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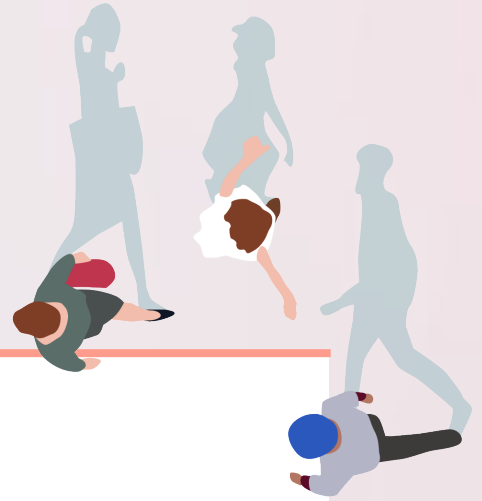
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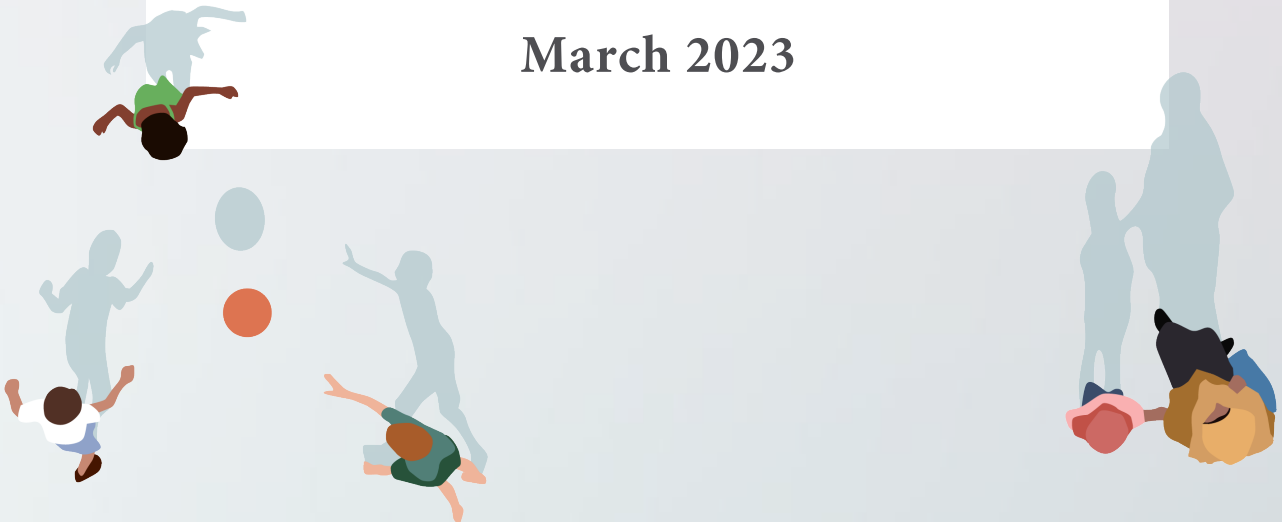


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KINSHIP CONNECTED: THE FEASIBILITY OF A PILOT RANDOMISED CONTROLLED TRIAL INVESTIGATING MENTAL HEALTH OUTCOMES FOR CHILDREN IN KINSHIP CARE

March 2023





What Works for
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Contents

Glossary of terms, abbreviations and acronyms	5
Executive summary	8
1. Introduction	10
Overview of report	10
Kinship care	11
Kinship Connected	12
2. Objectives	17
3. Methodology	18
4. Key findings	20
5. Limitations	40
6. Recommendations and next steps	41
References	44



Glossary of terms, abbreviations and acronyms

Adoption Order	Makes an adoption legal and gives the applicant parental rights and responsibilities for the child.
ASQ	Ages and Stages Questionnaire. Developmental and social-emotional screening questionnaire for children aged 0–6.
Baseline	A minimum or starting point used for comparison to a later point(s).
BITSEA	Brief Infant Toddler Social-Emotional Assessment. Questionnaire used to screen for social, emotional and behavioural problems and developmental delay in one- to three-year-olds.
Business as usual	The existing package of support offered to kinship carers and their families, without an intervention such as Kinship Connected. Typically this is the support provided by the local authority.
CAMHS	Child and Adolescent Mental Health Services.
Causal inference	Determining the independent or actual effect of an intervention or phenomenon.
Child Arrangement Order	This decides where a child lives, when a child spends time with each parent, and when and what other types of contact take place (e.g. phone calls). Child Arrangement Orders replace Residence Orders and Contact Orders.
Cluster randomisation	This is a form of randomisation where pre-existing groups of people such as schools, clinical treatment centres, or hospitals are randomised to receiving a treatment versus being observed (to serve as a control group).
Control or comparison group	Units or participants that do not receive an intervention. They may receive a standard treatment (such as business as usual care), a placebo or no treatment at all.
CYPMHS and CAMHS	Child and Young People’s Mental Health Services and Child and Adolescent Mental Health Services. CAMHS is an older



term for the main specialist NHS community service within the wider CYPMHS.²

DiD	Difference in Differences. DiD is a statistical technique that compares the average change over time in an outcome for a treatment group to the average change over time for a control or comparison group.
ECBI	Eyberg Child Behaviour Inventory measure for two- to 16-year-olds to assess children's disruptive behaviours and the extent to which parents find the behaviours troublesome.
Item	A single question in a questionnaire.
Maryland Scientific Methods Scale	This is a scale that is commonly used to assess the robustness of evaluation design. The scale ranges from 1 for studies showing a correlation between an intervention and an outcome at a single point in time, to 5 for RCTs. ³
Natural stepped wedge design	A stepped wedge design (see below) that takes advantage of natural lags in the commissioning process.
ONS	Office for National Statistics.
QED	Quasi-experimental design. A type of research design where individuals who receive an intervention are compared with individuals who do not receive the intervention. Statistic techniques account for any differences at the outset of the study.
PSM	Propensity Score Matching. PSM is a statistical matching technique that estimates the effect on a treatment group by accounting for the factors that predict receiving the treatment.
Randomisation	A technique used to randomly assign individuals to different arms of a trial, for example treatment and control groups for an RCT.
RCT	Randomised Controlled Trial. An RCT can be pilot (done as an experiment or test before being introduced more widely) or full-scale.

² For further information, see: nhs.uk/mental-health/nhs-voluntary-charity-services/nhs-services/children-young-people-mental-health-services-cypmhs

³ See Sherman, L., Gottfredson, D., MacKenzie, D., Eck, J., Reuter, P. & Bushway, S. (1998) *Preventing crime: What works, what doesn't, what's promising*. Baltimore, MD: Department of Criminology and Criminal Justice, University of Maryland.



RDD	Regression Discontinuity Design. RDD is a statistical technique to estimate an average treatment effect, by comparing observations lying either side of a threshold to which an intervention is assigned.
Residence Order	This has been replaced by Child Arrangement Orders, see above.
SCM	Synthetic Control Method. SCM is a statistical approach that compares the evolution of an outcome variable for a treatment group to the same outcome for a synthetic control group.
SCORE-15	15 questions used to assess family functioning. Questions focus on trust, listening, caring, crises and blaming behaviours within the family.
SDQ	Strengths and Difficulties Questionnaire. A questionnaire used to assess the mental health of two-year-olds and above.
Simple randomisation	A form of randomisation where each individual is randomly assigned to an arm of the trial. For a trial with treatment and control groups, this is comparable to a coin toss, where, for example, heads equals assignment to the treatment group and tails equals assignment to the control group.
Stepped wedge design	A form of cluster randomisation where clusters are subsequently randomised to the treatment group until all clusters receive treatment.
SGO	Special Guardianship Order. Individuals can apply for an SGO if a child cannot live with their birth parents and adoption is not right for them. A special guardian is responsible for looking after the child until they are 18.
SSDA903	This is a form that collects data about looked after children to evaluate the outcome of policy initiatives and to monitor objectives on looked after children.
Treatment group	Units or participants that receive an intervention.
WEMWBS	Warwick-Edinburgh Mental Wellbeing Scale. A robust and validated scale that provides a picture of mental wellbeing of an individual or group of people.



Executive summary

We investigated whether it would be possible to conduct a pilot Randomised Controlled Trial (RCT) of Kinship Connected to measure the mental health of children being cared for by kinship carers who are supported by Kinship Connected. Kinship Connected is an evidence-informed intensive support programme for kinship carers of children aged 0–18 years old. Specialist project workers provide practical and emotional one-to-one support for at least six months. Kinship Connected is a programme developed and run by Kinship – a charity for kinship carers.

This research was conducted by Ecorys, the University of Exeter and Kinship, and funded by What Works for Children's Social Care (WWCSC) and ran from April to December 2022.

The research was guided by four research questions:

- **RQ1:** Is randomisation acceptable to participants in this setting?
- **RQ2:** What are the key barriers and facilitators to potential participants taking part in this study?
- **RQ3:** What are the key barriers and facilitators for the study's success more widely?
- **RQ4:** What are the key design components of a proposed pilot study protocol?

