made it difficult to access the community resources to which most new mothers turn, for example, mother and toddler groups or health visitor sessions at local health clinics. Theme 6 Length of time taken on journeys to contact visits: All the CP carers had to live within a 20-mile radius of Coram, later within the boundary of the M25. For some, this could entail a journey of up to two hours by car or public transport.

Theme 7
Importance of knowing birth parents for children's identity needs: the CP carers who had the most contact with birth parents seemed to value the relationship most. All felt they would be able to tell the children about the 'real' parents, not ones just described in social work files as interpreted by local authority social workers, who might not themselves have known the people involved. one of the real benefits emerging from concurrent planning: it enables CP carers to give their children a truthful, balanced account of their birth parents as they grow older, incorporating both positives and negatives in age appropriate ways.

Theme 8
Concern for the birth parents: As well as respecting them, many CP carers expressed concern for the ordeal to which continuing contact exposed the birth parents. Vince thought it cruel for the birth mother when contact was prolonged for 12 months, just as it was for his wife, both being left on what he called a 'rollercoaster of uncertainty'. Many expressed sadness for the plight of birth parents, especially those struggling with drug problems.

Theme 9
Importance of contact supervisor: e.g. during concern about contact with dysfunctional birth families

Theme 10
Implications for matching and placement if CP carers voice their concerns: A few CP carers were reluctant to venture their criticisms of the process as they were aware of being continually assessed themselves and feared that if they 'failed' in any way, they could lose the child to whom they had become attached. several CP carers felt they had to be careful not to expose too many of their difficulties for fear of being regarded as unsuitable carers, demonstrating the continual effect of the anxiety created by the uncertainties intrinsic to concurrent planning.

Theme 11
Not getting to know the birth parents: For the four families where there had been no contact with birth parents, there was a feeling of disappointment after the build-up from the preparatory training groups, together with loss and regret that they could not talk later to the children about parents who were real to them. They felt this would be a lost opportunity for the children. Admittedly, they could see how they had gained from the quiet time they had had to get to know the children without the disruption of the contact visits.

Theme 12
Reliance on foster parents: parents relied on information provided by the foster carers, several of whom had met the birth parents and had photos of them that would be passed onto the children. Because the foster carers held information about the birth parents, some CP carers maintained contact with them and hoped that they would be the ones able to talk to the children later about their families of origin.

Theme 13
Avoiding problematic continuing direct contact and letter box contact: one couple were clear that direct contact would only continue while it was in the child's best interest. Letterbox contacts can be problematic, but most are directed through Coram, which can filter or encourage rewriting if the contents are inappropriate or disturbing either to child, CP carers or birth parents. This degree of care, not always taken by other organisations, is enormously helpful to all concerned. Indeed, many of the birth parents regularly seek advice from Coram when writing their annual letter to the adoptive parents of their child.

Theme 14
Concerns about contact with extended family: Some CP carers had concerns about these wider contacts when the relatives were themselves in touch with the birth parents. Direct contact does need to be safe for all concerned.

Theme 15

	Involvement of CP families extended family: Where extended family and friends were involved from the start – for example, the father of CP carer Bella collected the child from contact sessions when Bella had to work – the family relationships became and remained strong. Some CP carers commented on how the children now adopted were accepted and on a par with biological grandchildren – as one would hope. Theme 16 Extra support from Coram Social Workers: Most parents valued the support from their Coram social workers and from being a continuing part of the Coram 'family', as experienced in outings such as summer picnics. The Coram social worker was usually available to discuss any anxieties or to accompany the CP carer if contact sessions were difficult or in a different setting. Theme 17 Undersupport from local authority workers: If at times some CP carers found it difficult to request as much support from Coram as they felt they needed, more were openly critical about the local authority social workers. The majority of these criticisms centred on chaos as they experienced it within the local authority departments, leading to delays in placement and in preparation for court hearings. Where some birth parents presented difficulties, e.g. with aggression, they felt the local authority workers backed off, leaving the carers exposed. Several wondered if the needs of birth parents were being put before those of the child by professionals involved with the process. Theme 18 Helpfulness of children's guardians appointed by the courts: Parents had equally differing views of the helpfulness or otherwise of children's guardians appointed by the courts for the child. One had recommended trial rehabilitation rather late in the process, which had profoundly upset the CP carers. Others had intervened helpfully when there had been difficulties during contact with birth parents, in one case recommending the termination of contact. Theme 19 Changes late in the concurrent planning process being especially unsettling: an event that was unsettling for CP carers was when consideration was given to members of the extended birth family to become adopters well into the concurrent planning process. On the other hand, placements could be delayed if such consideration took place before the placement. Similar crises of uncertainty arose when court hearings for care orders or adoption were contested by birth parents.

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?	No *(researchers do not justify the research design or how they decided which method to use)*

	Recruitment Strategy	Was the recruitment strategy appropriate to the aims of the research?	Can't tell *(Researchers were not clear about how participants were selected, why those particular participants were selected. There were no discussions around recruitment.)*
	Data collection	Was the data collected in a way that addressed the research issue?	Can't tell *(Researchers did not justify the setting for data collection; were not explicit in how interviews were carried out; were not clear about the form the data took; there was no discussion of data saturation)*
	Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	Can't tell *(There was no critical examination of the researchers own role, potential bias, or influence)*
	Ethical Issues	Have ethical issues been taken into consideration?	Can't tell *(No discussion of ethics was included)*
	Data analysis	Was the data analysis sufficiently rigorous?	Can't tell *(unclear how thematic analysis was performed and how many researchers were involved. Unclear if researchers took into account contradictory findings; unclear 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?	Can't tell *(evidence for and against researchers' arguments are not discussed; or the credibility of findings (e.g. triangulation, respondent validation, more than one analyst))*

	Research value	How valuable is the research?	The research has some value *(There is no in-depth discussion of how research contributes to current understanding and literature; or new areas where new research was necessary)*
	Overall risk of bias and directness	Overall risk of bias	High
		Directness	Directly applicable

Kirton 2011

Bibliographic Reference	KIRTON Derek; THOMAS Cliff; A suitable case? Implementing multidimensional treatment foster care in an English local authority; Adoption and Fostering; 2011; vol. 35 (no. 2); 5-17

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 RQ1 RQ2 RQ3 RQ4 Evaluation of an intervention Multidimensional Treatment Foster Care
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 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.

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?	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)*

	Data collection	Was the data collected in a way that addressed the research issue?	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.)*
	Researcher and participant relationship	Has the relationship between researcher and participants been adequately considered?	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)*
	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

Study Characteristics

Study type	Interviews (unclear)
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
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)*

Section	Question	Answer
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)*

Appendix E – Forest plots

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

Appendix F – GRADE tables and CERQual tables

GRADE tables

Parent Management Training Oregon (PMTO) model vs CAU

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
Physical permanency at 12 months: legal discharge from foster care to a parent, as assessed by administrative data from the Child Welfare Agency.								
1 (Akin 2018a, 2018b)	RCT	918	ITT: HR 1.16 (0.98, 1.37)[4] Intervention completers only: HR 1.32 (1.09, 1.60)[5]	Very Serious[1]	N/A	Serious[2]	Serious[3]	Very low

1. Study was at high risk of bias
2. Study was only partially applicable to the review question
3. 95% CIs crossed the line of no effect
4. Intention to treat analysis
5. Controlled to only include those participants in the intervention arm who completed the training.

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
Positive exit over 5-year observation period: reunification, adoption, legal guardianship, kin-GAP/relative placement or family stabilized as evidenced by change in court status and the case being closed with the child welfare system								

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
1 (Berzin 2008)	RCT	50	OR 1.19 (0.35, 4.02)	Very Serious[1]	N/A	Serious[2]	Very Serious[3]	Very low

1. Study was at high risk of bias
2. Study was only partially applicable to the review question
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)

Engaging Moms Program (EMP) vs Family Drug Court (Intensive Case Management Services (ICMS))

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
Terminated parental rights (child placed in foster care or placed with relatives): assessed using court records								
1 (Dakof 2010)	RCT	61	OR 0.35 [0.12, 1.06]	Not Serious	N/A	Serious[1]	Serious[2]	Low
No terminated parental rights (child placed with relatives): assessed using court records								
1 (Dakof 2010)	RCT	61	OR 2.24 [0.51, 9.91]	Not Serious	N/A	Serious[1]	Very Serious[3]	Very low
Joint or sole custody: assessed using court records								

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
1 (Dakof 2010)	RCT	61	OR 1.68 [0.62, 4.59]	Not Serious	N/A	Serious[1]	Very Serious[3]	Very low

1. Study was based in the USA
2. Downgrade one level for serious imprecision since confidence intervals crossed one line of MID (defined as OR 0.8 and 1.25)
3. Downgrade two levels for very serious imprecision since confidence intervals crossed two lines of MID (defined as OR 0.8 and 1.25)

Family Drug and Alcohol Court vs Ordinary Care Proceedings

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
Proportion of families who were reunited and continued to live together at the end of proceedings: assessed retrospectively using Cafcass national electronic case records								
1 (Harwin 2018)	NRCT	240	**OR 1.77 (1.00 to 3.13)[1]**	Very Serious[2]	N/A	Not Serious	Serious[3]	Very low
Durability of reunification: the number of reunification mothers experiencing no disruption to family stability at 3 years follow up: defined as no relapse, no placement change, and no return to court as a single composite measure – assessed retrospectively using Cafcass national electronic case records								
1 (Harwin 2018)	NRCT	66	**OR 3.40 [1.07, 10.84] [1]**	Very Serious[2]	N/A	Not Serious	Serious[3]	Very low
Durability of reunification: the number of reunification children experiencing no disruption to family stability at 3 years follow up: defined as combination of no permanent placement change, no subsequent neglect, and no return to court for new proceedings in three years follow up after proceedings ended - assessed retrospectively using Cafcass national electronic case records								

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
1 (Harwin 2018)	NRCT	94	OR 2.07 [0.87, 4.91] [1]	Very Serious[2]	N/A	Not Serious	Serious[3]	Very low
Number of children reunified starting new proceedings due to actual or likely significant harm at 3-years follow up - assessed retrospectively using Cafcass national electronic case records								
1 (Harwin 2018)	NRCT	113	**OR 0.42 [0.19, 0.92]** [1]	Very Serious[2]	N/A	Not Serious	Serious[3]	Very low

1. Effect sizes were calculated using the number included in the analysis and the percentages reported by authors
2. Downgrade two levels for high risk of bias: Although there were many similarities between the comparison cohorts, several points were important. Mothers in the FDAC group were those who had accepted the intervention, while it was unclear if the comparison mothers would have accepted the intervention. This could be a very important difference since the willingness to take part in the intervention may be strongly related to the success of reunification. In addition there were differences between the groups for ethnicity, cases involving the likelihood of harm, babies born withdrawing from drugs, and the higher proportion of FDAC local authorities plans for placement with family and friends while comparison authorities had a higher proportion of placements with foster carers. The study also did not report the differences between groups for the gender of the children. While it is unclear how participants or providers of the intervention may have deviated from best practice, data is real world and therefore gives an indication of how the intervention would be performed in practice. The number of participants included in analysis varied significantly by outcome. At times this may be for good reason (e.g. a sub-analysis of reunified mothers) at other times it was unclear how much data was missing and for what reason. Data were taken from different local authorities which may have defined their outcomes differently. No blinding was performed, therefore judges and outcome assessors would likely have been aware of the interventions taken. The study used composite outcomes and only reported significant results (for data that was usable for the purposes of this review).
3. Downgrade one level for serious imprecision since confidence intervals crossed one line of MID (defined as OR 0.8 and 1.25)

Pathways home intervention vs Services as usual

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
Terminated parental rights at 18 months follow-up and placed in foster care or relative care: assessed using court records								
1 (DeGarmo 2013)	RCT	61	OR 0.35 [0.12, 1.06]	Not Serious	N/A	Serious[1]	Serious[2]	Low
No termination of parental rights, but placed with relatives at 18 months follow-up: assessed using court records								
1 (DeGarmo 2013)	RCT	61	OR 2.24 [0.51, 9.91]	Not Serious	N/A	Serious[1]	Very Serious[3]	Very low
Sole or joint custody at 18 months follow-up: assessed using court records								
1 (DeGarmo 2013)	RCT	61	OR 1.68 [0.62, 4.59]	Not Serious	N/A	Serious[1]	Very Serious[3]	Very low

1. Study was based in the USA
2. 95% CIs crosses one lines of the MID (OR 0.8, 1.25)
3. 95% CIs crossed two lines of the MID (OR 0.8, 1.25)

Parent for every child intervention vs Services as usual

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
Finalized permanency: adoption, legal guardianship or relational permanency (written contract between youth and a caring adult, known as either a permanency pact or a commitment contract)								
1 (Feldman 2016)[1]	RCT	177	OR 5.92 (1.71, 20.48)[2]	Very Serious[3]	N/A	Serious[4]	Not serious	Very low
Finalized permanency: adoption or legal guardianship								
1 (Feldman 2016)[1]	RCT	177	OR 1.45 (0.44, 4.76)[2]	Very Serious[3]	N/A	Serious[4]	Very serious[6]	Very low
Finalized relational permanency (written contract between youth and a caring adult, known as either a permanency pact or a commitment contract)								
1 (Feldman 2016)[1]	RCT	177	OR 26.56 (1.54, 458.13)[2]	Very Serious[3]	N/A	Serious[4]	Not serious	Very low
Pending permanency: adoption, legal guardianship or alternative permanency								
1 (Feldman 2016)[1]	RCT	177	OR 7.60 (0.92, 63.16)	Very Serious[3]	N/A	Serious[4]	Serious[5]	Very low

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

1. Participants were followed until they exited care or until end of data collection. Unclear average length of follow-up
2. Adjusted for recruitment cohort, custody type (DJJ versus child welfare), youth (aged >18 versus <15) and youth freed for adoption >15 years versus <10 years. Difference was still significant when uncontrolled.
3. Study was at high risk of bias
4. Study was only partially applicable to the review question
5. 95% CIs crosses one line of the MID (0.8, 1.25)
6. 95% CIs crosses both lines of the MID (0.8, 1.25)