In order to answer these research questions, we facilitated five focus groups: three with 13 kinship carers (including Kinship's Kinship Carer Advisory Group) and two with 10 Kinship and local authority staff in total. We also refined Kinship Connected's theory of change and logic model, scoped outcomes measurement tools and developed progression criteria to determine if a full-scale study is feasible and how it could be designed.

Regarding RQ1, focus group participants discussed the high levels of need of kinship carers supported by Kinship, and the associated negative implications that would arise from delaying access to support. Implications of these ethical concerns are that it was felt that access to the intervention should not be denied in areas where the intervention is already funded, and the control group should receive information and advice in case they should reach crisis point. A practical implication is that additional delivery for research purposes could be funded in areas where Kinship Connected is not yet commissioned. This would allow a range of research design options: natural stepped wedge RCT, cluster randomisation, simple randomisation on an ongoing basis, quasi-experimental design (QED), or theory-based evaluation.

Regarding RQ2, a key concern that focus group participants and Kinship staff had regarding kinship carers participating in the study is that the study could overburden carers in crisis. Other barriers for participation mentioned were the cost of living crisis, required time commitment and placement stability, where external factors leading to placement breakdown could lead to carers dropping out of the study. It was felt that an important facilitator for the study would be for carers to eventually receive support from Kinship Connected. Focus group participants valued the importance of research to expand the future support offer for kinship carers more than financial incentives, although incentives are likely to be important to secure and maintain participation in the study.

A main barrier for the success of the study is the variation of the characteristics and circumstances of kinship carers and the children they care for, and the associated variation in the treatment Kinship



Connected offers for each case. This threatens the validity of the treatment group and is a concern for the fidelity of delivery (the extent to which delivery is consistent across actors and as intended). Any differences in treatment across cases need to be recorded. Characteristics of kinship carers and the children they care for also need to be recorded, especially if the pilot study is not an RCT but is a QED.

A key facilitator for the success of the study will be to choose appropriate parameters for study design regarding the approach to randomisation; length of follow-up with study participants (maximising the potential to measure impact, minimise burden on participants, attrition); timing of outcome measurement (we suggest a minimum of three time points: a baseline measurement before the trial starts, six months follow-up, 12 months-follow up, and ideally, depending on funding, 18 months follow-up); and consent (we suggest to seek consent from all Kinship families in the involved local authorities).

Scoping of outcome measurement tools identified the Strengths and Difficulties Questionnaire (SDQ) as the most appropriate tool for measuring children and young people's mental health outcomes in this context, and it was viewed positively by kinship carers. The SDQ can be completed by kinship carers for the children or, from age 11 years upwards, by the children themselves. We consider the advantages and disadvantages of each approach, but ultimately propose that kinship carers complete the SDQ on behalf of children aged 2–18. Given the nature of the questions on difficult and potentially triggering issues, practical and emotional support for kinship carers and children before, during and after completing the questionnaires is vital.

We also outline progression criteria for a pilot RCT spanning ethical concerns and aspects of research design, recruitment and delivery.

The main limitation with this feasibility study is its limited scope. While findings from focus groups provided valuable qualitative insight, they may not be representative of all kinship carers, due to the small numbers involved and because participants were recruited by Kinship and often had taken part in one of their programmes.

The objective of this feasibility study was to answer the question: Is it possible to run a pilot RCT of the Kinship Connected intervention and what are the key design features of such a pilot?. We conclude that it is possible to run a pilot RCT. We would suggest funding for an additional roll out of Kinship Connected in local authorities where it is not yet commissioned, combined with a natural stepped wedge, cluster randomised trial design for the pilot. This would address some of the ethical, practical and logistical challenges that a study of this type typically offers. Overcoming these challenges will be crucial to involve a sufficient number of local authorities as well as kinship carers, the children they care for, project staff and local authority staff in any future study. In particular, with kinship carers experiencing a range of challenges and frequently being in crisis, they require any study to be as least burdensome as possible.



1. Introduction

Overview of report

This report presents the findings from a 2022 **feasibility study for a pilot Randomised Controlled Trial (RCT) of Kinship Connected**. What Works for Children's Social Care (WWCSC) provided funding to Ecorys, University of Exeter and Kinship to deliver the study.

The proposed pilot RCT would measure **mental health outcomes for children and young people cared for by a kinship carer who is taking part in Kinship's Kinship Connected programme**. This feasibility study aimed to understand under what conditions a pilot RCT of the Kinship Connected intervention would be feasible. Specifically, this feasibility study explored barriers and facilitators to potential recruitment, what the key outcomes should be, how data collection is best managed, and acceptability of randomisation.

An RCT is a type of research method. **In an RCT, participants are typically randomly assigned to either a treatment group – which receives the intervention that is being tested – or a control group which does not receive the intervention** and typically receives business as usual care. The two groups are then monitored and data on outcomes collected. The outcomes would then be compared to measure the impact of the support provided through the intervention.

The study built on previously conducted research by scoping the feasibility of undertaking a pilot RCT. **In this report, we also consider a quasi-experimental design (QED) if a pilot RCT proves unfeasible**. Unlike an RCT, a QED does not randomise participants, but instead uses statistical techniques to simulate an experiment. Crucially, **both RCT and QED methods offer a higher standard of evidence than previous research into kinship care**, offering Level 5 on the Maryland Scientific Methods Scale (Sherman et al., 1998) for the pilot RCT or Level 3 or 4 for QED. This means that greater confidence can be drawn in the study's conclusions, and causal inferences can be drawn. The pilot RCT is intended to support the eventual development of a full-scale RCT aimed at demonstrating the effectiveness of the intervention. It can also allow for causal inferences to be drawn.

After some background to kinship care and the Kinship Connected intervention, this report presents:

- Study objectives
- Methodology
- Key findings
- Limitations
- Recommendations and next steps.



Kinship care

Kinship care is where a person connected to a child, usually a family member or close friend, looks after the child full-time as their parents cannot. Kinship care is common and increasing. There is estimated to be around 200,000 children living in kinship care in the UK (Kinship 2021); more than double the number of children in local authority care (Kinship 2022).

There are many different types of kinship care and therefore local authorities have different duties and powers towards kinship carers depending on their legal situation. Kinship care includes children who may be:

- Living in an **informal arrangement** made by their parents – these kinship carers do not have parental responsibility for the child and have no automatic entitlement to support from their local authority, although the child can in theory be helped under Section 17 Child in Need provisions
- On a **Child Arrangements Order**, where the person named on the order shares parental responsibility with the parents and the local authority has discretion to provide a financial allowance
- Subject to a **Special Guardianship Order (SGO)**, where parental responsibility is shared between the parents and special guardians appointed by the court – the local authority has discretion to provide a financial allowance
- **“Looked after” by the local authority** and placed with kinship foster carers (who do not have parental responsibility for the child), where a financial allowance is paid (DfE, 2010).⁴

Kinship care is a complex family form that has not received the same levels of research, funding or support as other care options for children who are unable to live with their parents, such as foster care and adoption (Wellard et al., 2017; Hunt, 2019; Hunt, 2020). The children who live in kinship care have usually experienced similar traumatic experiences to children in mainstream foster care prior to living with their kinship carers, such as abuse and neglect (Farmer & Moyers, 2008; Selwyn et al., 2013; Hunt, 2020). As with other children who have experienced trauma, these experiences could affect their development, behaviour and ability to make and maintain relationships (Howe, 2005; Saunders & Selwyn, 2009; Wellard et al., 2017). However, **kinship carers often have additional vulnerabilities and needs when compared to parents, adoptive parents and foster carers**. They are more likely to be older, parent alone and experience social isolation, live in poverty, and be unemployed, poorly housed, have worse health and lower educational attainment (Aldgate & McIntosh, 2005; Farmer & Moyers, 2008; Nandy et al., 2011; Selwyn et al., 2013; Wijedasa, 2017; Hunt, 2020).

Foster care and adoption research has shown that the **support offered to carers of vulnerable children can have a direct impact on the outcomes for the children**; carers who receive adequate support for their own needs and in managing the needs of the children felt they provided

⁴ See kinship.org.uk/for-kinship-carers/what-is-kinship-care



better care for their children. Conversely, when they receive inadequate support they commonly find the parenting role more challenging (McSherry et al., 2016; Neil et al., 2018).

The additional needs of the children, combined with the vulnerabilities of their kinship carers, means that **kinship carers particularly benefit from additional support** (Saunders & Selwyn, 2009; Selwyn et al., 2013; Wade et al., 2014; Wellard et al., 2017; Hunt, 2018; Hunt 2020). However, in many cases **kinship carers and their children receive either insufficient support or no support at all** (Hunt & Waterhouse, 2012; Selwyn et al., 2013; Wellard et al., 2017; Grandparents Plus, 2018, 2019, 2020; Kinship, 2021).