Early intervention foster care vs Services as usual

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
Physical permanency within 2 years: reunification with biological parents or adoption (relative or non-relative) as determined by court records								
1 (Fisher 2005)	RCT	90	OR 1.16 (0.50, 2.70)	Serious[4]	N/A	Serious[1]	Very serious[2]	Very low
Breakdown of permanent placement during 2-year follow-up								
1 (Fisher 2005)	RCT	54	OR 0.21 (0.05, 0.87)	Serious[4]	N/A	Serious[1]	Serious[3]	Low

1. Study was only partially applicable to the review question
2. 95% CIs crosses two lines of the MID (0.8, 1.25)

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
3. 95% CIs crosses one line of the MID (0.8, 1.25) 4. Study was at moderate risk of bias								

Family Finding Intervention (FFI) vs CAU

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
Relational permanency: continued contact and emotional support from at least one adult, assessed using case records and administrative data								
1 (Landsman 2014/Boel-studt 2017)	RCT	243	OR 2.47 (1.39, 4.38)	Serious[1]	N/A	Serious[2]	Not Serious	Low
Physical permanency: Reunification with parents, relative adoption or non-relative adoption								
1 (Landsman 2014/Boel-studt 2017)	RCT	243	OR 1.11 (0.67, 1.85)	Serious[1]	N/A	Serious[2]	Very serious[3]	Very low
Physical permanency: Reunification with parents								
1 (Landsman 2014/Boel-studt 2017)	RCT	243	OR 0.82 (0.48, 1.41)	Serious[1]	N/A	Serious[2]	Very serious[3]	Very low

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
Physical permanency: Relative adoption								
1 (Landsman 2014/Boel-studt 2017)	RCT	243	OR 8.51 (1.91, 37.89)	Serious[1]	N/A	Serious[2]	Not Serious	Low
Physical permanency: Non-relative adoption								
1 (Landsman 2014/Boel-studt 2017)	RCT	243	OR 0.68 (0.33, 1.37)	Serious[1]	N/A	Serious[2]	Very serious[3]	Very low

1. Study was at moderate risk of bias.
2. Study was only partially applicable to the review question.
3. 95% CIs cross both lines of the MID (0.8, 1.25)

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)	RCT	210	OR 1.19 (0.63 to 2.27)[1]	Very Serious[2]	N/A	Serious[3]	Very Serious[4]	Very low
Permanency at 2 years: assessed using child welfare administrative database (Stability plus legal discharge to study caregiver in the form of reunification with birth parent, adoption by study kin or non-kin caregiver, or legal guardianship by kin caregiver)								
1 (Pasalich 2016/Spieker 2014)	RCT	210	OR 1.72 (0.73 to 4.04)[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. Odds ratio and 95% CIs taken directly from study.
2. Study was at high risk of bias.
3. Study was only partially applicable to the review question.
4. 95% CIs crossed both lines of the MID (0.8, 1.25).

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
Positive exits from care over 6.5 months: foster-parent reported positive reasons for the child's exit from the foster/kinship programme e.g. reunification or adoption								
1 (Price 2008)	RCT	700	OR 2.09 (1.32, 3.31)[1]	Very Serious[2]	N/A	Serious[3]	Not serious	Very low
Negative exits from care over 6.5 months: foster-parent reported negative reasons for the child's exit from the foster/kinship programme e.g. moved to another foster placement, a more restrictive placement, or child runaways								
1 (Price 2008)	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)	RCT	700	OR 0.73 (0.52 to 1.03)[1]	Very Serious[2]	N/A	Serious[3]	Serious[5]	Very low

1. Odds ratios were estimated from reported percentages for these outcomes (unclear amount of missing data)
2. Study was at high risk of bias
3. Study was only partially applicable to the review question
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)

Cognitive and educational interventions (participants were randomized to cognitive or educational interventions however results are pooled) vs Services as usual

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
Strengths and difficulties questionnaire immediately following the intervention: Self-report by adopters (MD <0 favours intervention)								
1 (Rushton 2010)	RCT	37	MD 2.13 (-1.45, 5.72)[1]	Very serious[2]	N/A	Not serious	NE[3]	Very low
Strengths and difficulties questionnaire 6 months post intervention: Self-report by adopters (MD <0 favours intervention)								
1 (Rushton 2010)	RCT	37	MD 0.79 (-2.85, 4.45)[1]	Very serious[2]	N/A	Not serious	NE[3]	Very low
Expression of feelings immediately following intervention: Self-report by adopter (MD >0 favours intervention)								
1 (Rushton 2010)	RCT	37	MD 10.4 (-2.5, 23.4)[1]	Very serious[2]	N/A	Not serious	NE[3]	Very low
Expression of feelings 6 months post-intervention: Self-report by adopters (MD >0 favours intervention)								
1 (Rushton 2010)	RCT	37	MD 6.18 (-4.8, 17.2)[1]	Very serious[2]	N/A	Not serious	NE[3]	Very low
Post-placements problems immediately following intervention: Self-report by adopters (MD <0 favours intervention)								

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
1 (Rushton 2010)	RCT	37	MD -0.08 (-3.0, 3.25)[1]	Very serious[2]	N/A	Not serious	NE[3]	Very low
Post-placement problems 6 months post-intervention: Self-report by adopters (MD <0 favours intervention)								
1 (Rushton 2010)	RCT	37	MD 0.91 (-3.99, 2.17)[1]	Very serious[2]	N/A	Not serious	NE[3]	Very low
Frequency of daily hassles immediately following intervention: Self-report by adopters (MD <0 favours intervention)								
1 (Rushton 2010)	RCT	37	MD -1.81 (-6.19, 2.55)[1]	Very serious[2]	N/A	Not serious	NE[3]	Very low
Frequency of daily hassles 6 months post-intervention: Self-report by adopters (MD <0 favours intervention)								
1 (Rushton 2010)	RCT	37	MD 0.91 (-3.5, 5.4)[1]	Very serious[2]	N/A	Not serious	NE[3]	Very low
Intensity of daily hassles immediately following intervention: Self-report by adopters (MD <0 favours intervention)								
1 (Rushton 2010)	RCT	37	MD -7.01 (-15.19, 1.16)[1]	Very serious[2]	N/A	Not serious	NE[3]	Very low
Intensity of daily hassles 6 months post-intervention: Self-report by adopters (MD <0 favours intervention)								

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
1 (Rushton 2010)	RCT	37	MD -1.78 (-8.34, 4.7)[1]	Very serious[2]	N/A	Not serious	NE[3]	Very low

1. Adjusted for baseline measurements for the outcome (linear regression).
2. Study was only partially applicable to the review question
3. Assessment of precision was not possible as the study reported mean differences and confidence intervals but did not provide raw data (or standard deviations). The quality was downgrade two levels because of this. P values were provided and the differences were non-significant.

Intensive case management model vs Services as usual

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
Accessed substance abuse services: assessed using administrative data								
1 (Ryan 2006)	RCT	331	OR 1.78 (0.98, 3.25)	Serious[1]	N/A	Serious[2]	Serious[3]	Very low
Re-entered foster care by 12 months follow-up: assessed using administrative data								
1 (Ryan 2006)	RCT	331	OR 1.70 (0.68, 4.26)	Serious[1]	N/A	Serious[2]	Very serious[4]	Very low

1. Study was at moderate risk of bias
2. Study was only partially applicable to the review question

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
3. 95% CIs crosses one line of the MID (0.8, 1.25) 4. 95% CIs crosses two lines of the MID (0.8, 1.25)								

Wendy's Wonderful Kids vs usual adoption recruitment services

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
Unadjusted odds of adoption in experimental group: children were categorized as having been adopted if the child had been discharged from foster care and the reason for discharge was indicated to be adoption, or if the child had a valid adoption finalization date in the Statewide Automated Child Welfare Information System data								
1 (Vandivere 2015)	RCT	956	OR 1.77 p <0.01	Very Serious[1]	N/A	Serious[2]	NE[3]	Very low
Odds of adoption in experimental group: children were categorized as having been adopted if the child had been discharged from foster care and the reason for discharge was indicated to be adoption, or if the child had a valid adoption finalization date in the Statewide Automated Child Welfare Information System data								
1 (Vandivere 2015)	RCT	956	OR 1.81 p<0.01[4]	Very Serious[1]	N/A	Serious[2]	NE[3]	Very low

1. Study was downgraded two levels for very serious risk of bias: due to problems with randomisation, allocation concealment, and significant amounts of missing data following randomisation.
2. Study was based in the USA
3. Downgraded twice as imprecision was not estimable
4. Adjusted for the correlation in adoption rates within recruiters, agencies, and jurisdictions, age, race, and diagnosed disability.

Recovery coach vs Services as usual

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
Physical permanency: reunification with biological parents within 3-year follow-up period								
1 (Ryan 2016)	RCT	1623	**OR 1.32 (1.04, 1.67)**	Not serious	N/A	Serious[1]	Serious[2]	Low
Stable physical permanency: reunification with biological parents within 3-year follow-up period (and did not return to care within 12 months of reunification)								
1 (Ryan 2016)	RCT	1623	**OR 1.47 (1.12, 1.91)**	Not serious	N/A	Serious[1]	Serious[2]	Low

1. Study was only partially applicable to the review question
2. 95% CIs crosses one line of the MID (0.8, 1.25)

Charleston collaborative project vs Services as usual

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
Permanency at 3-months: reunified with original parent(s) or caregiver(s)								
1 (Swenson 2000)	RCT	71	OR 0.75 (0.23, 2.38)	Very serious[1]	N/A	Serious[2]	Very serious[3]	Very low

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
Permanency at 3-months: reunified with original parent(s) or caregiver(s), relative or family friend								
1 (Swenson 2000)	RCT	71	OR 0.70 (0.25, 1.92)	Very serious[1]	N/A	Serious[2]	Very serious[3]	Very low
Permanency at 3-months post-intervention: reunified with original parent(s) or caregiver(s), relative or family friend								
1 (Swenson 2000)	RCT	69	OR 0.76 (0.28, 2.09)[4]	Very serious[1]	N/A	Serious[2]	Very serious[3]	Very low
Incidence of abuse at 3-months post-intervention: assessed by caseworker								
1 (Swenson 2000)	RCT	71	OR 0.15 (0.01, 3.95)	Very serious[1]	N/A	Very serious[5]	Very serious[3]	Very low

1. Study was at high risk of bias
2. Study was only partially applicable to the review question
3. 95% CIs crosses two lines of the MID (0.8, 1.25)
4. Two participants removed consent and were not included in the analysis reported in the paper, these participants are included in this analysis as the paper reports that at the 3 month follow-up, only one additional participant was
5. Study was only partially applicable to the review question. In addition, for this outcome it is unclear whether the sample includes only those participants who achieved permanency or the entire sample (including those remaining in foster care).

Family finding specialist vs Services as usual

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
Positive foster care placement change compared to baseline: assessed in terms of restrictiveness using administrative data at 1-4 years (depending on time of enrolment) (see Appendix D for further information on how this outcome was score)								
1 (Vandivere 2017)	RCT	517	OR: 1.00[1] β (SE): 0.00 (SE 0.29)[1]	Not serious	N/A	Serious[2]	NE[3]	Very Low
Negative foster care placement change compared to baseline: assessed using administrative data at 1-4 years (depending on time of enrolment) (see Appendix D for further information on how this outcome was score)								
1 (Vandivere 2017)	RCT	517	OR: 1.26[1] β (SE): 0.23 (SE 0.27)[1]	Not serious	N/A	Serious[2]	NE[3]	Very Low
Permanency (Reunification with biological parents, adoption or guardianship): assessed using administrative data at 1-4 years (depending on time of enrolment)								
1 (Vandivere 2017)	RCT	564	OR: 0.88[1] β (SE): -0.13 (SE 0.25)[1]	Not serious	N/A	Serious[2]	NE[3]	Very Low
Permanency (Reunification with biological parents): assessed using administrative data at 1-4 years (depending on time of enrolment)								

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
1 (Vandivere 2017)	RCT	548	OR: 0.98[1] β (SE): -0.02 (SE 0.39)[1]	Not serious	N/A	Serious[2]	NE[3]	Very Low
Discharged from foster care: assessed using administrative data at 1-4 years (depending on time of enrolment)								
1 (Vandivere 2017)	RCT	548	OR: 1.08[1] β (SE): 0.08 (SE 0.29)[1]	Not serious	N/A	Serious[2]	NE[3]	Very Low
Re-allegation of abuse or neglect: assessed using administrative data at 1-4 years (depending on time of enrolment)								
1 (Vandivere 2017)	RCT	542	OR: 0.90[1] β (SE): -0.10 (SE 0.26)[1]	Not serious	N/A	Serious[2]	NE[3]	Very Low
Substantiated claim of re-allegation of abuse or neglect: assessed using administrative data at 1-4 years (depending on time of enrolment)								
1 (Vandivere 2017)	RCT	537	OR: 0.36[4] β (SE): -1.01 (SE 0.50)[4]	Not serious	N/A	Serious[2]	NE[3]	Very Low

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
Discharged from foster care to a relative: assessed using administrative data at 1-4 years (depending on time of enrolment)								
1 (Vandivere 2017)	RCT	558	OR: 0.91[1] β (SE): -0.10 (SE 0.32)[1]	Not serious	N/A	Serious[2]	NE[3]	Very Low
Re-entry into care (among those discharged during study period): assessed using administrative data at 1-4 years (depending on time of enrolment)								
1 (Vandivere 2017)	RCT	349	OR: 1.00[1] β (SE): 0.00 (SE 0.29)[1]	Not serious	N/A	Serious[2]	NE[3]	Very Low

1. Taken directly from the study, no significant difference between groups reported.
2. Study was only partially applicable to the review question
3. Study only reported odds ratio (without confidence intervals), beta coefficient and standard error. It was not possible to assess imprecision using this. Imprecision was downgraded two levels due to this. The study reported when a comparison was significant (P<.10, .05 and .01).
4. Taken directly from the study, there were significantly fewer (P<.05) instances of substantiated re-allegation of abuse or neglect in the treatment arm.

Intensive fostering vs Standard judicial proceedings

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
Reconvicted at time 1 (year following entry to intervention compared to year following release from custodial sentence): Assessed using administrative data.								
1 (Biehal 2011)	Quasi-experimental	47	OR 0.21 (0.06, 0.75)	Serious[1]	N/A	Not serious	Not serious	Very low[2]
Reconvicted at time 2 (year following exit from intervention compared to year following release from custodial sentence): Assessed using administrative data.								
1 (Biehal 2011)	Quasi-experimental	47	OR 0.94 (0.25, 3.51)	Serious[1]	N/A	Not serious	Very serious[3]	Very low[2]
Re-entered custody at time 1 (year following entry to intervention compared to year following release from custodial sentence): Assessed using administrative data.								
1 (Biehal 2011)	Quasi-experimental	47	OR 0.28 (0,08, 0.99)	Serious[1]	N/A	Not serious	Serious[4]	Very low[2]
Re-entered custody at time 2 (year following exit from intervention compared to year following release from custodial sentence): Assessed using administrative data.								
1 (Biehal 2011)	Quasi-experimental	47	OR 0.64 (0.20, 2.05)	Serious[1]	N/A	Not serious	Very serious[3]	Very low[2]

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
Living with parent or relative at time 1 (year following entry to intervention compared to year following release from custodial sentence): Assessed by self-report								
1 (Biehal 2011)	Quasi-experimental	43[5]	OR 3.16 (0.95, 10.54)	Serious[1]	N/A	Not serious	Serious[4]	Very low

1. Study was at moderate risk of bias.
2. Quality assessment began at Low as the study was not an RCT.
3. 95% CIs crossed both lines of the MID (0.80, 1.25).
4. 95% CIs crossed one line of the MID (0.80, 1.25).
5. Study notes that data for 4 participants were not available for this outcome. It is unclear which groups these pertain to. ITT group numbers were used for analysis. Additionally, as 9 participants in the control group had re-entered custody at this follow-up point, it is unclear whether these participants would otherwise be living with parents.

On The Way Home vs Services as Usual

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
Not maintaining placement in school: defined as not maintaining enrolment in the community school setting at 1 year follow up								
1 (Trout 2013)	RCT	87	OR 0.30 (0.12 to 0.75)	Serious[1]	N/A	Serious[2]	Not serious	Low
Re-entry into foster care at 1 year follow up								

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
1 (Trout 2013)	RCT	87	OR 0.18 (0.05 to 0.65)	Serious[1]	N/A	Serious[2]	Not serious	Low
Family-reported home stability at 12 months: measured using School & Home Placement Change Questionnaire								
1 (Trout 2019)	RCT	196	OR 1.00 P value 0.99	Very Serious[3]	N/A	Serious[2]	NE[4]	Very Low
Family-reported home stability at 21 months: measured using School & Home Placement Change Questionnaire								
1 (Trout 2019)	RCT	196	**OR 3.05 P-value 0.03**	Very Serious[3]	N/A	Serious[2]	NE[4]	Very Low
School-reported school stability at 12 months: measured using School & Home Placement Change Questionnaire								
1 (Trout 2019)	RCT	196	OR 0.94 P value 0.86	Very Serious[3]	N/A	Serious[2]	NE[4]	Very Low
School-reported school stability at 21 months follow up: measured using School & Home Placement Change Questionnaire								
1 (Trout 2019)	RCT	196	OR 2.02 P-value 0.14	Very Serious[3]	N/A	Serious[2]	NE[4]	Very Low

1. Study was at moderate risk of bias: Randomization process was unclear. Although the author notes that there are no significant differences in baseline characteristics between groups, these are not reported, and it is unclear which characteristics were compared. As not all participants will be returning to their parent's home it is important that differences between the groups for this variable are compared

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

2. Marked down once for indirectness as study was from the USA
3. Study was marked down twice for high risk of bias: Process of randomisation unclear, unclear if allocation concealment. Unclear approach to missing data and loss to follow up. Unclear if intent to treat analysis used. Unclear if deviations between comparison groups. the overall attrition rates for the three analytic samples (i.e., posttest caregiver outcomes, posttest school and community placement outcomes, and follow-up school and community placement outcomes) were 31.55% (n = 59), 17.11% (n = 32), and 29.41% (n = 55), respectively. Missing data was substantial and could be related to placement stability. Non-UK based study. In addition, it was unclear if participants were "true" in care subjects i.e. under the principle care of the child welfare system.
4. Study was downgraded twice as imprecision was not estimable

Fostering Healthy Futures (FHF) vs CAU

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
Whether a child had attained permanency by 1 year post intervention: assessed using administrative records (case closure)								
1 (Taussig 2012)	Randomised Controlled Trial	110	OR 1.67 (95%CI 0.78 to 3.54)	Serious[1]	N/A	Serious[2]	Very Serious[3]	Very low
Association between being in the intervention group and permanency: assessed using administrative records (case closure)								
1 (Taussig 2012)	Randomised Controlled Trial	110	OR 1.81 (95%CI 0.77 to 4.22)[4]	Serious[1]	N/A	Serious[2]	Very Serious[3]	Very low

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

1. 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.
2. Downgrade 1 level for serious indirectness since study was based in USA
3. Downgrade 2 levels for very serious imprecision since estimate of effect crossed 2 lines of MID (defined as OR 0.80 and OR 1.25)
4. Adjusted for 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

Concurrent planning vs Standard Adoption and permanency agencies

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
Children experiencing only one move before permanent setting or final interview (the two control groups were combined for this outcome)								
1 (Monck 2004)	Quasi-experimental	68	OR 7.14 (1.93, 26.46)	Very serious[1,3]	N/A	Not serious	Not serious	Very low[2]
Mean number of months spent in impermanent care (control group 1 only: Manchester Adoption Society)								
1 (Monck 2004)	Quasi-experimental	47	MD -11.76 (-8.89, -14.63)	Very serious[1,3]	N/A	Not serious	Not serious	Very low[2]

No. of studies	Study design	Sample size	Effect size (95% CI)	Risk of bias	Inconsistency	Indirectness	Imprecision	Quality
Mean number of months spent in impermanent care (control group 2 only: Trafford Adoption and Permanency Team)								
1 (Monck 2004)	Quasi-experimental	45	MD -9.32 (-7.06, -11.58)	Very serious[1,3]	N/A	Not serious	Not serious	Very low[2]

5. Study was at high risk of bias.
6. Quality assessment began at Low as the study was not an RCT.
7. Study notes that only 4 participants did not achieve permanency by end of data collection (it is unclear which group these belong to).

CERQual tables

Experience of practitioners delivering Parent Management Training Oregon (PMTO)

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
Training of practitioners						
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

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
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 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.	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
Facilitators to learning PMTO – some participants were highly committed to	1	**No concerns**	**No concerns**	**Serious concerns**	**Minor concerns**	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
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.				Only 1 study contributed to this theme.	Study was from outside of the UK	
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. 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.	1	**No concerns**	**Minor concerns** Theme covered several different ways in which PMTO training had improved the practice of the practitioners.	**Serious concerns** Only 1 study contributed to this theme.	**Minor concerns** Study was from outside of the UK	Very Low
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	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
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.						
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 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.	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
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	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
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.						
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, 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	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
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
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	1	**No concerns**	**Minor concerns** Theme covered several different organisational barriers to 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
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 accommodating climate and improved the implementation.			effectiveness of PMTO			

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
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	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
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.						

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	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
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.						
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	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
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.						
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	1	**Minor concerns** Unclear why the participants selected were the most appropriate to provide access to the type of	**Minor concerns** Theme covered several aspects of practically encouraging the youth voice. Unclear the number of	**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
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. 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.		knowledge sought by the study. All were over the age of 18 yet family group conferences occur at younger ages.	participants who agreed with each of these aspects.			
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	1	**Minor concerns** Unclear why the participants selected	**No concerns**	**Serious concerns**	**Minor concerns** Study was from the USA	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
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.		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.		Only 1 study contributed to this theme.		
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	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
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.						
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. 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	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
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	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
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 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	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
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
1. **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.	1	**No concerns**	**No concerns**	**Serious concerns** Only one study contributed to this theme	**Minor concerns** Study took place in the USA	Very Low
2. **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	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.	**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
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.			Therefore, it was unclear what exactly leads to this feeling of being rushed.			
3. **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	1	**No concerns**	**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.	**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
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 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.						
4. **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	1	**No concerns**	**No concerns**	**Serious concerns** Only one study	**Minor concerns** Study took place in the USA	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
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.				contributed to this theme		
5. **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
6. **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 help identify possible local providers. TFC parents reported few difficulties in logistics regarding	1	**No concerns**	**No concerns**	**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
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.						
7. **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.	1	**No concerns**	**Minor concerns** Several distinct aspects of the support that foster carers found to be helpful was outlined here.	**Serious concerns** Only one study contributed to this theme	**Minor concerns** Study took place in the USA	Very Low
8. **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	1	**No concerns**	**No concerns**	**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
youth similarly to how she treated her biological children as a “mainstreaming” process.						
9. **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.	1	**No concerns**	**Minor concerns** Several aspects that could lead to placement breakdown were described here. Some of which may require very different responses.	**Serious concerns** Only one study contributed to this theme	**Minor concerns** Study took place in the USA	Very Low
10. **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
11. **Creating relationships with birth families.** The Circle Program was felt to be more likely to	1	**Serious concerns**	**No concerns**	**Serious concerns**	**Minor concerns**	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
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.		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.	However, participation of birth families could be encouraged in one of several ways.	Only one study contributed to this theme.	Study took place in Australia	
12. **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.	**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

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
		Thematic analysis process was not described explicitly.				
13. **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
14. **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',	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	**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
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'!		appropriate or why some chose not to take part. Focus group methods were not made explicit. Thematic analysis process was not described explicitly.				
15. **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
16. **Training essential particularly in trauma theory, attachment and self-knowledge.** Contents of training - Training in trauma theory, attachment and selfknowledge were also	1	**Serious concerns** Qualitative methods were not appropriate to evaluate effectiveness of the intervention in terms	**No concerns**	**Serious concerns** Only one study	**Minor concerns** Study took place in Australia	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
identified as essential components by foster carers and foster care workers alike.		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.		contributed to this theme.		
17. **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	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
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.						
18. **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
19. **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	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	**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
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 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.		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.				
20. **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

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
21. **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
22. **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
23. **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	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
concluded that the family consultant role would be eliminated going forward and that needed family work would be conducted by the program supervisor.						
24. **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 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	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
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 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
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	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	**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
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.		apparent triangulation, respondent validation, or 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	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
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: "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,	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** 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	**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
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 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.		the use of more than one analyst.	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: "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	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	**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
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)"		apparent 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: "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	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
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)"						
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
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	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
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.						
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)"	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
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)	1	**Serious concerns** Unclear how participants were recruited and selected. No in-depth description of the analysis	**No concerns** However, this theme offered no suggestions as to	**Serious concerns** Only one study	**Minor concerns** Data was likely collected prior to 2010	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
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)"		process. Unclear if sufficient data presented to support the findings. No apparent triangulation, respondent validation, or the use of more than one analyst.	how matching could be improved	contributed to this theme		
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 (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.	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
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 capacity to ease pressures at times of difficulty was valued by carers.	1	**Serious concerns** Unclear how participants were recruited and selected. No in-depth description of the analysis process. Unclear if	**Minor concerns** It is unclear what was meant by "issues of co-ordination"	**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
		sufficient data presented to support the findings. No apparent triangulation, respondent validation, or the use of more than one analyst.				
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	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
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.'						
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	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	**Minor Concerns** Theme encompassed several aspects of difficulty in working with Children's Social Workers. Both in relinquishing control	**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
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: "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		apparent triangulation, respondent validation, or the use of more than one analyst.	and stepping back too much.			

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
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 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.	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