Despite the challenges that kinship carers and their children face, and the lack of support many receive, there is evidence that the **outcomes for children in kinship care can be good and better than in other forms of care** (Aldgate & McIntosh, 2005; Farmer & Moyers, 2008; Selwyn et al., 2013; Wellard et al., 2017). There is also evidence that **additional support can achieve positive outcomes for children cared by kinship carers** (Schofield & Beek, 2005; Crittenden, 2012; Bifulco & Thomas, 2013; McSherry et al., 2016; Hunt, 2020). However, **this evidence rarely links to mental health outcomes, particularly of the children cared for, or makes causal inferences.**

Kinship Connected

Kinship Connected is Kinship's flagship programme for kinship carers. It aims to redress a lack of support for kinship families. It is an evidence-informed intensive support programme for kinship carers of children aged 0–18 years old. **Specialist project workers provide practical and emotional one-to-one support for up to six months**, and beyond if there is a need for further support. Support can include advocacy, active listening, helping kinship carers access local and national grants, signposting to other agencies, priority access to Kinship's advice line, confidence-building and training and skills development. Individual face-to-face support is provided in carers' homes or where needed: for example, accompanying carers and children to school meetings.

Peer support groups also play a key part in the programme, as there is evidence that they can make a significant difference to kinship carers' lives (York Consulting, 2017; Starks, 2018; Starks & Whitley, 2020). Groups give kinship carers an opportunity to share their stories, listen to each other, offer advice, and provide moral support. Kinship carers have also requested sessions that provide information about things they are experiencing in their life, at that time – such as trauma experienced by the child and possibly the kinship care and therapeutic parenting which may help to address this. Project workers are experienced in many areas of working with vulnerable children and families, and deliver these sessions themselves. By taking part in a peer support group, kinship carers' knowledge and expertise of their own situation increases, as does their confidence in their parenting skills (Starks & Whitley, 2020). Peer support groups are held in community venues, such as church halls or cafes, or virtually.

The frequency, duration and type of support provided by Kinship Connected is determined by each carer's individual needs, circumstances and score on the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS): a recognised tool for assessing adult mental health. Carers set goals at the beginning of the programme and Kinship project workers support them to achieve these goals. Each carer is assigned a priority level – high, medium or low – with the aim to reach the low priority level, once they have built their resilience, increased their self-confidence, and expanded their



support network. Individual support usually ranges from three times per week for high need cases to once a week or less for low priority ones. Frequency of peer support groups varies, as they are run locally, but typically groups meet weekly or monthly. Other activities are provided on an ad hoc basis.

Evidence of Kinship Connected's impact on kinship carers has been acknowledged by independent research (York Consulting, 2017; Starks, 2018; Starks & Whitley, 2020; MacAlister, 2022). Qualitative research with kinship carers also found improvements in children's development and behaviour, including their mental health and wellbeing. **A pilot RCT would add to this evidence base**, as well as address some of the research gaps mentioned earlier that apply to kinship care more generally, such as lack of focus on child outcomes and offering a higher standard of evidence than previous research.

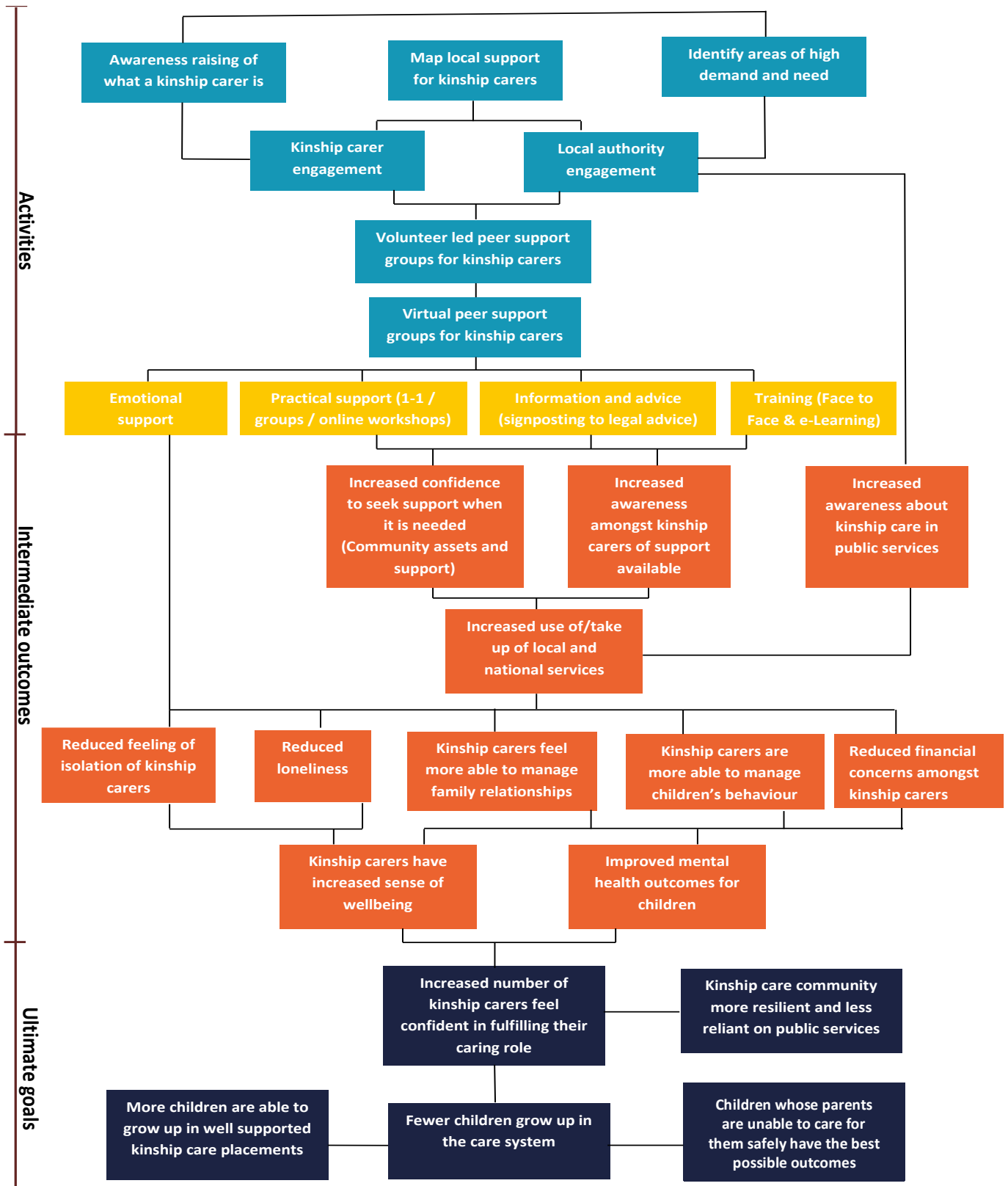
As of February 2023, Kinship Connected is commissioned by 18 local authorities in England and Wales. Although its programme of support is consistent across England and Wales, local authorities can implement their own preferences. For example, some local authorities encourage self-referrals to the programme, while others act as a gateway for referrals, preferring referrals to come directly from social work teams. Other local authorities only allow referrals of kinship carers that have an SGO, although Kinship encourages an open programme for all kinship carers of children aged 0–18 regardless of background or the nature of their caring arrangements.

The Kinship Connected logic model, based on its theory of change, is detailed in Figure 1.1. This is underpinned by a solid understanding of the client group and research summarised previously, and based on developmental work by Kinship to understand the pathways by which outcomes on the project can be achieved. This included a workshop as part of Nesta's Connected Communities Innovation Fund,⁵ and insight from external evaluations and service delivery. The theory of change was refined following comment from Nesta, other charities involved in the workshop and Kinship's delivery team.

⁵ [nesta.org.uk/connected-communities-innovation-fund-meet-grantees](https://www.nesta.org.uk/connected-communities-innovation-fund-meet-grantees)



Figure 1.1: Kinship Connected logic model





Kinship Connected is designed to impact on children’s mental health and wellbeing by ensuring kinship carers have the capacity to meet their kinship children’s needs. The theory of change highlights that children’s mental health outcomes are positively influenced by several key factors, including:

- **Kinship carers are better able to manage children’s challenging behaviour.** Children in kinship care often display challenging behaviour towards kinship carers and towards others (Crittenden, 2012; Kinship, 2021), as they have often experienced abuse, neglect or trauma in the care of their parents (Hunt, 2020). This can impact their mental health in two ways – firstly, as mental health problems can (but not always) manifest themselves in poor behaviour (DfE, 2018) and, secondly, due to the significant strain on carers who may experience challenging behaviour, which in turn affects their caring. As a result, carers need support to help their children manage their own behaviours (Holt & Birchall, 2020). Kinship Connected has supported carers to feel secure physically and emotionally, enabling them to build resilience and peer support networks (Starks & Whitley, 2020). These strengths have enabled kinship carers to support children to manage their own vulnerabilities including their emotional difficulties and mental health.
- **Kinship carers feeling more confident in their ability to manage family relationships.** An aspect of kinship care that causes some children distress is the contact they have with their parents, with evidence showing there is a “complex and dynamic relationship” between a child’s contact with their parents and their wellbeing (Iyer et al., 2020). This research has also found that, with support, special guardians can mitigate some of the more challenging aspects of contact, making it more beneficial for the children and with positive impacts on wellbeing. In addition, Kinship Connected has encouraged the Secure Base Model caring where caregivers provide a consistent and positive home and family environment to children who have experienced trauma (Schofield & Beek, 2005).
- **Reduced financial concerns.** Poverty and kinship care are intrinsically linked, with the 2011 Census identifying that children in kinship care are particularly likely to live in the poorest areas and in households experiencing deprivation (Wijedasa, 2015). There is evidence that reducing financial concerns reduces stress for carers who live in poverty (Wade et al., 2014) and increases their ability to meet the needs of their children (McGrath & Wrafter, 2021). This evidence fits with Maslow’s Hierarchy of Need (Maslow, 1943), namely that reducing financial concerns reduces poverty, minimises stress on carers and allows carers to better support children without having to spend as much emotional and physical energy trying to meet their own and their children’s physiological needs such as for food and warmth. Improving finances may also have direct effects on children through reducing their own stress and providing access to additional opportunities, hence benefiting mental health.