Experience of carers undertaking Concurrent Planning

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
Children becoming distressed during contact: particular difficulties, at around 6 months, in separating from the primary caregiver. This is something that is seen in most children, in most families, as a normal if difficult developmental stage, when there is tension in the child between dependence, separation and individuation.	1	**Serious concerns** Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method was not explicit. Unclear how thematic analysis was performed and how many researchers were involved. Unclear if researchers took into account contradictory findings.	**No concerns**	**Serious concerns** Only one study contributed to this theme.	**No concern**	Very Low
Concurrent planning concerns regarding frequency of contact: The CP carers complained that if contact was very frequent – three or five times a week – there was not time for recovery. Contact could lead to disruption for establishing routines. Several CP carers noticed that children were more clingy after contact. They might need a very quiet time for the next 24 hours to settle. The CP carers complained that if contact was very frequent – three or five times a week – there was not time for recovery: they had to be on the road again the next day. They felt the children needed to have more of the quiet time at home which most babies can have when very young. Behavioural issues were also found to occur before and after contact. Nearly all the CP carers, although accepting the timeframe, felt that the infants needed more opportunity than had been	1	**Serious concerns** Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method was not explicit. Unclear how thematic analysis was performed and how many researchers were involved. Unclear if researchers took into account contradictory findings.	**Minor concerns** Some aspects of this theme related to the disruption of contact on behaviour, routines, accessing community resources and the need for recovery and quiet time.	**Serious concerns** Only one study contributed to this theme.	**No concern**	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
given to settle with them and in homes where everything was new and different. The infant might be placed on a Friday and contact would begin on the following Monday. Some reported contact starting the next day, before either infant or CP carer had found or settled into basic care routines and rhythms. It would seem that the peace and quiet the CP carers asked for initially could make sense for these vulnerable children, all of whom had experienced at least one previous move. Disruptive frequency of contact: journeys and scheduling could actively disrupt routines – getting up, feeding, bathing, and so on. Furthermore, it meant there was little time just to 'be', as is possible for most infants. some comments on how attending contact sessions three or more times a week made it difficult to access the community resources to which most new mothers turn, for example, mother and toddler groups or health visitor sessions at local health clinics.						
Arranging handovers so that parents were not upset if infants showed a preference to be with the carers. Many CP carers paid special attention to arranging handovers so that parents were not upset if the infants showed a preference to be with the carers, for example by sitting next to parents so it was not so obvious that the child held out his arms to the returning carer. But some were very aware of a child's need to establish eye or physical contact with the carer. These CP carers knew that this linked to their own need to re-establish contact with the child they had left in uncertain circumstances.	1	**Serious concerns** Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method was not explicit. Unclear how thematic analysis was performed and how many researchers were involved. Unclear if researchers took	**No concerns**	**Serious concerns** Only one study contributed to this theme.	**No concern**	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
		into account contradictory findings.				
Comments from the contact supervisor: how difficult it was for some birth parents when the infant showed a preference for the CP carers and would offer suggestions on how they might help the child (particularly 5 to 8 months). She observed how difficult it was for some birth parents when the infant showed a preference for the CP carers and would offer suggestions on how they might help the child. She might tell them that that is what babies are like at that age, as she had noticed how the infants had more difficulty in spending time with birth parents from five to eight months, depending on the particular child, a time when they could show that they realised something was different from their usual experience with the CP carer. She was aware of their relief when reunited with their CP carers.	1	**Serious concerns** Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method was not explicit. Unclear how thematic analysis was performed and how many researchers were involved. Unclear if researchers took into account contradictory findings.	**No concerns**	**Serious concerns** Only one study contributed to this theme.	**No concern**	Very Low
Concerns about the experience of the child during contact sessions. A number of CP carers wondered about the experience of children during contact with their birth parents. One said the birth mother changed the baby more often than was necessary; another thought the mother did not know how to feed the baby her bottle, which must be why she was always so hungry and tearful after contact. Another carer reported that the birth mother, having heard the child loved her bath, had given her one but the child had screamed. It must have been such a different experience from the bath at home. Comments from contact supervisor: The supervisor	1	**Serious concerns** Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method was not explicit. Unclear how thematic analysis was performed and how many researchers were involved. Unclear if researchers took	**No concerns** Different aspects regarding the experience of children during contact, but all problems seemed to stem from the inexperience of the birth parent in handling the child.	**Serious concerns** Only one study contributed to this theme.	**No concern**	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
felt that what can confuse the children is when the birth parents do things with them differently from the carers; even more so when they do the same things but differently**.** For example, feeding and bathing. When the child refuses a bottle given to it in a different way from normal, she might have to call the carer back so the child is not left hungry.		into account contradictory findings.				
Importance of foster carers in easing the transition to prospective adoptive parents, for continuity of routines. Many of the CP carers were able to give graphic descriptions of the children in the first 24 hours or few days after moving from foster carers, namely the infants' responses to the disruption of their previous attachments. Several were very explicit about how helpful they had found the foster carers' understanding of the infants, and the feeding and sleeping regimes they had set up, and how these had eased the transitions for children and carers at the time of placement. Some also felt that the security of the rhythms and of the known routines, which they were trying to continue, had been abruptly broken once contact started. For infants placed straight from hospital there was no time to establish routines before contact began. Reliance on foster parents: parents relied on information provided by the foster carers, several of whom had met the birth parents and had photos of them that would be passed onto the children. Because the foster carers held information about the birth parents, some CP carers maintained contact with them and hoped that they would be the ones	1	**Serious concerns** Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method was not explicit. Unclear how thematic analysis was performed and how many researchers were involved. Unclear if researchers took into account contradictory findings.	**No concerns**	**Serious concerns** Only one study contributed to this theme.	**No concern**	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
able to talk to the children later about their families of origin.						
Realisation by CP carers of how much the infants were missing the foster carers to whom they were already attached. Several carers gave poignant accounts of their realisation of how much the infants were missing the foster carers to whom they were already attached.	1	**Serious concerns** Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method was not explicit. Unclear how thematic analysis was performed and how many researchers were involved. Unclear if researchers took into account contradictory findings.	**No concerns**	**Serious concerns** Only one study contributed to this theme.	**No concern**	Very Low
How long children and CP carers should be given to get to know one another and settle following the move from foster carers or hospital before contact starts. Greater period of transition may be helpful. A theme that emerged from a number of narratives is how long children and CP carers should be given to get to know one another and settle following the move from foster carers or hospital before contact starts. While appreciating the philosophy that continuing contact with birth parents will help rehabilitation when that becomes possible, many CP carers felt the babies themselves needed more time. The move from foster carers, where they might have been for some months, was a major separation in their lives. Like CP carer Fiona, a small number spoke specifically of realising that the babies	1	**Serious concerns** Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method was not explicit. Unclear how thematic analysis was performed and how many researchers were involved. Unclear if researchers took into account contradictory findings.	**No concerns**	**Serious concerns** Only one study contributed to this theme.	**No concern**	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
were mourning the loss of their previous foster carers. Some CP carers felt the children were moved too swiftly from foster care. One couple pressed for more introductory meetings than had been planned by the local authority social worker. They were aware the child was losing his primary attachment. This can be generalised to planning moves for all young children in the care system.						
Children born to drug/alcohol misusing parents: When the infant was a long time in hospital, the CP carers expressed great concern for what that experience might have meant to the child e.g. being alone during hospitalised detoxification, concerns regarding development and health fallout. One numerically large group consists of children born to drug and/or alcohol misusing parents: 14 out of 23 in the contact group and all four of those in the non-contact group. Many, but not all, of these children had had to go through a hospitalised detoxification at birth. When the infant was a long time in hospital, the CP carers expressed great concern for what that experience might have meant to the child Some still detected what they believed to be the sequelae of detoxification and possibly also of pre-natal drug/alcohol exposure, in jerkiness and in states of unexplained distress or slow weight gain.	1	**Serious concerns** Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method was not explicit. Unclear how thematic analysis was performed and how many researchers were involved. Unclear if researchers took into account contradictory findings.	**Minor concerns** This theme describes a range of health problems as a sequalae to being born to drug/alcohol misusing parents	**Serious concerns** Only one study contributed to this theme.	**No concern**	Very Low
Poor passage of medical information about health issues to the foster carers/CP carers: e.g. hepatitis infections. One of the children has hepatitis C and another child's diagnosis of the same condition was later reversed. Miranda was shocked that the foster carer had not been told that Jade had hepatitis	1	**Serious concerns** Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected.	**Minor concerns** This theme shows some examples of uncertainty regarding pre-existing medical conditions upon	**Serious concerns** Only one study contributed to this theme.	**No concern**	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
C. Una discovered, as a result of a routine blood test at four months, that Jill had hepatitis C. Una is distressed by the difficulties the condition may pose Jill later in life. Three more children were placed with an uncertainty about hepatitis C. The CP carers did not want to delay placement and were naturally relieved that later tests were negative. They knowingly accepted the risk that is implicit in the placement of very young infants who might later be adopted and whose health and development cannot yet be adequately assessed.		Interview method was not explicit. Unclear how thematic analysis was performed and how many researchers were involved. Unclear if researchers took into account contradictory findings.	taking on a foster child for adoption.			
Continuing sensitivity to separation and change following adoption placements. Continuing sensitivity to separation and change is a factor that emerged in descriptions of some of the children. One adoptive mother said she would look for a particularly nurturing primary school for her son who shows anxiety in new places and situations, and sudden emotional collapses that do not seem to be triggered by anything specific. She wondered how much these states are the sequelae of early detoxification and a rather under-stimulating foster placement.	1	**Serious concerns** Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method was not explicit. Unclear how thematic analysis was performed and how many researchers were involved. Unclear if researchers took into account contradictory findings.	**No concerns**	**Serious concerns** Only one study contributed to this theme.	**No concern**	Very Low
Comments from the contact supervisor: the need to help the parent to play with the child during contact sessions. She might also have to help the parent to learn how to play with the child, not just to offload their own difficulties onto her while leaving the child unstimulated and ignored.	1	**Serious concerns** Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method was not	**No concerns**	**Serious concerns** Only one study contributed to this theme.	**No concern**	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
		explicit. Unclear how thematic analysis was performed and how many researchers were involved. Unclear if researchers took into account contradictory findings.				
Comments from the contact supervisor: help the parent to recognise the child's gesture towards them and to find ways to help them to respond. The supervisor had a special concern for the children distressed when their attempts to interact with their birth parent were not reciprocated, in which case they might turn to her instead. She saw it as part of her task to help the parent to recognise the child's gesture towards them and to find ways to help them to respond. In this way birth parents who were deemed likely to fail in their child care could be helped to greater success, even though, in this sample, in only one case did such support contribute to the rehabilitation of the child.	1	**Serious concerns** Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method was not explicit. Unclear how thematic analysis was performed and how many researchers were involved. Unclear if researchers took into account contradictory findings.	**No concerns**	**Serious concerns** Only one study contributed to this theme.	**No concern**	Very Low
Continuing contact: CP carers have concerns about these wider contacts when the extended family may still be in touch with birth parents. Only one child still has direct contact with her birth mother. For others there is letterbox contact through Coram. Some children have continuing contact with sibling groups or extended family, although their CP carers have concerns about these wider contacts when the extended family may still be in touch with birth parents. Direct contact does need to be safe for all concerned.	1	**Serious concerns** Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method was not explicit. Unclear how thematic analysis was performed and how many researchers were involved.	**Minor concerns** It is unclear to what extent this theme was reflected in the whole sample studied.	**Serious concerns** Only one study contributed to this theme.	**No concern**	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
		Unclear if researchers took into account contradictory findings.				
Uncertainty leading to uncertainty in attachment (of the CP caregiver): CP carers had opted to be part of Coram's Concurrent Planning Project, hoping at the end of the day that they would have the chance of adopting a very young child. They had also chosen to take the risk that the adoption might not happen.	1	**Serious concerns** Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method was not explicit. Unclear how thematic analysis was performed and how many researchers were involved. Unclear if researchers took into account contradictory findings.	**No concerns**	**Serious concerns** Only one study contributed to this theme.	**No concern**	Very Low
Difficulties with consent: The CP carers had no part in the legal process of concurrent planning and no parental responsibility. This was an issue in one case, where a child became ill and in need of urgent medical intervention for which the CP carer could not give permission. That responsibility lay with children's services or the birth parents.	1	**Serious concerns** Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method was not explicit. Unclear how thematic analysis was performed and how many researchers were involved. Unclear if researchers took into account contradictory findings.	**No concerns**	**Serious concerns** Only one study contributed to this theme.	**No concern**	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
Benefits of training: the Coram training had led them not to expect the infants to attach too quickly, helping to ensure that attachments developed at a pace that was right for the infants, who were still totally dependent on others for their survival.	1	**Serious concerns** Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method was not explicit. Unclear how thematic analysis was performed and how many researchers were involved. Unclear if researchers took into account contradictory findings.	**No concerns**	**Serious concerns** Only one study contributed to this theme.	**No concern**	Very Low
Length of time taken on journeys to contact visits: All the CP carers had to live within a 20-mile radius of Coram, later within the boundary of the M25. For some, this could entail a journey of up to two hours by car or public transport.	1	**Serious concerns** Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method was not explicit. Unclear how thematic analysis was performed and how many researchers were involved. Unclear if researchers took into account contradictory findings.	**No concerns**	**Serious concerns** Only one study contributed to this theme.	**No concern**	Very Low
Importance of knowing birth parents for children's identity needs: the CP carers who had the most contact with birth parents seemed to value the relationship most. All felt they would be able to	1	**Serious concerns** Researchers do not justify the research design. Unclear recruitment	**No concerns**	**Serious concerns** Only one study	**No concern**	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
tell the children about the 'real' parents, not ones just described in social work files as interpreted by local authority social workers, who might not themselves have known the people involved. one of the real benefits emerging from concurrent planning: it enables CP carers to give their children a truthful, balanced account of their birth parents as they grow older, incorporating both positives and negatives in age appropriate ways. Not getting to know the birth parents: For the four families where there had been no contact with birth parents, there was a feeling of disappointment after the build-up from the preparatory training groups, together with loss and regret that they could not talk later to the children about parents who were real to them. They felt this would be a lost opportunity for the children. Admittedly, they could see how they had gained from the quiet time they had had to get to know the children without the disruption of the contact visits.		strategy and why certain participants were selected. Interview method was not explicit. Unclear how thematic analysis was performed and how many researchers were involved. Unclear if researchers took into account contradictory findings.		contributed to this theme.		
Concern for the birth parents and uncertainty of the concurrent planning process: As well as respecting them, many CP carers expressed concern for the ordeal to which continuing contact exposed the birth parents. Vince thought it cruel for the birth mother when contact was prolonged for 12 months, just as it was for his wife, both being left on what he called a 'rollercoaster of uncertainty'. Many expressed sadness for the plight of birth parents, especially those struggling with drug problems.	1	**Serious concerns** Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method was not explicit. Unclear how thematic analysis was performed and how many researchers were involved. Unclear if researchers took	**No concerns**	**Serious concerns** Only one study contributed to this theme.	**No concern**	Very Low