Kinship’s other programmes⁶ include:

- **Kinship Reach**, a remote one-to-one support programme, operating in nine local authority areas as of February 2023

⁶ kinship.org.uk/commission-our-services



- **Kinship Ready**, an online preparatory programme for new special guardians or those thinking about becoming one. As of February 2023, it is being delivered in 17 local authority areas across England and Wales. Six workshops over 12 months cover topics such as contact, trauma and attachment, support plans, overview of legal orders and where to go for help and support.

Kinship carers can also benefit from Kinship's:

- Confidential, non-judgemental and free advice service
- Someone Like Me telephone peer-to-peer support, which connects kinship carers with other kinship carers who can give friendly guidance and support
- Pilot peer online chat service: A free and confidential a safe space for carers to talk with an experienced kinship carer who will respond in real time
- Applications for free or subsidised holidays
- Family events
- Kinship Care Week activities: For one week each year Kinship hosts Kinship Care Week, where kinship caring is celebrated through social media engagement and local family events
- Facebook page: A place for carers to keep updated on kinship care, join a monthly advice surgery, get involved in lively discussions, share stories, news and events, and support each other.

Professionals working with kinship carers can also access support including the Kinship Care Professionals network, which has more than 1,000 members and holds quarterly national online meetings where professionals can share practice issues, and an annual Knowledge Exchange event.



2. Objectives

The objective of this feasibility study will be to answer the question: **Is it possible to run a pilot RCT of the Kinship Connected intervention and what are the key design features of such a pilot?**

The overall aim of this study and the potential pilot RCT is to provide the best possible evidence regarding whether Kinship Connected improves mental health outcomes for children and young people.

The following research questions will be explored to determine the feasibility and acceptability of a pilot RCT and what the key design features of such a pilot should be:

- **RQ1:** Is randomisation acceptable to participants in this setting?
- **RQ2:** What are the key barriers and facilitators to potential participants taking part in this study?
- **RQ3:** What are the key barriers and facilitators for the study's success more widely?
- **RQ4:** What are the key design components of a proposed pilot study protocol?

If this study finds that a pilot RCT is feasible, this will be commissioned separately and will establish the potential for running a full-scale RCT. The pilot study will also estimate key parameters for the design of a full-scale RCT, such as response rates and standard deviations of outcomes.



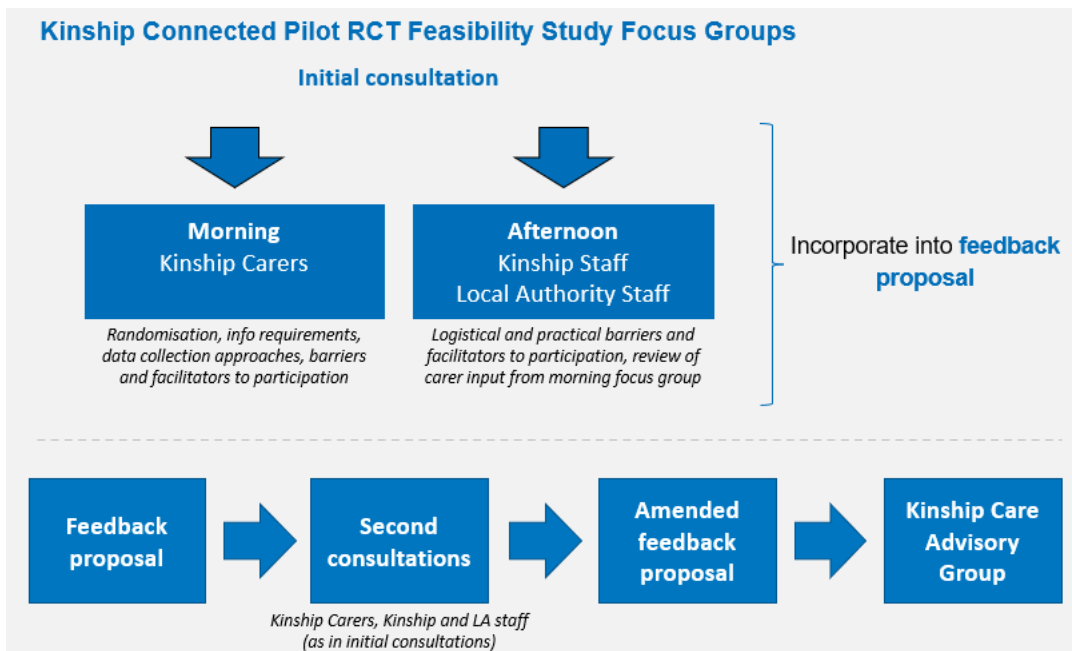
3. Methodology

The feasibility study methodology was derived based on feasibility studies conducted previously. It comprised:

- Refining Kinship Connected’s theory of change and logic model (see Figure 1.1), to understand the pathways by which outcomes on the project can be achieved and provide a conceptual framework to guide the feasibility study
- Scoping outcomes measurement tools
- Developing progression criteria, which determine if a full-scale is feasible and its design components (see RQ4 section)
- Three focus groups with 13 kinship carers in total, including one with Kinship’s Kinship Carer Advisory Group
- Two focus groups with 10 Kinship and local authority staff in total.

The focus groups were undertaken and analysed iteratively, seeking to develop the feedback expressed in the first two focus groups – one with kinship carers and one with staff – into the next two focus groups with kinship carers and staff, and finally with kinship carers on Kinship’s Kinship Carer Advisory Group (Figure 3.1). Focus groups lasted approximately 45 minutes and took place online.

Figure 3.1: Focus groups format



Kinship carers were recruited by Kinship contacting those that have been involved in a Kinship programme. Eight of the 13 kinship carers had taken part in Kinship Connected, three in Kinship Reach and two were known to Kinship but had not taken part in one of their programmes. Most of the



11 that had taken part in programmes were past cases though there were two current cases. The focus groups featured kinship carers from 10 local authorities from a mix of metropolitan and non-metropolitan areas across the north, midlands and south of England. For the nine kinship carers where data was known, kinship carers were aged 37 or older, with most aged 58 or over, and included one male kinship carer and at least two kinship carers from an ethnic minority.

The feasibility study protocol is registered as DOI: 10.17605/OSF.IO/GXDT7 here: osf.io/gxdt7. The feasibility study was approved by the Ecorys Ethics Committee and data was collected, managed and processed in accordance with legal obligations and industry best practice.



4. Key findings

Overview of key findings

The report now discusses the key findings in relation to each of the research questions, which were:

- **RQ1:** Is randomisation acceptable to participants in this setting?
- **RQ2:** What are the key barriers and facilitators to potential participants taking part in this study?
- **RQ3:** What are the key barriers and facilitators for the study's success more widely?
- **RQ4:** What are the key design components of a proposed pilot study protocol?

RQ1: Is randomisation acceptable to participants in this setting?

Main considerations

When first presented with the outline for an RCT, **some kinship carers taking part in the focus groups said that they would be willing to take part in the research.** However, throughout the discussions, it became clear that there were **ethical concerns with randomisation**, and particularly for the control group to not receive the intervention and potentially delaying their access to Kinship Connected, with one-to-one support seen as particularly beneficial. Kinship carers and Kinship project workers also commented on the timeliness and effectiveness of support that Kinship can offer compared to local authority support, including from children's services.

Kinship carers – all of whom had received support from Kinship – gave parallel examples of **negative implications of delaying access to effective support.** One member believed that if they had been able to access support from Kinship earlier, they would have been able to maintain a child's placement that eventually broke down. Another participant felt that if they had known their options earlier through Kinship Connected, they would not have accepted an SGO – they perceived an SGO not to provide enough mental health support to children, which is needed due to the trauma that children have experienced – and so they did not have informed choice prior to Kinship Connected. Another member told a similar story about not being informed about all the options of help available for their first five years of caring prior to Kinship Connected – and trying to access help but not receiving it. In this case they believed they would have benefited from an SGO rather than a Residence Order.