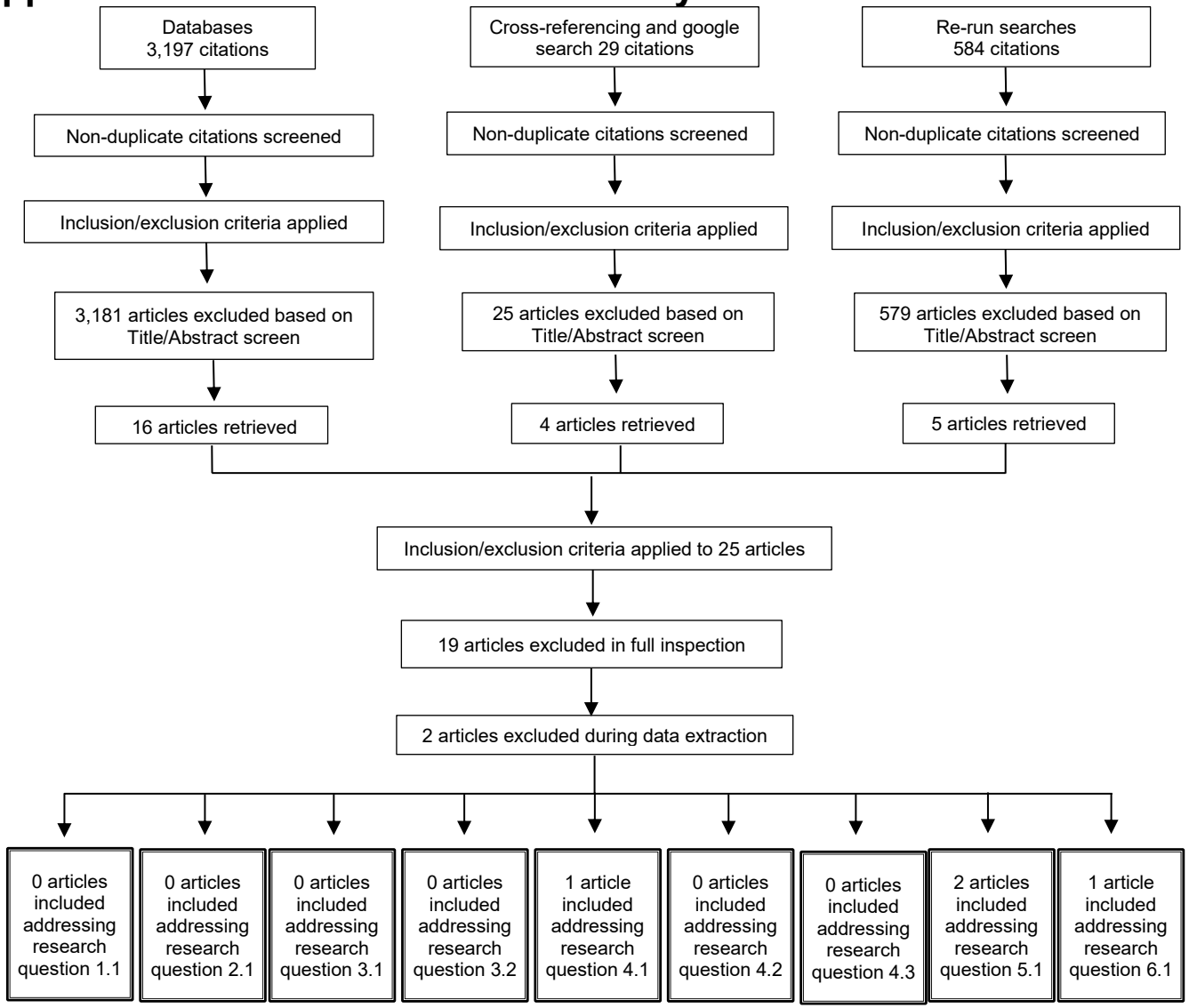
Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
		into account contradictory findings.				
Importance of contact supervisor: e.g. during concern about contact with dysfunctional birth families	1	**Serious concerns** Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method was not explicit. Unclear how thematic analysis was performed and how many researchers were involved. Unclear if researchers took into account contradictory findings.	**No concerns**	**Serious concerns** Only one study contributed to this theme.	**No concern**	Very Low
Implications for matching and placement if CP carers voice their concerns: A few CP carers were reluctant to venture their criticisms of the process as they were aware of being continually assessed themselves and feared that if they 'failed' in any way, they could lose the child to whom they had become attached. several CP carers felt they had to be careful not to expose too many of their difficulties for fear of being regarded as unsuitable carers, demonstrating the continual effect of the anxiety created by the uncertainties intrinsic to concurrent planning.	1	**Serious concerns** Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method was not explicit. Unclear how thematic analysis was performed and how many researchers were involved. Unclear if researchers took into account contradictory findings.	**No concerns**	**Serious concerns** Only one study contributed to this theme.	**No concern**	Very Low
Avoiding problematic continuing direct contact and letter box contact through Coram: one couple	1	**Serious concerns**	**No concerns**	**Serious concerns**	**No concern**	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
were clear that direct contact would only continue while it was in the child's best interest. Letterbox contacts can be problematic, but most are directed through Coram, which can filter or encourage rewriting if the contents are inappropriate or disturbing either to child, CP carers or birth parents. This degree of care, not always taken by other organisations, is enormously helpful to all concerned. Indeed, many of the birth parents regularly seek advice from Coram when writing their annual letter to the adoptive parents of their child.		Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method was not explicit. Unclear how thematic analysis was performed and how many researchers were involved. Unclear if researchers took into account contradictory findings.		Only one study contributed to this theme.		
Involvement of CP families extended family: Where extended family and friends were involved from the start – for example, the father of CP carer Bella collected the child from contact sessions when Bella had to work – the family relationships became and remained strong. Some CP carers commented on how the children now adopted were accepted and on a par with biological grandchildren – as one would hope.	1	**Serious concerns** Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method was not explicit. Unclear how thematic analysis was performed and how many researchers were involved. Unclear if researchers took into account contradictory findings.	**No concerns**	**Serious concerns** Only one study contributed to this theme.	**No concern**	Very Low
Extra support from Coram Social Workers: Most parents valued the support from their Coram social workers and from being a continuing part of the Coram 'family', as experienced in outings such as summer picnics. The Coram social worker was	1	**Serious concerns** Researchers do not justify the research design. Unclear recruitment strategy and why certain	**Minor concerns** Unclear that this theme covers the full range of "extra" support available, or how many	**Serious concerns** Only one study	**No concern**	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
usually available to discuss any anxieties or to accompany the CP carer if contact sessions were difficult or in a different setting.		participants were selected. Interview method was not explicit. Unclear how thematic analysis was performed and how many researchers were involved. Unclear if researchers took into account contradictory findings.	made use of this support – which seemed varied.	contributed to this theme.		
By comparison, undersupport from local authority workers: If at times some CP carers found it difficult to request as much support from Coram as they felt they needed, more were openly critical about the local authority social workers. The majority of these criticisms centred on chaos as they experienced it within the local authority departments, leading to delays in placement and in preparation for court hearings. Where some birth parents presented difficulties, e.g. with aggression, they felt the local authority workers backed off, leaving the carers exposed. Several wondered if the needs of birth parents were being put before those of the child by professionals involved with the process.	1	**Serious concerns** Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method was not explicit. Unclear how thematic analysis was performed and how many researchers were involved. Unclear if researchers took into account contradictory findings.	**Minor concerns**	**Serious concerns** Only one study contributed to this theme.	**No concern**	Very Low
Helpfulness of children's guardians appointed by the courts: Parents had equally differing views of the helpfulness or otherwise of children's guardians appointed by the courts for the child. One had recommended trial rehabilitation rather late in the process, which had profoundly upset the CP carers. Others had intervened helpfully when there had been difficulties during contact with birth parents, in one case recommending the termination of contact.	1	**Serious concerns** Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method was not explicit. Unclear how thematic analysis was	**Minor concerns** Contrasting views over the usefulness of the children's guardian. Perhaps this was dependant on who's "side" the guardian had taken during proceedings.	**Serious concerns** Only one study contributed to this theme.	**No concern**	Very Low

Theme	Studies	Methodological limitations	Coherence	Adequacy	Relevance	Confidence
		performed and how many researchers were involved. Unclear if researchers took into account contradictory findings.				
Changes late in the concurrent planning process being especially unsettling: an event that was unsettling for CP carers was when consideration was given to members of the extended birth family to become adopters well into the concurrent planning process. On the other hand, placements could be delayed if such consideration took place before the placement. Similar crises of uncertainty arose when court hearings for care orders or adoption were contested by birth parents.	1	**Serious concerns** Researchers do not justify the research design. Unclear recruitment strategy and why certain participants were selected. Interview method was not explicit. Unclear how thematic analysis was performed and how many researchers were involved. Unclear if researchers took into account contradictory findings.	**No concerns**	**Serious concerns** Only one study contributed to this theme.	**No concern**	Very Low

Appendix G – Economic evidence study selection



Appendix H – Economic evidence tables

Evidence tables

Lynch 2014

Study	Lynch FL, Dickerson JF, Saldana L et al. (2014) Incremental net benefit of early intervention for preschool-aged children with emotional and behavioral problems in foster care. Children and Youth Services Review 36: 213-219			
Study details	**Population & interventions**	**Costs**	**Outcomes**	**Cost effectiveness**
Economic analysis: cost-effectiveness analysis **Study design:** economic analysis conducted alongside RCT (Fisher 2009) **Approach to analysis:** analysis used placement stability as the measure of efficacy of the intervention, net monetary benefit regression was used to explore uncertainty at different willingness to pay (WTP) values **Perspective:** US public sector **Time horizon:** 24 months **Intervention effect duration:** 24 months **Discounting:** not reported	**Population:** 117 foster children, aged 3 to 5 years **Cohort settings** **Intervention 1:** Multidimensional Treatment Foster Care for Pre-schoolers (MTFC-P), n=57 **Intervention 2:** regular foster care (RFC), n=60	**Mean total costs:** Full sample **Int1**: $27,204 (£23,065) **Int2**: $30,090 (£25,512) p<0.005[1] Placement instability sample[2] **Int1**: $29,595 (£25,092) **Int2**: $36,061 (£30,5742) p<0.05[1] **Currency & cost year:** US dollars, 2008[3] **Cost components incorporated:** health, social welfare and education, interventions costs (including staff supervision, time to	**Permanent placement[4]:** Full sample **Int1**: 36.84% (21/57) **Int2**: 31.67% (19/60) p=0.787 Placement instability sample **Int1:** 48.28% (3/23) **Int2:** 13.04% (14/29) p=0.002	**Full incremental analysis:** MTFC dominated RCF being less expensive and resulting in more permanent placements in both full sample and placement instability sample **Analysis of uncertainty:** Deterministic sensitivity analyses were not conducted. Cost-effectiveness acceptability curve not reported. **Mean incremental net monetary benefit for WTP $10,000 (£8,064)** Full sample $4,591 (95% CI −596 to 9,779) £3,892 (95% CI -505 to £8,291) Placement instability sample

		develop treatment plans, and staff training)		$8,087 (95% CI 188 to 15,987) £6,857 (95% CI 159 to £13,554)
Data sources				
Outcomes: Baseline rate of placement breakdown and efficacy of MTFC were obtained from direct analysis of individual patient data of a RCT comparing MTFC-P to RFC (Fisher 2009). **Costs:** Health and social services provided outside of MTFC-P and RFC were captured using questionnaires completed by clinical staff as part of the fidelity and monitoring checks over the duration of the trial. The cost of MTFC-P was estimated from the Fisher 2009 clinical records and estimates provided by study staff using a bottom-up approach. Service valuation used published unit costs (Gold 1996, Lynch 2011).				
Comments				
Source of funding: The authors declared not to have any conflict of interest. The research was funded by multiple US public sector grants.				
Overall applicability: Partially applicable				
Analysis conducted from the US public sector perspective. No discounting was applied in the second year of the analysis.				
Overall quality: Very serious limitations				
The authors reported that the study was not powered to detect a difference in the permanent placement outcome in the subpopulation with history of placement instability (Fisher 2009). Complete clinical and services data were available for 69% of participants, missing data were imputed using statistical multiple imputation with chained equations. The time horizon of the analysis is limited to the 24-month duration of the RCT, the long-term effects of the interventions were therefore not explored.				

[1]Mean total public agency costs were statistically significantly different between MTFC-P and RFC groups, adjusted for gender, number of placements prior to start of the study and baseline severity. The sum of the individual cost components incurred by the MTFC-P or RFC populations (Table 1, Lynch 2014) did not match the total costs for MTFC-P and RFC reported by the author. The analyst calculated these to be $27,229 for MTFC-P and $30,002 for RCF, which had no impact in the conclusions of the analysis. The total costs included in the economic evidence tables were those estimated in the original publication.

[2]A subgroup of children had 4 or more placements (placement instability) before inclusion in the study, which included 52 children (29 MTFC-P, 23 RFC).

[3]Converted from 2008 US dollars to 2020 British pounds accounting for inflation, currency conversion and purchasing power parities, conversion ratio 1.179, EPPI Centre cost converter accessed on the 03/03/2020.

[4]The primary outcome 'permanent placement' was calculated as the number of attempted permanent placements before a permanent placement was achieved, divided by the total number of cases in each group. A placement was considered permanent if the child was reunited with a biological parent or adopted by a relative/non-relative

Sharac 2011

Study	Sharac J, McCrone P, Rushton A et al. (2011) Enhancing adoptive parenting: a cost-effectiveness analysis. Child and Adolescent Mental Health 16(2): 110-115			
Study details	**Population & interventions**	**Costs**[3]	**Outcomes**	**Cost effectiveness**
Economic analysis: Cost-effectiveness analysis **Study design:** economic analysis conducted alongside RCT **Approach to analysis:** Costs were compared using regression model to account for baseline differences **Perspective:** NHS and personal social services **Time horizon:** 6 months **Intervention effect duration:** 6 months **Discounting:** Not applicable	**Population:** UK adoptive parents of children aged 3 to 8 years **Cohort settings** **Intervention 1:** Cognitive behavioural approach[1] (CBA), n=10 or Educational Approach[2] (EA), n=9 **Intervention 2:** Service as usual (SAU), n=18	**Mean total costs:** CBA or EA: mean £6,069 (standard deviation [SD] £3,983) SAU: £4,066 (SD £6,361) Adjusted difference: £1,988 (95% CI: -£2,057to £5,137) **Currency & cost year:** British pounds, year not reported, assumed 2009-2010 **Cost components incorporated:** health and social care resources use	**Mean QALYs:** Not reported **Child mental health** <u>Strengths and Difficulties Questionnaire:</u> CBA+EA: Lower SAU: Higher Difference: 0.79, favours SAU **Carer outcomes:** <u>Parental Satisfaction Questionnaire:</u> CBA+EA: Higher SAU: Lower Difference: 4.90 (95% CI not reported), favours CBA+EA	**Full incremental analysis:** <u>Strength and Difficulties Questionnaire:</u> SAU dominates as it was both more effective and less expensive than CBA+EA. <u>Parental Satisfaction Questionnaire:</u> ICER: £406/unit improvement in the satisfaction with parenting scale **Analysis of uncertainty:** None
Data sources				
Outcomes: Baseline scores and relative treatment effects were obtained from direct analysis of individual patient data of an RCT conducted in English children (Rushton 2010). Strengths and Difficulties questionnaire, 0= difficulties are close to average; 40=very high difficulties (Goodman 1997). Parental Feedback Questionnaire consists of 23 items rated on 4-point scales, with 4 being the most positive (Davies 1998). **Quality of life weights:** Not applicable **Costs:** The number of intervention sessions were recorded by the advisors allocated to each family. These were then costed using unit cost of social worker time, including salary, overheads and training (Curtis 2007). Other service use such as local authority professionals, mental health or health services was measured using the Client Service Receipt Inventory (Beecham & Knapp 2001) and was then assigned to nationally available costs (Curtis 2007).				