The perceived impact of Kinship Connected on kinship carers, in terms of avoiding negative outcomes, reflects the aforementioned **research evidence of the programme's success working with kinship carers** (York Consulting, 2017; Starks, 2018; Starks & Whitley, 2020; MacAlister, 2022). This is a noteworthy point as RCTs are appropriate for interventions where the impact has not



been established. RCTs should generally be conducted from a position of equipoise, where we do not know whether a novel treatment is effective or not. However, the studies cited focused on kinship carers (not the children they care for), and the standard of evidence in the studies was Level 3 or lower on the Maryland Scientific Methods Scale (Sherman et al., 1998). Although there is a developing body of evidence – with four studies cited, not just one or two studies in isolation – there remains an opportunity to undertake a study with more robust research methods to establish the impact of the programme more definitively.

The need to establish impact robustly is enhanced when the rollout of Kinship Connected is considered. An RCT is not about denying families support who would otherwise get it. **Funding for research purposes could be provided to fund delivery that would not ordinarily happen**, enabling more families to access services, either by expanding into new local authorities or extend capacity in ones where the intervention already runs. The former is definitely a possibility. As of February 2023, Kinship Connected operates in 18 local authorities – 17 in England and one in Wales⁷ – which is 10% of all 176 top-tier local authorities across England and Wales, so leaves potential for rollout into the remaining local authorities, of which there is already some demand to roll out the programme into new areas. Therefore, it would be possible to **randomise access to Kinship Connected so that no kinship carer is denied access to the programme in an area where it is already funded**. This process could also take advantage of natural lags in the commissioning process – for example, some local authorities will seek to commission Kinship Connected sooner than other local authorities – which could be exploited via a **natural stepped wedge RCT** for programmes rolled out in a staggered way. Here local authorities would not have the timing of rollout randomised, but if that timing process is conceptualised as being random (or at least unrelated to our primary outcome) then it can be treated as a stepped wedge design. A drawback with this approach are the set-up costs that would be required in the new local authority areas, so may be deemed expensive or, where there are fixed costs, limit the sample size.

Cluster randomisation would also be possible, where local authority units themselves would be concurrently randomised with a 50/50 chance of being allocated access to Kinship Connected. In order to incentivise local authorities randomised to the control arm, we would offer the intervention to them at the end of the study. For this reason, and because it involves randomising across large local authority areas, cluster randomisation can be prohibitively large and therefore expensive, as well as a reduced level of power from randomising at the local authority level rather than the individual level.

These approaches sit against **individual randomisation**, where all participants have a 50/50 chance of receiving the programme, regardless of the local authority they live in. Employing individual randomisation could mean that control group participants reside in the same local authority as treatment group participants that receive support, which kinship carers and delivery staff were generally uncomfortable with.

Nevertheless, a number of kinship carers said that many **families they know of that have taken part in Kinship Connected have high levels of need for support**. For example, children's behavioural and mental health problems were cited – so severe in one case that the kinship carer

⁷ Local authorities that commission Kinship Connected are available here: kinship.org.uk/commission-our-services/kinship-connected



gave up work.⁸ When these families are in a crisis situation, they need help straight away. For example, one focus group participant mentioned that they were at crisis point when they initially received support from Kinship, and if they were told that they would need to wait a year, they would “fall apart”. In the focus groups, kinship carers referred to some of the consequences of not receiving support, including potentially placement breakdown and kinship carers losing their children. One went on to say:

“I would be worried that some families would not be able to cope without the support, I would have struggled because I wasn’t getting help from my social workers. I was very stressed, and I was contemplating just giving up. Without that support I would have given up and a child would have ended up in the [care] system, so there needs to be something else in place if you don’t receive it.” (Kinship carer)

Other kinship carers said that:

“To have got to that point where you are asking for help, to be turned down does not sit well.” (Kinship carer)

“We would need to take the high level of need people out of the equation as we have got people experiencing near mental breakdowns and deaths in the family and it feels like you are playing God, so I don’t think it is appropriate for them.” (Kinship carer)

To address these issues, all participants in the control group should receive business as usual practice, so no participant will be denied a service that they would have received in the absence of the study. As a minimum, we would expect business as usual to involve access to information and advice should they reach crisis point and other existing support from the local authority. Information on the business as usual care should be collected to inform the analysis and interpretation of results. The consent process will explain clearly how the randomisation works and inform potential participants about the need for robust evaluation of interventions.

Focus group participants commented that **existing local authority support for kinship carers can vary** (see RQ2 section), **which presents a practical challenge when forming control groups across local authorities**. Any pilot RCT should seek to minimise, if not avoid, this issue, and where possible consider the feasibility of controlling for this issue (for example, differences between local authorities, or contact time with support worker) in any analysis.

One issue to consider is whether randomisation occurs on an ongoing basis as kinship carers and children progressively become identified for the programme, or once a certain number of children and families have agreed to participate in the study. This is likely to be dictated by how quickly local authorities can be engaged in the study, as it will take time to reach sufficient numbers of children and families to participate. Given this, **randomisation on an ongoing basis would appear to be more appropriate**. One challenge that this approach will pose is that participants will have different start (“baseline”) and end points, which may relate to different durations of treatment. This will need to be monitored in any pilot RCT, as well as assessing the estimated time for effects (if any) to occur to inform the design of a full-scale RCT.

⁸ As well as level of need, likelihood to engage with support is also a factor for some local authorities in prioritising access to Kinship Connected.



Ensuring this study is conducted to the **highest ethical standards** is particularly important given the nature of the client group involved and the potential need to randomise participants into treatment and comparator groups in any RCT. The approach should seek informed consent from participants, have patient and public involvement (namely from kinship carers and kinship children) in developing any future research, and be submitted to an appropriate ethical review body – for example, the WWCS Research Ethics Committee – so it meets the highest ethical standards. An Equality Impact Assessment and risk assessments should be undertaken, particularly for fieldwork, to include Disclosure and Barring Service (DBS) checks and safeguards for lone working and COVID-19. These assessments should be informed by relevant ethical frameworks and industry guidelines; for example:

- Frameworks such as the INCLUDE Ethnicity Framework, the UK Framework for Health and Social Care Research and the Economic and Social Research Council’s framework for research ethics
- Guidance from the Centre for Ethnic Health Research and the National Institute for Health and Care Research
- The Market Research Society and Social Research Association codes of conduct.

Alternatives

A **quasi-experimental design (QED) approach** is similar to the proposed pilot RCT in that it would involve comparison of outcomes between a treatment and a comparison group. The main difference is that the assignment of participants to the treatment and comparison groups is not random. This means that important differences between the two groups would need to be adjusted for, and so it would be difficult to minimise bias to the same extent as an RCT. Examples of QED include a stepped wedge or waiting list (like with a stepped wedge RCT, the comparison group would still be able to access the intervention but would need to wait one year so their outcomes can be measured) and a matching or weighting method such as Propensity Score Matching (PSM) or Difference in Differences (DiD). The stepped wedge approach is likely to be the most feasible as the local authorities forming the comparison group will receive the programme as a subsequent point (Table 4.1).

Table 4.1: Key considerations for research design

Potential design	Overview	Advantages	Drawbacks
Pilot RCT	Potential participants in Kinship Connected are randomly allocated to a treatment group that receives the intervention or a	Randomisation ensures that the treatment and control group are balanced in important ways and is the most effective method for mitigating the risk of selection bias and confounding factors affecting estimates of the treatment effect.	Practical and ethical challenges may impact on the ability to engage local authorities in the study



	control group that does not	Highest standard of evidence: Level 5 (out of 5) on the Maryland Scientific Methods Scale (Sherman et al., 1998)	
QED option 1 – “Stepped wedge” or “waiting list” design	Exploits a staggered rollout or high demand for service to identify children not accessing the service, to form a matched comparison group with similar characteristics to treatment group	Treatment/comparison groups internal to the local authorities allow for control of background characteristics specific to the local authority, and could widen the outcomes included, to include locally specific measures	Outcome measurement for the control group is limited to the time period that young people are on waiting list, and must control for factors that predict who receives the service first
QED option 2 – Matching or weighting method such as PSM or DiD	Identifies families with similar characteristics from other local authorities (with which Kinship has an existing relationship)	Young people could be tracked over the duration of the project to assess longer-term outcomes	Requires approvals from the local authorities involved and confirmation that a data linkage application is possible
No QED – Theory-based evaluation only	Uses the theory of change and adopts Realist Evaluation principles to explore counterfactuals through scenario-building and testing	Conducive to an evaluation involving complexity – e.g. to explore concepts of system change, connectivity and more subjective shifts in practices and attitudes arising from the transition towards the new service	Theory-based evaluation is considered a lower standard of evidence compared with an RCT or QED

A QED approach would address concerns with randomisation expressed by focus group participants. Participants were more favourable of a study where families with the highest levels of need or in crisis are prioritised to receive Kinship Connected support. QED is still a robust approach: Level 3 or 4 on the Maryland Scientific Methods Scale (Sherman et al., 1998), with Level 4 offering comparison between multiple treatment and control units (likely in this case to be local authorities), units with only minor differences or controlling for these differences.