Comments
Source of funding: UK Department of Health and subsequently by the Department for Children, Schools and Families) and the Nuffield Foundation**.**
Overall applicability: Partly applicable
Questionnaires' scores used as a measure of the efficacy of the intervention, which may have limited applicability to the NICE decision making context. Perspective of costs was not clearly stated, but costing included NHS and personal social services usage.
Overall quality: Very serious limitation
Study conducted alongside a small trial with very low quality. Sample size was underpowered to assess a true difference in the primary outcomes and costs between comparators so authors combined costs and effects of CBA and EA, which may have influenced the conclusions about the individual interventions. No analysis of uncertainty was conducted. The analysis was limited to the 6-month duration of the trial and did not explore the long-term effect of the intervention. Resource use was self-reported which may have generated imprecise estimates (recall bias).

[1]*The cognitive behavioural approach was adapted from Webster-Stratton (2003), which consists of training carers on how to decrease unacceptable and increase acceptable behaviours by using praise and rewards, logical consequences and problem-solving skills*

[2]*Adopters under the educational approach were helped to improve their understanding of the meaning of the children's behaviour and its connection with past experiences*

[3]*Costs inflated to sterling 2020 using the EPPI reviewer cost converter accessed on the 03/03/2020, conversion factor 0.83*

Study quality checklists

Lynch 2014

Study identification **Lynch FL, Dickerson JF, Saldana L et al. (2014) Incremental net benefit of early intervention for preschool-aged children with emotional and behavioral problems in foster care. Children and Youth Services Review 36: 213-219**		
Guidance topic: LACYP guideline update		**Question no:** 5.1
Checklist completed by: Rui Martins		
Section 1: Applicability (relevance to specific review questions and the NICE reference case as described in section 7.5) This checklist should be used first to filter out irrelevant studies**.**	**Yes/partly/no/unclear/NA**	**Comments**
1.1 Is the study population appropriate for the review question?	Yes	
1.2 Are the interventions appropriate for the review question?	Yes	

1.3 Is the system in which the study was conducted sufficiently similar to the current UK context?	Partly	US context
1.4 Are the perspectives for costs clearly stated and are they appropriate for the review question?	Yes	
1.5 Are all direct effects on individuals included, and are all other effects included where they are material?	Partly	Only measure of effectiveness of the interventions used in the analysis was placement stability
1.6 Are all future costs and outcomes discounted appropriately?	No	
1.7 Are QALYs, derived using NICE's preferred methods, or an appropriate social care-related equivalent used as an outcome? If not, describe rationale and outcomes used in line with analytical perspectives taken (item 1.4 above).	NA	
1.8 If applicable, are costs and outcomes from other sectors fully and appropriately measured and valued?	Yes	Health, social welfare, and education
1.9 Overall judgement: Partially applicable		
Other comments:		
Section 2: Study limitations (the level of methodological quality) This checklist should be used once it has been decided that the study is sufficiently applicable to the context of the guideline	**Yes/partly/no/unclear/NA**	**Comments**
2.1 Does the model structure adequately reflect the nature of the topic under evaluation?	NA	
2.2 Is the time horizon sufficiently long to reflect all important differences in costs and outcomes?	Partly	The analysis takes the 24-month duration of the RCT. No attempt was made to extrapolate the effect of the intervention in the medium to long-term.
2.3 Are all important and relevant outcomes included?	The	Only measure of effectiveness of the interventions used in the analysis was placement stability, chosen based on statistical significance.

2.4 Are the estimates of baseline outcomes from the best available source?	Yes	
2.5 Are the estimates of relative intervention effects from the best available source?	Partly	Evidence from a single RCT with missing data in 31% of participants.
2.6 Are all important and relevant costs included?	Yes	
2.7 Are the estimates of resource use from the best available source?	Yes	
2.8 Are the unit costs of resources from the best available source?	Yes	
2.9 Is an appropriate incremental analysis presented or can it be calculated from the data?	Yes	
2.10 Are all important parameters whose values are uncertain subjected to appropriate sensitivity analysis?	Yes	
2.11 Is there no potential conflict of interest?	No	
2.12 Overall assessment: Very serious limitations		
Other comments: None		

Sharac 2011 – UK

Study identification **Sharac J, McCrone P, Rushton A et al. (2011) Enhancing adoptive parenting: a cost-effectiveness analysis. Child and Adolescent Mental Health 16(2): 110-115**		
Guidance topic: LACYP guideline update		**Question no:** 5.1
Checklist completed by: Rui Martins		
Section 1: Applicability (relevance to specific review questions and the NICE reference case as described in section 7.5) This checklist should be used first to filter out irrelevant studies.	**Yes/partly/no/unclear/NA**	**Comments**
1.1 Is the study population appropriate for the review question?	Yes	
1.2 Are the interventions appropriate for the review question?	Yes	

1.3 Is the system in which the study was conducted sufficiently similar to the current UK context?	Yes	
1.4 Are the perspectives for costs clearly stated and are they appropriate for the review question?	Partly	Perspective not clearly stated but costing considered a UK social care perspective.
1.5 Are all direct effects on individuals included, and are all other effects included where they are material?	Yes	
1.6 Are all future costs and outcomes discounted appropriately?	NA	6-month analysis
1.7 Are QALYs, derived using NICE's preferred methods, or an appropriate social care-related equivalent used as an outcome? If not, describe rationale and outcomes used in line with analytical perspectives taken (item 1.4 above).	No	Cost-effectiveness analysis
1.8 If applicable, are costs and outcomes from other sectors fully and appropriately measured and valued?	Yes	
1.9 Overall judgement: Directly applicable		
Other comments:		
Section 2: Study limitations (the level of methodological quality) This checklist should be used once it has been decided that the study is sufficiently applicable to the context of the guideline	**Yes/partly/no/unclear/NA**	**Comments**
2.1 Does the model structure adequately reflect the nature of the topic under evaluation?	Partly	Effectiveness of the intervention assessed using several validate instruments. These measures were not formally modelled. Differences between interventions captured as differences in resources used (NHA and social care).
2.2 Is the time horizon sufficiently long to reflect all important differences in costs and outcomes?	No	Medium to long-term effect of the interventions was not modelled.

2.3 Are all important and relevant outcomes included?	Partly	Carers and children followed-up at the end of the 10 sessions being delivered. Differences between comparators were not assessed beyond this point.
2.4 Are the estimates of baseline outcomes from the best available source?	NA	
2.5 Are the estimates of relative intervention effects from the best available source?	No	Intervention groups merged although they had different components and principles.
2.6 Are all important and relevant costs included?	Partly	Only in the period comprising the delivery of the intervention.
2.7 Are the estimates of resource use from the best available source?	Partly	Service usage was self-reported and prone to bias.
2.8 Are the unit costs of resources from the best available source?	Yes	
2.9 Is an appropriate incremental analysis presented or can it be calculated from the data?	Yes	
2.10 Are all important parameters whose values are uncertain subjected to appropriate sensitivity analysis?	No	
2.11 Is there no potential conflict of interest?	No	
2.12 Overall assessment: Very serious limitation		
Other comments: None		

Appendix I – Health economic model

No economic modelling was undertaken for this review question.

Appendix J – Excluded studies

Effectiveness studies

Study	Reason for exclusion
(2002) Evaluation of Family Preservation and Reunification Programs: Final Report.: 1-487	Does not contain a population of interest
(2000) Supportive residential services to reunite homeless mentally ill single parents with their children. Psychiatric Services 51(11): 1433-1435	Description of intervention only
`HOPKINS Graham (2003) Dangerous liaison?. Community Care 201103: 44	Description of intervention only
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	Outcome(s) not of relevance to this review
Akin, Becci A, Lang, Kyle, McDonald, Thomas P et al. (2018) Randomized study of PMTO in foster care: Six-month parent outcomes. Research on Social Work Practice 28(7): 810-826	- no outcomes of interest reported
Albert, Vicky N and King, William C (2008) Survival analyses of the dynamics of sibling experiences in foster care. Families in Society 89(4): 533-541	Intervention not of relevance to this review
ANDERSSON Maria; SALLNAS Marie; LUNDSTROM Tommy (2014) Good idea, bad prerequisite, zero result: the meaning of context in implementing aftercare for young people in secure unit care. Journal of Children's Services 9(3): 248-260	Non-RCT and Non-UK

Study	Reason for exclusion
Avery, Rosemary J and Butler, J. S (2001) Timeliness in the adoptive placement of photolisted children: The New York State Blue Books. Adoption Quarterly 4(4): 19-46	Intervention not of relevance to this review
Bagdasaryan, Sofya (2005) Evaluating family preservation services: Refraining the question of effectiveness. Children and Youth Services Review 27(6): 615-635	Does not contain a population of interest
Balsells, Maria Angels, Pastor, Crescencia, Mateos, Ainoa et al. (2015) Exploring the needs of parents for achieving reunification: The views of foster children, birth family and social workers in Spain. Children and Youth Services Review 48: 159-166	Non-UK qualitative study
Bassett H.; Lampe J.; Lloyd C. (2001) Living with under-fives: A programme for parents with a mental illness. British Journal of Occupational Therapy 64(1): 23-28	Does not contain a population of interest
Barone, Lavinia; Ozturk, Yagmur; Lionetti, Francesca (2019) The key role of positive parenting and children's temperament in post-institutionalized children's socio-emotional adjustment after adoption placement. A RCT study. Social Development 28(1): 136-151	- Unclear that population are LACYP International adoption
BERRY Marianne; McCAULEY Kelly; LANSING Tracie (2007) Permanency through group work: a pilot intensive reunification program. Child and Adolescent Social Work Journal 24(5): 477-493	non-UK non-RCT
Berry, Marianne, Propp, Jennifer, Martens, Priscilla et al. (2007) The use of intensive family preservation services with adoptive families. Child & Family Social Work 12(1): 43-53	Does not contain a population of interest
BIEHAL Nina (2007) Reuniting children with their families: reconsidering the evidence on timing, contact and outcomes. British Journal of Social Work 37(5): 807-823	Systematic review used as source of primary studies

Study	Reason for exclusion
BOHANNAN Theresa; GONZALEZ Carlene; SUMMERS Alicia (2016) Assessing the relationship between a peer-mentoring program and case outcomes in dependency court. Journal of Public Child Welfare 10(2): 176-196	non-UK non-RCT
BOLES Sharon M. and et al (2007) The Sacramento Dependency Drug Court: development and outcomes. Child Maltreatment 12(2): 161-171	non-UK non-RCT
Brannstrom, Lars; Vinnerljung, Bo; Hjern, Anders (2013) Long-term outcomes of Sweden's Contact Family Program for children. Child abuse & neglect 37(6): 404-14	Does not contain a population of interest
Burke, Raymond V, Schlueter, Cortney, Bader, Erin et al. (2018) Post-adoption services for high-risk families and their children: Preliminary results of a state-wide intervention. American Journal of Family Therapy 46(2): 122-138	Does not contain a population of interest
Cameron, Christopher L, Birnie, Kathryn, Dharma-Wardene, Melina W et al. (2007) Hospital-to-community transitions. A bridge program for adolescent mental health patients. Journal of psychosocial nursing and mental health services 45(10): 24-30	Does not contain a population of interest
Carnochan, Sarah; Lee, Chris; Austin, Michael J (2013) Achieving timely reunification. Journal of evidence-based social work 10(3): 179-95	Review article but not a systematic review
Carnochan, Sarah; Moore, Megan; Austin, Michael J (2013) Achieving timely adoption. Journal of evidence-based social work 10(3): 210-9	Review article but not a systematic review

Study	Reason for exclusion
Carnochan, Sarah; Rizik-Baer, Daniel; Austin, Michael J (2013) Preventing re-entry to foster care. Journal of evidence-based social work 10(3): 196-209	Systematic review used as source of primary studies
Chambers, Ruth M, Brocato, Jo, Fatemi, Maryam et al. (2016) An innovative child welfare pilot initiative: Results and outcomes. Children and Youth Services Review 70: 143-151	non-UK non-RCT
Chambers, Jeff M, Lint, Sandy, Thompson, Maggie G et al. (2019) Outcomes of the Iowa Parent Partner program evaluation: Stability of reunification and re-entry into foster care. Children and Youth Services Review 104	- non-UK non-randomised study
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	Not relevant to this review question
CHOI Sam and RYAN Joseph P. (2007) Co-occurring problems for substance abusing mothers in child welfare: matching services to improve family reunification. Children and Youth Services Review 29(11): 1395-1410	non-UK non-RCT
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	Outcome(s) not of relevance to this review
Coakley, Tanya M (2008) Examining African American fathers' involvement in permanency planning: An effort to reduce racial disproportionality in the child welfare system. Children and Youth Services Review 30(4): 407-417	Intervention not of relevance to this review