Other QED methods such as Synthetic Control Method (SCM) and Regression Discontinuity Design (RDD) were considered but discounted as they are not likely to be feasible in this context. SCM would likely require a large, aggregated, area-based design (for example, comparing local authority performance), plus a relatively long pre-intervention period for robust weighting and creation of the synthetic control, which is not likely to be feasible given that outcomes will most likely rely on primary



data collection. SCM may be more feasible if using administrative data collection – for example, from SSDA 903 returns, though is still likely to be suboptimal given the likely pre-intervention period and area-based design required. RDD would require a threshold for support or assignment variable, such as level of need, which would be difficult because the decision whether a family is supported or not through Kinship Connected is based on a number of factors and difficult to quantify.

Other options could be to investigate a different outcome to children's mental health, or to measure the time from kinship carers requesting support to support being provided. In this example, matched cases could be compared between local authorities where Kinship operates with those that it does not to see if Kinship provides more timely support.

If a quasi-experimental design (QED) is not possible, evaluation could be conducted using a **theory-based evaluation approach**, looking at changes before and after the intervention (without a comparison group) and involving qualitative research and observational techniques such as consultations with Kinship Connected participants, staff and stakeholders. The main drawback of these approaches is that it would be difficult to attribute any perceived impact to the Kinship Connected programme.

RQ2: What are the key barriers and facilitators to potential participants taking part in this study?

In addition to considerations around randomisation (RQ1), participant involvement in a pilot RCT is dependent on a range of factors. These are discussed in turn.

Vital progression criteria will be assessing whether local authorities, and by extension kinship families and children, are **committed to taking part in the study** (see RQ4 section). The pilot RCT should take a realistic and pragmatic approach to overcoming any practical, logistical and ethical challenges and securing buy-in from all stakeholders, emphasising the importance of high standards of evidence, that funding is delivery that would not ordinarily happen (expanding into new local authorities or extending capacity in existing local authorities), and the number of local authorities involved in RCTs via WWCS and elsewhere.

An important facilitator for participants to take part in a study is being able to receive support from Kinship Connected at some point. Local authorities' approaches to, and support for, kinship carers vary – described as a “postcode lottery” by Kinship staff – though typically carers receive “little or no support from local authorities” (Starks & Whitley, 2020). This is often because local authorities have limited funding and capacity for support for kinship carers beyond legal obligations, and waiting lists for support can be long. This means that looked after children tend to receive the most support from a local authority (particularly those subject to a Child Protection Plan), but those who are not looked after (for example, where a Special Guardianship Order or Child Arrangements Order has been made) do not. This concern was echoed by a participant, who added that there are also differences in eligibility for local authority support. Some local authorities accept anyone who is referred for support from other local authority services, other agencies or self-referrals, whereas others will only deal with those who have the highest levels of need for support.



Kinship carers and staff concurred that there was a lack of support from local authorities directly. One Kinship worker said:

“Kinship [Connected] can often step in earlier than social care can, which is needed when families are in crisis ... in those cases Kinship [Connected] and Kinship Reach can be lifelines for people.” (Kinship worker)

Reflecting this, the worker told of two contrasting examples: one where a social worker was able to assist a family and another case where they did not, and the child went into care. A kinship carer also commented on differences in support – on this occasion, due to caring for one of their children being considered a private arrangement:

“I get finance for one child but not the other. Both are on Residence Orders and both came to us via social services recommendations, but they [the local authority] reckons the one I don't get paid is a private arrangement so I am not entitled to it [finance].” (Kinship carer)

Some participants also mentioned that, **with kinship carers being in crisis, they may not have the capacity to take part in a research study, or at the very least would require any study to be as least burdensome as possible:**

“At the start of the journey of taking in a kinship child, your head is so full and all you want to do is take care of the child – it is hard to understand the trauma the child have been through. I don't think that research would be beneficial at that point.” (Kinship carer)

Other barriers and facilitators to potential participants taking part in this study could include:

- **Financial incentives or vouchers**, to recruit and retain participants. However, kinship carers in the focus groups were more concerned with **ethical challenges** (a barrier) and the **importance of the research** for future support (a facilitator) than financial incentives, although in practice these are likely to be important to secure and maintain participation in the study. Kinship carers did however emphasise wanting to get their views across via research, be kept informed about it and see its reporting outputs at the end of the study:

“Research is a really good tool to try and get your point across and for people to listen.” (Kinship carer)

- **The cost of living crisis** is likely to be a barrier to participation, and stress the importance and value of incentives
- The **time commitment** involved – focus group participants commented that a short questionnaire would be welcomed
- **Placement stability:** External factors that lead to high numbers of placement breakdowns amongst the treatment and/or control groups could lead to high levels of attrition.



RQ3: What are the key barriers and facilitators for the study's success more widely?

Programme delivery and study design

Kinship Connected programme delivery varies from case to case, both due to different needs between families and because the programme can be commissioned differently across local authorities. Support can involve different blends of activities with each family, and different lengths, with project worker support stretching beyond six months if there is real need for it identified.

Differences in local authorities' commissioning of Kinship Connected can be varied. One difference is that local authorities choose whether they want all referrals to come via them or whether Kinship can also accept self- or peer-referrals via the community – which Kinship encourages. In some areas referrals are capped per quarter to manage capacity. The programme is generally open to all kinship carers of children aged 0–18 regardless of background or caring or child protection status, though in some local authorities only special guardians are eligible, which might limit the sample. In addition, Kinship Connected may be commissioned alongside Kinship's other programmes or in isolation. All of these factors can change over time, so that there are differences between local authorities in their commissioning of Kinship Connected, but also within local authorities over time.

These differences present issues for the validity of the treatment group. Where possible, differences among the treatment group should be recorded and controlled for, in a complementary way that differences among the control group should be controlled for to enable a valid comparison (see RQ1 section previously).

A key facilitator for the success of the study is **choosing the right parameters for the study design**. As well as approach to randomisation, the length of follow-up with study participants should maximise the potential to measure impact whilst minimising burden on participants and attrition.

We recommend that the provider undertaking the pilot RCT seeks **consent from all kinship families** in the local authorities involved in the study. Therefore, sample sizes will more likely be constrained by the number of local authorities participating. Based on similar studies, a minimum of 50 families participating should be sufficient for the purposes of a pilot RCT, with the primary purpose to outline a full RCT rather than for impact estimates. Initial estimates from Kinship forecast Kinship Connected to be rolled out in a further five local authorities, subject to funding, involving approximately 300 children and 200 kinship carers (approximately 60 children and 40 kinship carers per location).

We propose that the mental health outcomes of each group would be measured over a 12-month period, using a **questionnaire at three points**:

- Before the trial
- Six months after the trial has begun, to coincide with the end of Kinship Connected support (Kinship Connected support lasts for six months in most cases)
- After a further six months (to maintain the same interval), to measure medium-term impact.



Subject to funding, an additional measure after an additional six months (12 months after the end of support and 18 months since the baseline questionnaire) could measure longer-term impact, and incorporate the full impact of extended cases and re-referrals. However, this could potentially extend local authority involvement and delay support for kinship carers and/or local authorities (depending on how randomisation is achieved) in the control group.

Because it is proposed that children will be followed up six (or 12) months after their involvement with Kinship Connected, it will be necessary for Kinship to maintain a relationship with the child and family after the support has ended, in order to measure medium- or long-term impact. Kinship staff did not foresee any issues with this and said that even after kinship carers have completed their support, the vast majority of kinship carers remain engaged and many stay in touch or access Kinship’s other support services or group networks.

Allowing for a rolling period of recruitment, and including preparation and analysis, we estimate that the pilot RCT study would most likely last approximately three years, comprising:

- Set up, ethical approval and recruitment: six to 12 months
- Survey: 24 months (rolling)
- Analysis and reporting: Six months.

A suggested timeline is illustrated in Figure 4.1.