Study	Reason for exclusion
Courtney, Mark E and Hook, Jennifer L (2012) Timing of exits to legal permanency from out-of-home care: The importance of systems and implications for assessing institutional accountability. Children and Youth Services Review 34(12): 2263-2272	Not an investigation of an intervention
Cowen, Perle Slavik and Reed, David A (2002) Effects of respite care for children with developmental disabilities: evaluation of an intervention for at risk families. Public health nursing (Boston, Mass.) 19(4): 272-83	Does not contain a population of interest
D'Andrade, Amy C (2009) The differential effects of concurrent planning practice elements on reunification and adoption. Research on Social Work Practice 19(4): 446-459	non-UK non-RCT
DAGENAIS Christian and et al (2004) Impact of intensive family support programmes: a synthesis of evaluation studies. Children and Youth Services Review 26(3): 249-263	Does not contain a population of interest
de Kemp, Raymond A. T, Veerman, Jan W, ten Brink, L. Tjeerd et al. (2003) The assessment of imminence of risk of placement: Lessons from a Family First program in the Netherlands. Children and Youth Services Review 25(3): 251-270	Not an investigation of an intervention
de Paul, Joaquin and Arruabarrena, Ignacia (2003) Evaluation of a treatment program for abusive and high-risk families in Spain. Child welfare 82(4): 413-42	Does not contain a population of interest
Delfabbro, Paul H, Barber, James G, Cooper, Lesley et al. (2002) The role of parental contact in substitute care. Journal of Social Service Research 28(3): 19-39	non-UK non-RCT

Study	Reason for exclusion
Dewey, Jennifer, Tipon, Grace, DeWolfe, Joanna et al. (2013) The path from process to outcomes: a cross-site evaluation of 24 family connection grantee projects. Child welfare 92(6): 9-39	Does not contain a population of interest
Drozd, Filip, Bergsund, Hans Bugge, Hammerstrom, Karianne Thune et al. (2018) A systematic review of courses, training, and interventions for adoptive parents. Journal of Child and Family Studies 27(2): 339-354	Systematic review used as source of primary studies
Edelstein, Susan B, Gonzalez, Araceli, Langley, Audra K et al. (2017) Preparing and partnering with families to support the adoption of children from foster care. Adoption Quarterly 20(1): 119-133	Outcome(s) not of relevance to this review
Farber, Michaela L. Z, Timberlake, Elizabeth, Mudd, Helen Patricia et al. (2003) Preparing parents for adoption: An agency experience. Child & Adolescent Social Work Journal 20(3): 175-196	Outcome(s) not of relevance to this review
Farmer, Elaine and Wijedasa, Dinithi (2013) The reunification of looked after children with their parents: What contributes to return stability?. British Journal of Social Work 43(8): 1611-1629	Study design does not meet inclusion criteria
FERNANDEZ Elizabeth and et al (2019) Children returning from care: the challenging circumstances of parents in poverty. Children and Youth Services Review 97: 100-111	Not an investigation of an intervention
Fernandez, Elizabeth (2013) Accomplishing permanency: Reunification pathways and outcomes for foster children. Accomplishing permanency: Reunification pathways and outcomes for foster children.	Systematic review used as source of primary studies
FOGGIT Rachel (2003) Adoption options. Community Care 17403: 34	Study design does not meet inclusion criteria

Study	Reason for exclusion
Font, Sarah; Sattler, Kierra; Gershoff, Elizabeth (2018) When Home is Still Unsafe: From Family Reunification to Foster Care Reentry. Journal of marriage and the family 80(5): 1333-1343	Not an investigation of an intervention
Frame, L; Berrick, J D; Brodowski, M L (2000) Understanding reentry to out-of-home care for reunified infants. Child welfare 79(4): 339-69	Study design does not meet inclusion criteria
Frey, Lauren, Cushing, Gretta, Freundlich, Madelyn et al. (2008) Achieving permanency for youth in foster care: Assessing and strengthening emotional security. Child & Family Social Work 13(2): 218-226	Not an investigation of an intervention
GILKES Liz and KLIMES Ivana (2003) Parenting skills for adoptive parents. Adoption and Fostering 27(1): 19-25	Study design does not meet inclusion criteria
Green, Beth L, Furrer, Carrie, Worcel, Sonia et al. (2007) How effective are family treatment drug courts? Outcomes from a four-site national study. Child maltreatment 12(1): 43-59	non-UK non-RCT
Grella, Christine E, Needell, Barbara, Shi, Yifei et al. (2009) Do drug treatment services predict reunification outcomes of mothers and their children in child welfare?. Journal of substance abuse treatment 36(3): 278-93	non-UK non-RCT
Haack, Mary, Alemi, Farrokh, Nemes, Susanna et al. (2004) Experience with family drug courts in three cities. Substance abuse 25(4): 17-25	Outcome(s) not of relevance to this review
Hansen, Mary Eschelbach and Hansen, Bradley A (2006) The economics of adoption of children from foster care. Child welfare 85(3): 559-83	Not an investigation of an intervention

Study	Reason for exclusion
HEBERT Sophie T.; ESPOSITO Tonino; HELIE Sonia (2018) How short-term placements affect placement trajectories: a propensity-weighted analysis of re-entry into care. Children and Youth Services Review 95: 117-124	non-UK non-RCT
Hess, P M; McGowan, B G; Botsko, M (2000) A preventive services program model for preserving and supporting families over time. Child welfare 79(3): 227-65	Does not contain a population of interest
HILL Catherine and EDWARDS Maria (2009) Birth family health history: adopters' perspectives on learning about their child's health inheritance. Adoption and Fostering 33(2): 45-53	Does not contain a population of interest
Hughes, Jean R and Gottlieb, Laurie N (2004) The effects of the Webster-Stratton parenting program on maltreating families: fostering strengths. Child abuse & neglect 28(10): 1081-97	Does not contain a population of interest
Hyun, Myungsun and Seo, Mia (2003) Rehabilitation for homeless adolescent substance abusers at a halfway house in Korea. Taehan Kanho Hakhoe chi 33(8): 1161-70	Does not contain a population of interest
Jansson, Lauren M; Svikis, Dace S; Beilenson, Peter (2003) Effectiveness of child case management services for offspring of drug-dependent women. Substance use & misuse 38(14): 1933-52	Does not contain a population of interest
JEDWAB Merav; CHATTERJEE Anusha; SHAW Terry V. (2018) Caseworkers' insights and experiences with successful reunification. Children and Youth Services Review 86: 56-63	non-UK non-RCT
JENSON Cary E. and et al (2010) Developing strong helping alliances in family reunification. Journal of Public Child Welfare 3(4): 331-353	non-UK non-RCT

Study	Reason for exclusion
Johnson-Motoyama, Michelle, Brook, Jody, Yan, Yueqi et al. (2013) Cost analysis of the strengthening families program in reducing time to family reunification among substance-affected families. Children and Youth Services Review 35(2): 244-252	non-UK non-RCT
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	Does not contain a population of interest
KELLY Greg and et al (2007) Permanence planning in Northern Ireland: a development project. Adoption and Fostering 31(3): 18-27	Study design does not meet inclusion criteria
KIRK Raymond and GRIFFITH Diane (2004) Intensive family preservation services: demonstrating placement prevention using event history analysis. Social Work Research 28(1): 5-16	Does not contain a population of interest
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	non-UK non-RCT
KOLKO David J.; BAUMANN Barbara L.; CALDWELL Nicola (2003) Child abuse victims' involvement in community agency treatment: service correlates, short-term outcomes, and relationship to reabuse. Child Maltreatment 8(4): 273-287	Does not contain a population of interest
Kriebel, Dawn Kastanek, Wigfield, Allan, Reilly, Debbie et al. (2002) Preparing for Change: Results from a Therapeutic Intervention with Foster Children in the Midst of Permanency Planning. Adoption Quarterly 6(2): 59-65	Study design does not meet inclusion criteria

Study	Reason for exclusion
Landsman MJ, Groza V, Tyler M, Malone K. Outcomes of family-centered residential treatment. Child Welfare. 2001 May 1;80(3).	Quasi-experimental non-UK study
Leathers, Sonya J (2003) Parental visiting, conflicting allegiances, and emotional and behavioral problems among foster children. Family Relations: An Interdisciplinary Journal of Applied Family Studies 52(1): 53-63	non-UK non-RCT
Leathers, Sonya J (2002) Parental visiting and family reunification: could inclusive practice make a difference?. Child welfare 81(4): 595-616	non-UK non-RCT
Lee R.E. and Stacks A.M. (2004) In whose arms? Using relational therapy in supervised family visitation with very young children in foster care. Journal of Family Psychotherapy 15(4): 1-14	non-UK non-RCT
LEWANDOWSKI Cathleen A. and PIERCE Lois (2002) Assessing the effect of family-centered out-of-home care on reunification outcomes. Research on Social Work Practice 12(2): 205-221	Data not reported in extractable format
Lewandowski, Cathleen A and Pierce, Lois (2004) Does family-centered out-of-home care work? Comparison of a family-centered approach and traditional care. Social Work Research 28(3): 143-151	non-UK non-RCT
Mackie, J.F., Foti, T.R., Agu, N. et al. (2020) Early childhood court in Florida: Qualitative results of a statewide evaluation. Child Abuse and Neglect 104: 104476	- non-UK qualitative study of intervention not covered in this review
Madden, Elissa E, Maher, Erin J, McRoy, Ruth G et al. (2012) Family reunification of youth in foster care with complex mental health needs: Barriers and recommendations. Child & Adolescent Social Work Journal 29(3): 221-240	non-UK non-RCT

Study	Reason for exclusion
Maltais C., Cyr C., Parent G. et al. (2019) Identifying effective interventions for promoting parent engagement and family reunification for children in out-of-home care: A series of meta-analyses. Child Abuse and Neglect 88: 362-375	Systematic review used as source of primary studies
Maluccio, Anthony N (2000) What works in family reunification. What works in child welfare.: 163-169	Review article but not a systematic review
Martin, Mavin H, Barbee, Anita P, Antle, Becky F et al. (2002) Expedited permanency planning: evaluation of the Kentucky Adoptions Opportunities Project. Child welfare 81(2): 203-24	non-UK non-RCT
McNICOL Claire and KIRKPATRICK Ruth (2005) The good goodbye: helping children through transitions using storytelling. Scottish Journal of Residential Child Care 4(2): 31-42	Study design does not meet inclusion criteria
McWey, Lenore M and Mullis, Ann K (2004) Improving the lives of children in foster care: The impact of supervised visitation. Family Relations: An Interdisciplinary Journal of Applied Family Studies 53(3): 293-300	Not of relevance to this review question
Meezan, William and McBeath, Bowen (2008) Market-based disparities in foster care outcomes. Children and Youth Services Review 30(4): 388-406	not an investigation of an intervention
MENDES Philip and PURTELL Jade (2017) An evaluation of housing outcomes from a support program for young people transitioning from out-of-home care in Victoria, Australia. Scottish Journal of Residential Child Care 16(2)	Non-UK qualitative study

Study	Reason for exclusion
Milburn, Nicole L; Lynch, Marell; Jackson, Jennifer (2008) Early identification of mental health needs for children in care: a therapeutic assessment programme for statutory clients of child protection. Clinical child psychology and psychiatry 13(1): 31-47	Outcome(s) not of relevance to this review
Miller, Keith A, Fisher, Philip A, Fetrow, Becky et al. (2006) Trouble on the journey home: Reunification failures in foster care. Children and Youth Services Review 28(3): 260-274	Outcome(s) not of relevance to this review
Miranda, J (2017) Improving outcomes for older youth adopted from foster care. Journal of the american academy of child and adolescent psychiatry 56(10): S101	Abstract only
Modlin, Heather (2003) The Development of a Parent Support Group as a Means of Initiating Family Involvement in a Residential Program. Child & Youth Services 25(12): 169-189	Intervention description report only
MONCK Elizabeth (2003) Fast track to placements. Community Care 17403: 36-37	Not a peer reviewed publication
MONCK Elizabeth (2004) Concurrent planning: meeting the needs of younger looked after children. Childright 205: 9-11	No methods described No outcome of interest reported
NCT04382677 (2020) Families Together: intervention for Reunified Families. https://clinicaltrials.gov/show/NCT04382677	- RCT trial registry
NCT00701194 (2008) Early Intervention Foster Care: a Prevention Trial. Https://clinicaltrials.gov/show/nct00701194	Not of relevance to this review question

Study	Reason for exclusion
NCT01744951 (2012) Adoption-specific Treatment Prevention Pilot Trial. Https://clinicaltrials.gov/show/nct01744951	Not of relevance to this review question
NCT02173314 (2014) Nevada Initiative to Reduce Long-Term Foster Care. Https://clinicaltrials.gov/show/nct02173314	Not of relevance to this review question
Osborne, C., Warner-Doe, H., LeClear, M. et al. (2019) The Effect of CASA on Child Welfare Permanency Outcomes. Child maltreatment: 1077559519879510	- non-UK observational study
Oxford, Monica L, Marcenko, Maureen, Fleming, Charles B et al. (2016) Promoting birth parents' relationships with their toddlers upon reunification: Results from Promoting First Relationships home visiting program. Children and Youth Services Review 61: 109-116	Not of relevance to this review question
PENNELL Joan (2006) Restorative practices and child welfare: toward an inclusive civil society. Journal of Social Issues 62(2): 259-279	non-UK non-RCT
PEPYS Sarah and DIX Jennie (2000) Inviting applicants, birth parents and young people to attend an adoption panel: how it works in practice. Adoption and Fostering 24(4): 40-44	Intervention description report only
Pine, Barbara A and Spath, Robin (2009) Permanent families for adolescents: Applying lessons learned from a family reunification demonstration program. Achieving permanence for older children and youth in foster care.: 223-243	non-UK non-RCT
Pine, Barbara A, Spath, Robin, Werrbach, Gail B et al. (2009) A better path to permanency for children in out-of-home care. Children and Youth Services Review 31(10): 1135-1143	non-UK non-RCT