Figure 4.1: Illustrative timeline for a pilot RCT

	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12
INTERVENTION (KINSHIP CONNECTED) TASK												
Setup in new local authorities												
Delivery												
Keeping in Touch with treatment and comparator groups												
RESEARCH TASK												
Strand 1: Inception and project management												
Project inception												
Research tools design	○											
Study Steering Committee												
Project management and updates	○	○	○	○	○	○	○	○	○	○	○	○
Strand 2: Scoping the pilot RCT												
Set up data collection tools												
Scope the treatment and comparison groups for the pilot RCT												
Strand 3: Pilot RCT												
Data management plan			○									
Ethical approvals												
Randomisation												
Recruitment												
Data collection												
Data entry												
Analysis												
Trial management												
Strand 4: Dissemination, outputs and anticipated impact												
Reporting					○							○
Dissemination						○						○
Data archiving												

○ = Output related to milestone



The **different circumstances and levels of need for support of kinship carers and their families**, which has already been mentioned in relation to their effects on randomisation, will have wider implications for study design. By using randomisation, an RCT is the best statistical method to control for these factors. Even so, it will be important to check for balance on these factors between the treatment and control group or, if employing a QED, to make adjustment for them as much as possible. These characteristics could include:

- Kinship carer relationship (for example, grandparent, sibling, aunt, uncle or cousin)
- Formal or informal care, and type (for example, SGO, Child Arrangement Order, private arrangement)
- Time in kinship care
- Age when first placed
- Time order has been in place (if relevant)
- Number of children (own and kinship children) in the household
- Demographic characteristics of kinship carer (for example, age, ethnic group, health status)
- Demographic characteristics of children (for example, age, ethnic group)
- Kinship carer is single parent or not
- Kinship carer income and employment status
- Adverse childhood or other traumatic events for the child
- Specific difficulties of the child such as disability or autism diagnosis or attachment disorder
- Access to financial allowances and therapeutic support for children.

One key parameter is age of children being cared for, since there may be differences between the age groups and how the intervention works on them. The needs of children aged 2–4 years will be very different from children aged 15–17 years, for example. For the pilot RCT, a broad age range can be considered, in order to test efficacy for a full RCT. However, a full RCT may need to limit its age range to avoid diluting its findings.

Outcome measurement tools

The mental health of children in kinship care was identified as the key outcome of interest for the pilot RCT, because of the paucity of existing research evidence and also through the theory of change and logic model (Figure 1.1). This outlines that children’s mental health outcomes are influenced by kinship carers:

- Being more able to manage children’s behaviour



- Being more able to manage family relationships
- Having reduced financial concerns.

Mental health outcomes, particularly for young children, encompass a wide range of complex and interrelated domains (Szaniecki & Barnes, 2016). They can range from outcomes associated with day-to-day wellbeing to outcomes involving acute episodes involving Child and Young People’s Mental Health Services (CYPMHS) intervention or hospitalisation.

Another consideration when selecting the outcome to measure is the measurement tools available. There are copious numbers of tools to assess mental health. We have reviewed a range of tools that may be applied to assess the mental health of children, infants and babies. These are listed alongside a brief description in Table 4.2.

Table 4.2: Potential standardised measures for children’s mental health

Measure for children’s mental health	Brief description
Strengths and Difficulties Questionnaire (SDQ)	25 items plus impact supplement and follow-up questions for two-year-olds and above, completed by parents or carers (or option for young people aged 11+ to complete) to produce total scores of child adjustment, externalising and internalising problems.
Brief Infant Toddler Social-Emotional Assessment (BITSEA)	42-item parent/carer-report ⁹ questionnaire used to screen for social, emotional and behavioural problems and developmental delay in 1–3-year-olds.
Ages and Stages Questionnaire (ASQ)	Developmental and social-emotional screening questionnaire for children aged 0–6.
Eyberg Child Behaviour Inventory (ECBI)	36-item measure for 2–16-year-olds ¹⁰ to assess children’s disruptive behaviours (externalising behaviour only) and the extent to which parents find the behaviours troublesome.
ONS 4 personal wellbeing questions	The four questions (0–10 scale) ask about life satisfaction, happiness, things done in life feeling worthwhile, and anxiety. Data is available on peers in the general population.

⁹ In addition to parents and carers, nursery, teaching, support, local authority, Kinship staff or other professionals could assist with completion.

¹⁰ There is a slightly different questionnaire for parent/carers of 2–3-year-olds, with the item on reflectiveness is softened, two items on anti-social behaviour are replaced by items on oppositionality and the other 22 items remain the same.



Multidimensional Perceived Social Support scale	12 items that measure the perceived adequacy of the available amount of social support.
The SCORE-15	15 questions used to assess family functioning. Questions focus on trust, listening, caring, crises and blaming behaviours within the family.
Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS)	14-item questionnaire used by Kinship Connected to assess mental wellbeing Validated from age 11 years and upwards.

We suggest that the Strengths and Difficulties Questionnaire (SDQ) is the most appropriate tool for measuring children and young people’s mental health outcomes in this context. The SDQ is widely recognised and has good psychometric properties (EIF, 2020; Goodman, 2001). The SDQ is wide-ranging with 25 items, plus impact supplement and follow-up questions, on psychological attributes, including child adjustment and both externalising and internalising problems. These incorporate emotional symptoms, conduct, hyperactivity and inattention, peer relationships and prosocial behaviour. The SDQ is available to a wide age range and in a variety of languages so as to not inhibit participation of participants who do not have English as a first language.

The key advantages of the SDQ compared with other tools are that it does not require specialist training, is widely used by local authorities and is mandated by government as it forms part of the SSDA903 standard statistical return for all looked after children (plus those who have recently left care, up to the age of 21). In some local authorities it is an assessment tool as part of therapy or as a requirement for an application to the Adoption Support Fund, or research studies (for example, Ecorys et al., 2023). Indeed, some of the kinship carers in the focus groups were familiar with the SDQ and had filled it out for their children. It can also be considered a robust tool (Midgley et al., 2019). All of the above factors should help with engaging local authorities in supporting the use of the tool and potential future studies more generally. For monitoring purposes and to ensure representativeness of the recruited sample, we advise that the SDQ is supplemented with questions on kinship carers and their children’s demographic background, time in care and/or legal order (for example, an SGO) and levels of previous support from Kinship or another organisation.

Kinship staff will be equipped to manage practical considerations around engaging children and families in the research, gathering consent and supporting visit arrangements. The initiation visits will be supported by a dedicated helpline to a named researcher for any follow-up queries or concerns.

SDQ completion by children aged 11 and above warrants further consideration, since a parent/carer report is not necessarily the same as actual change in children’s mental health. Self-completion of the SDQ is possible for those aged 11 and above in addition to carer completion (Goodman, 2001; Youth in Mind, 2020). Given the possibility to restrict the age range of children involved in the study (see RQ3 section), it is possible that a future RCT could consider four separate data collection approaches depending on the age groups involved:



- Only those aged under 11 (parent/carer SDQ)
- Only those aged 11 and over (self-report SDQ)
- Both under 11 and 11 and over (parent/carer SDQ, with potential to use self-report as additional measure for those 11 and over)
- Both under 11 and 11 and over (parent/carer SDQ for all ages) (proposed).

For the pilot RCT, we recommend that a broad age range can be considered, in order to test efficacy for a full RCT. However, a full RCT may need to limit its age range to avoid diluting its findings, if sufficient sample sizes across age ranges cannot be maintained.

We propose that kinship carers complete the SDQ on behalf of children aged 2–18 involved in the study. Carer-report is how SDQs are completed for the SSDA903 return, and data from parent/carer and young person SDQ reports are not necessarily identical (Midgley et al., 2019), which favours consistency over completion. Most kinship carers and staff in the focus groups expressed reservations with children of any age completing the SDQ. Issues expressed included:

- Could be triggering for the child
- Children have gotten angry in the past because they feel there is too much interference in their lives
- It would require support from the kinship carer (or other professional such as Kinship, local authority or school staff) anyway
- There are large differences between children within and across ages – some would be able to complete it, and some not
- Wording is generally OK and age-appropriate, though some children may struggle with the wording still
- Children might not fill it in accurately or provide honest answers – they might just put what they think people want to hear (this could also be an issue with carer-report)
- Children might believe they could get into trouble or be passed judgement from their answers.

The SDQ is not recommended for use with 0–1-year-olds. This means that a small cohort of children in kinship care would not be able to complete the SDQ, as is the case for the SSDA903 return. However, we do not believe there exists another measure which incorporates ages 0–18 (or above), and not one that has the advantages of the SDQ outlined above, particularly its recognition and use. This may in part reflect that the mental health of a 0–1-year-old is very different from older children as outlined above, which questions the merits of a study featuring children aged 0–18 (or above).

Given the low numbers of 0–1-year-olds likely to be involved and the specific measures required, we would suggest doing a separate study focusing specifically on this age group with specific measures. If a study was to focus on a smaller age range incorporating the 0–1 age range, it would be possible



to use a measure more appropriate for babies and infants, such as the BITSEA. However, again measures other than SDQ do not benefit from the same level of recognition and use. It would also be possible to measure the mental health outcomes of 0–1-year-olds using qualitative research (though this lower standard of evidence would make attributing impact more difficult) or a different measure to the SDQ used with other study participants (though the lack of comparison between different measures would question the merits of doing so and essentially conducting two separate studies).

The SDQ can be completed on paper or online via mobile, tablet or computer. Kinship carers had contrasting views on whether they preferred paper or online completion, and **a hybrid approach offering both paper and online completion was favoured**. Reservations cited included that some kinship carers might not be computer literate or have access to devices, so paper completion should be an option, whereas those preferring online completion liked the ability to complete there and then and not have forms lying around that could get lost or be triggering.