Study	Reason for exclusion
RANDALL John (2009) Towards a better understanding of the needs of children currently adopted from care: an analysis of placements 2003-2005. Adoption and Fostering 33(1): 44-55	Intervention description report only
Reifsteck, Judith (2005) Failure and Success in Foster Care Programs. North American Journal of Psychology 7(2): 313-326	Not an investigation of an intervention
Reilly, Thom and Platz, Laurie (2004) Post-Adoption Service Needs of Families with Special Needs Children: Use, Helpfulness, and Unmet Needs. Journal of Social Service Research 30(4): 51-67	non-UK non-RCT
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	
Rivera, Marny and Sullivan, Rita (2015) Rethinking Child Welfare to Keep Families Safe and Together: Effective Housing-Based Supports to Reduce Child Trauma, Maltreatment Recidivism, and Re-Entry to Foster Care. Child welfare 94(4): 185-204	non-UK non-RCT
Rodrigo, Maria Jose, Correa, Ana Delia, Maiquez, Maria Luisa et al. (2006) Family preservation services on the Canary Islands: Predictors of the efficacy of a parenting program for families at risk of social exclusion. European Psychologist 11(1): 57-70	Outcome(s) not of relevance to this review
Rushton A. (2004) A Scoping and Scanning Review of Research on the Adoption of Children Placed from Public Care. Clinical Child Psychology and Psychiatry 9(1): 89-106	Review article but not a systematic review
Ryan, Joseph P, Perron, Brian E, Moore, Andrew et al. (2016) Foster home placements and the probability of family reunification: Does licensing matter?. Child abuse & neglect 59: 88-99	Not an investigation of an intervention

Study	Reason for exclusion
Ryan, Joseph P and Schuerman, John R (2004) Matching family problems with specific family preservation services: a study of service effectiveness. Children and Youth Services Review 26(4): 347-372	Does not contain a population of interest
Sanchirico, Andrew and Jablonka, Kary (2000) Keeping foster children connected to their biological parents: The impact of foster parent training and support. Child & Adolescent Social Work Journal 17(3): 185-203	non-UK non-RCT
Selwyn, J, Frazer, L, Quinton, D et al. (2006) Paved with Good Intentions: The Pathway to Adoption and the Costs of Delay. British Journal of Social Work 36(4): 561-576	Not an investigation of an intervention
Sloan, Frank A, Gifford, Elizabeth J, Eldred, Lindsey M et al. (2013) Do specialty courts achieve better outcomes for children in foster care than general courts?. Evaluation review 37(1): 3-34	Non-UK, retrospective observational study
Somervell, Ann M; Saylor, Coleen; Mao, Chia-Ling (2005) Public health nurse interventions for women in a dependency drug court. Public health nursing (Boston, Mass.) 22(1): 59-64	non-uk non-RCT
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
Steele, Lynn (2000) The day fostering scheme: A service for children in need and their parents. Child & Family Social Work 5(4): 317-325	Outcome(s) not of relevance to this review
Sturgess, Wendy and Selwyn, Julie (2007) Supporting the placements of children adopted out of care. Clinical child psychology and psychiatry 12(1): 13-28	pre-2010 qualitative study

Study	Reason for exclusion
Swan, Alyssa M, Bratton, Sue C, Ceballos, Peggy et al. (2019) Effect of CPRT with adoptive parents of preadolescents: A pilot study. International Journal of Play Therapy 28(2): 107-122	Does not contain a population of interest
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	Not of relevance to this review question
Thompson, Ronald W, Ringle, Jay L, Way, Mona et al. (2010) Aftercare for a cognitive-behavioral program for juvenile offenders: A pilot investigation. The Journal of Behavior Analysis of Offender and Victim Treatment and Prevention 2(3): 198-213	non-UK non-RCT
Tyler, Patrick M, Thompson, Ronald W, Trout, Alexandra L et al. (2017) Important elements of aftercare services for youth departing group homes. Journal of Child and Family Studies 26(6): 1603-1613	Study design does not meet inclusion criteria
Tyuse, Sabrina W; Hong, Philip P; Stretch, John Jack (2010) Evaluation of an intensive in-home family treatment program to prevent out-of-home placement. Journal of evidence-based social work 7(3): 200-18	Does not contain a population of interest
Wade, Jim (2011) Preparation and transition planning for unaccompanied asylum-seeking and refugee young people: A review of evidence in England. Children and Youth Services Review 33(12): 2424-2430	Not of relevance to this review question
White, Kevin R (2016) Placement discontinuity for older children and adolescents who exit foster care through adoption or guardianship: A systematic review. Child & Adolescent Social Work Journal 33(4): 377-394	Systematic review used as source of primary studies

Study	Reason for exclusion
WIGFALL Valerie; MONCK Elizabeth; REYNOLDS Jill (2006) Putting programme into practice: the introduction of concurrent planning into mainstream adoption and fostering services. British Journal of Social Work 36(1): 41-55	Qualitative study published earlier than 2010
Wilmshurst, LA (2002) Treatment programs for youth with emotional and behavioral disorders: an outcome study of two alternate approaches. Mental health services research 4(2): 85-96	Does not contain a population of interest
Wind, Leslie H, Brooks, Devon, Barth, Richard P et al. (2005) Adoption Preparation: Differences Between Adoptive Families of Children With and Without Special Needs. Adoption Quarterly 8(4): 45-74	Outcome(s) not of relevance to this review
Worsham, Nancy L, Kretchmar-Hendricks, Molly D, Swenson, Natalia et al. (2009) At-risk mothers' parenting capacity: an epistemological analysis of change through intensive intervention. Clinical child psychology and psychiatry 14(1): 25-41	Non-UK qualitative study
Worcel SD, Furrer CJ, Green BL, Burrus SW, Finigan MW. Effects of family treatment drug courts on substance abuse and child welfare outcomes. Child Abuse Review: Journal of the British Association for the Study and Prevention of Child Abuse and Neglect. 2008 Nov;17(6):427-43.	Non-UK non-randomised 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	non-UK non-RCT
Zhang S., Huang H., Wu Q. et al. (2019) The impacts of family treatment drug court on child welfare core outcomes: A meta-analysis. Child Abuse and Neglect 88: 1-14	Systematic review used as source of primary studies

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
DIXON, Jo (2011) How the care system could be improved. Community Care 17211: 16-17	- Exclude - not an economic evaluation
Hansen, M.E. (2008) The value of adoption.	- Exclude - Cost benefit analysis of the value of adoption. Does not assess the cost-effectiveness of interventions promoting or facilitating adoption.
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

Appendix K – Research recommendations – full details

Research recommendation

What is the effectiveness of interventions to support the stability of placements in looked-after children and young people moving out of care to permanency (incorporating the perspectives of looked after children and permanency carers)?

Why this is important

Once a child enters care, a home placement will be sought which is the right placement for the child or young person. However, placement moves are common. This review considered what specific interventions are effective for improving permanency outcomes after transition however few studies reported long-term placement durability outcomes, including post-permanency outcomes showing that the looked after person was thriving in their new long-term placement e.g. mental or emotional wellbeing outcomes, quality of life, health outcomes (e.g. sexual health, nutrition, dentition, health behaviours, or risk-taking behaviours), or behavioural, educational, and social functioning following transition. Finally, another review completed for this guideline did not find sufficient qualitative evidence on the perspective of adopters and long-term permanency carers regarding the transition out of care and how this could be improved.

Rationale for research recommendation

Importance to 'patients' or the population	Moves out of care or between care settings may require special supports to ensure the long-term success of these placements. Indeed, good support for looked after children and young people in their movement out of care into adoption could have the dual effect of ensuring long term stability for the child and encouraging other potential adopters. Achieving permanence is associated with better outcomes for looked after children and young people.
Relevance to NICE guidance	Interventions to promote a successful transition out of care into permanency have been considered in this guideline. In another review, the perspectives of looked after children, young people and their carers regarding support for transition out of care were also considered.

Relevance to the NHS, public health, social care and voluntary sectors	Besides the many benefits of permanent placements for looked-after children and young people. Preventing placement breakdown beneficial to the NHS, public health, and social care sectors, for whom time and resources may be required to assist in the identification of alternative placements for those in whom placements have broken down. Following move out of care, a breakdown of placement would also lead to the return of the child to the care system and "take up" a place that could have been offered to another child in care.
National Priorities	High: this research question is relevant to national statutory policy documents such as Statutory Guidance on Adoption For local authorities, voluntary adoption agencies and adoption support agencies from the Department of Education.
Current evidence base	RCT evidence was identified for this review question. The most commonly reported outcome in the evidence base described whether a person in care had achieved permanency in the first place, usually through adoption, reunification, or permanent kinship placement. Unfortunately, while this measure was useful to show that the process to gain a permanent placement had been successful, the committee considered that it said little about the longer-term success of that placement in terms of health, safety, wellbeing, or stability. In addition, another review completed for this guideline did not find sufficient qualitative evidence on the perspective of adopters and long-term permanency carers regarding support for the transition out of care and how this could be improved.
Equality considerations	Research should consider the differences in approaches required for looked after young children, and those who are older, or adolescents.

	Research should consider the different approaches required for different kinds of permanency carer e.g. connected carer, long-term foster carer, special guardians, and adopters Research should consider additional support needed for those with mental and emotional health problems, learning disabilities, speech language or communication needs, or behavioural disorders. Research should consider additional support needed for those who are parents in care. Unaccompanied asylum seekers may require different approaches to help them settle in to new permanent placements, as well as those who have a history of trauma, going missing, exploitation, or experience of human trafficking.

Modified PICO table

Population	Looked-after children and young people transitioning out of care to living with their adoptive or birth parents or special guardians, or into connected care.
Intervention	Interventions to support carers and looked after children in the transition period out of care into permanency, with a view to equip the permanency carer to support the looked after person long term.
Comparator	Usual care, waiting list, or another approach to support the transition of looked after children and young people transitioning out of care into permanency.
Outcome	The long-term durability of permanency placements. Mental or emotional wellbeing, quality of life, health outcomes (e.g. sexual health, nutrition, dentition, health behaviours, or risk-taking behaviours), or behavioural,

	educational, and social functioning of the looked after person following transition The perspective of the permanency carer regarding the support received during transition and how this could be improved.
Study design	A mixed methods study should test an intervention to improve the transition of looked after persons out of care into permanency and additionally gather information on the perspectives of the permanency carer and looked after person regarding the transition process and the support received. The study should assess the effectiveness of the intervention using a randomised controlled trial or controlled prospective experimental study. The qualitative aspect of the study should use qualitative methods (e.g. semi-structured interview or focus group) with thematic analysis to draw out themes.
Timeframe	The timeframe of the study should consider both the period immediately after transition and long term outcomes (e.g. 1 – 2 years later).
Additional information	None

Research recommendation

What is the effectiveness of mental health support for promoting reunification with birth parents?

Why this is important

Reunification with birth parents, where possible and safe, may be the most desirable outcome for the looked after person themselves and the birth parent. This outcome could help to restore the natural relationship between child and birth mother. However, the underlying reasons leading to the child being taken into care in the first place must be fully explored and addressed. Currently there is evidence for the use of Drug and Alcohol Courts to aid reunification by intervening and providing support for drug addiction in the birth parent. However, rates of mental health problems are also high among birth parents who have had a child removed, these problems may also contribute to the reasons for children going into care.

There is currently insufficient evidence to explore the benefit of mental health support targeted at birth parents and the family unit, to support successful reunification in looked after children and young people.

Rationale for research recommendation

Importance to 'patients' or the population	Moves out of care or between care settings may require special supports to ensure the long-term success of these placements. Indeed, good mental health support for birth parents and the family unit could support reunification and ensure long term stability for the child. Achieving permanence is associated with better outcomes for looked after children and young people.
Relevance to NICE guidance	Interventions to promote a successful transition out of care into permanency, including reunification, have been considered in this guideline. In another review, the perspectives of looked after children, young people and their carers regarding support for transition out of care were also considered.
Relevance to the NHS, public health, social care and voluntary sectors	Besides the many benefits of permanent placements for looked-after children and young people. Preventing placement breakdown beneficial to the NHS, public health, and social care sectors, for whom time and resources may be required to assist in the identification of alternative placements for those in whom placements have broken down. Following move out of care, a breakdown of placement would also lead to the return of the child to the care system and "take up" a place that could have been offered to another child in care.
National Priorities	High: this research question is relevant to national statutory policy documents such as The Children Act 1989 Guidance and Regulations Volume 2: Care Planning, Placement and Case Review (2010, updated 2015) Department for Schools, Children and Families.

Current evidence base	RCT evidence was identified looking at Drug and Alcohol Courts, Recovery Coaches, and the Intensive case management model which focus on support for drug and alcohol addiction to promote reunification. Some of these interventions included components to support the mental health of birth parents, however, mental health support was not the primary focus of those interventions.
Equality considerations	Research should consider the differences in approaches required for looked after young children, and those who are older, or adolescents. Research should consider additional support needed for looked after children with mental and emotional health problems, learning disabilities, speech language or communication needs, or behavioural disorders.

Modified PICO table

Population	Looked-after children and young people transitioning out of care to reunification with birth parents or special guardians, or into connected care.
Intervention	Interventions to support the mental health of birth parents alongside court processes to determine the possibility of reunification, and alongside other support services to equip the birth parent to support the looked after person long term.
Comparator	Usual care, waiting list, or another approach to support the transition of looked after children and young people transitioning out of care into permanency.
Outcome	The long-term durability of permanency placements. Mental or emotional wellbeing, quality of life, health outcomes (e.g. sexual health, nutrition, dentition, health behaviours, or risk-taking behaviours), or behavioural,

	educational, and social functioning of the looked after person following transition. Adverse events such as safeguarding risks or placement breakdowns The perspective of the birth parent regarding the support received during transition and how this could be improved.
Study design	A mixed methods study should test an intervention to improve the transition of looked after persons out of care into reunification with birth parents and additionally gather information on the perspectives of the birth parent and looked after person regarding the transition process and the support received. The study should assess the effectiveness of the intervention using a randomised controlled trial or controlled prospective experimental study. The qualitative aspect of the study should use qualitative methods (e.g. semi-structured interview or focus group) with thematic analysis to draw out themes.
Timeframe	The timeframe of the study should consider moderate (e.g. 6 months) and long-term outcomes (e.g. 1 – 2 years later).
Additional information	None

Appendix L – References

Other references

None

Appendix M – Other appendix

No additional information for this review question.