Given the practicalities of completing questionnaires and the nature of the questions on difficult and potentially triggering issues, **practical and emotional support for kinship carers and children before, during and after completing the questionnaires is vital**. Support could be provided by Kinship staff (for the treatment group), local authority or nursery or school staff (for the control group) and by the research team (supporting staff to facilitate completion). In addition, staff suggested that support could be provided through support groups run by Kinship or other organisations.

Staff interviewed were happy to provide practical and emotional support to kinship carers and children in order to complete the questionnaires and any follow-up. As well as in-person support, kinship carers were generally content with support being provided remotely, which some staff preferred to have the option to do so. Staff cited busy workloads could be a barrier to supporting families and securing buy-in of staff to support the study. As with means to secure the buy-in of local authorities and other stakeholders discussed in the RQ2 section, to secure buy-in of workers to support the study, we recommend emphasising the importance of the research to future rollout and potentially benefiting other families.

One issue noted by Kinship staff is that they do not have a direct relationship with the child of the kinship carer, as Kinship Connected is designed to support the kinship carer – the benefits of which are being tested if they impact on children’s mental health outcomes (see logic model in Figure 1.1). Though typically project workers have good relationship with the children cared for, sometimes kinship carers do not want workers there with the child, because children can see the service is for the kinship carer and not them. This was thought to be rare, however.

A practical issue is that we are proposing that kinship carers would be supported to complete questionnaires for a study into the impact of a service by project workers who are key actors in providing that service (treatment group), or by local authority or nursery or school staff (control group). In that sense the study would not be a blinded experiment. However, given the nature of the issue being disclosed, and the practicalities of maintaining contact with families, we feel there are no other practical options. It should also be noted that different methods of obtaining the outcome measures between the treatment and control groups may challenge the validity of the results, and so may be an issue for a full-scale RCT trying to establish impact. However, we believe these issues are likely to be minimal in practice given that, for example, the questionnaires do not refer to the programme, so it would be difficult to skew answers within it towards the programme.



The SDQ was generally viewed fairly positively by kinship carers and was not too long; although some felt it was a bit long and repetitive, and that kinship carers might feel a bit despondent looking at a long list of questions that reflect negatively on the child. They suggested that a project worker could be there to reassure them and help them fill it out.

Another point kinship carers made was the **need for more holistic assessment than just a questionnaire**. It was pointed out that there was nowhere on the form to give qualitative responses on the form – for example, to feed back on changes or improvements – and that the SDQ doesn't address the issues kinship carers experience with their children. This reservation could be addressed in any future study by undertaking qualitative research to triangulate the findings from the survey, particularly individual consultations to add depth behind the survey results. One kinship carer articulated their reservations about the use of the SDQ, which other kinship carers may have – and could be counteracted by referring to the value of the research for potential future rollout:

“I don't know whether it is just a tick box for the council?” (Kinship carer)

Because the SDQ is mandated by government and collected as part of the SSSA903 standard statistical return for looked after children, **there is the possibility that a study could take advantage of SSSA903 data returns**, rather than collecting primary data. However, aligning the existing data collection with timescales appropriate for an impact evaluation – namely collecting a baseline, subsequent and medium- and/or long-term survey return, is likely to prove challenging. In addition, this would also limit the study scope to children looked after.

Permission would need to be sought from the copyright holders before using the SDQ.

The SDQ responses would be the main data used for this RCT. However, although outside of the scope of this feasibility study and subject to additional funding, in addition to a measure of children's mental health, a full-scale RCT could consider the use of a measure of kinship carers' parenting confidence or competence. This may still show impact even if children's mental health did not change much or at all, which is possible not least given that Kinship Connected's primary focus are kinship carers rather than their children. Likewise, additional children's measures, on for example behaviour or attachment, could provide interesting findings and widen the possibility of change being observed.

RQ4: What are the key design components of a proposed pilot study protocol?

The research objectives are linked to progression criteria, which can determine whether there is a sound basis to proceed to a pilot RCT design that is acceptable to participants (namely local authorities, Kinship staff, families and children), possible to deliver and address what the key design components of that study are.

Progression criteria are presented in Table 4.3. These include a traffic light rating for each criterion, establishing what is required to advance to a pilot RCT (green light), further improvement by amending the design (amber), or those which would indicate a pilot RCT is not possible (red light).



Table 4.3: Progression criteria for a pilot RCT of mental health outcomes of children in kinship care

Criterion Logic	Go: Advance to pilot RCT	Amend: Develop the design further	Stop: Do not proceed to pilot RCT
Study design			
Eligibility Clear eligibility criteria are needed for recruitment and to ensure representativeness of the recruited sample (see below).	Inclusion and exclusion criteria are clearly defined.	Inclusion and exclusion criteria do not yet cover all forms of support Kinship Connected offers, but can be amended to include that (see representative concerns below) or there is agreement on conducting the RCT for a subgroup of target participants.	Inclusion and exclusion criteria cannot be clearly defined (for example, because there is too much heterogeneity in the target audience of Kinship Connected).
Representativeness It is possible to conduct a pilot RCT on the target audience of Kinship Connected.	Carers and children representative of the target audience of Kinship Connected can be randomised to treatment and control group.	A subset of carers and children representative of the target audience of Kinship Connected can be randomised to treatment control group. In this case, the trial would not be able to conclude effectiveness of Kinship Connected for all of its target audience, but for part of it. (No change necessary, but implications for the generalisability of the results.)	It is not possible to include carers and children who are representative of the target audience of Kinship Connected in the pilot RCT.
Outcomes Agreement on primary and secondary outcomes.	There is agreement on the primary and secondary outcomes that should be measured.	There are some disagreements on what primary and secondary outcomes should be, but these can be resolved through discussion.	It is unclear what primary and secondary outcomes should be.
Acceptance of outcome measures Carers and children need to be willing to complete outcome	Carers accept SDQ as outcome measure.	Carers accept SDQ as outcome measure under certain circumstances that can be built into the design – e.g. they require that they	SDQ not acceptable as outcome measure.



Criterion Logic	Go: Advance to pilot RCT	Amend: Develop the design further	Stop: Do not proceed to pilot RCT
measures, otherwise attrition will be high (and make the pilot RCT unfeasible).		themselves choose whether SDQ is completed by them or by their cared-for children.	
Feasibility of collecting outcome data If outcome measures are accepted by carers and children, this data needs to be collected.	Data collection feasible – i.e. staff support available for data collection in treatment and control group.	Support for data collection available for particularly vulnerable participants.	Participants cannot be supported in completing the questionnaire.
Agreement on RCT design and randomisation approach Necessary to progress to pilot RCT stage – concerns might be the considerable diversity in carers and children (age, ethnicity, adverse childhood experiences such as abuse and neglect, possibly others).	A design and randomisation approach that meets carer and research needs can be agreed upon (ethical concerns below).	Concerns about the design and/or randomisation	There is no form of RCT design and/or randomisation approach that would meet carer and research needs.
Agreement on target group Kinship Connected supports carers of children of any age up to 18 years – this is potentially a very diverse target population of children in terms of age and children's background (50% with abuse/neglect).	Target group identified that is defined enough in order to reduce issues of heterogeneity (ages and characteristics of children are different, which can affect outcomes).	Target group identified, but there may be issues of heterogeneity. OR Target group identified, but so closely defined that findings are not necessarily generalisable to other contexts.	Analysis would have to be conducted on a too heterogeneous group of children – e.g. 120 children can only be recruited if they are aged 2–18, but it wouldn't make sense to analyse the SDQ outcomes for these children jointly, requiring subgroup analysis,



Criterion Logic	Go: Advance to pilot RCT	Amend: Develop the design further	Stop: Do not proceed to pilot RCT
			which would ultimately reduce the power of the analysis below an acceptable level.
<p>Agreement on characteristics of control group The control group is one of the key elements of an RCT and needs to be clearly defined.</p>	<p>A control group can be designed that gives Kinship Connected a fair comparison, but does not withhold support from those most in need – e.g. business as usual care.</p>	<p>Control group is effectively a different intervention (because of ethical concerns). In this case, no changes are necessary, but the test for whether Kinship Connected works is harder to pass for Kinship.</p>	<p>It is not possible to create an acceptable control group that allows to test for the effectiveness of Kinship Connected.</p>
Engagement			
<p>Successful recruitment of a sufficient number of local authorities to make the pilot RCT workable.</p>	<p>4+ local authorities involved (as initial brief was aiming for 5 local authorities).</p>	<p>2–4 local authorities involved (likely some bias in findings).</p>	<p>0–1 local authorities involved (likely bias in findings due to unequal groups at the outset of the trial).</p>
<p>Successful recruitment of a sufficient number of eligible children/families to the trial.</p>	<p>63 children can be recruited to the trial – assuming an attrition rate of up to 20%, which would provide a minimum sample of 50 children – or equivalent recruitment rate per month (Avery et al., 2017).</p>	<p>55–63 children – assuming an attrition rate of between 10% and 20%, which would provide a minimum sample of 50 children (or equivalent recruitment rate per month) can be recruited to the trial. This may require a longer recruitment period, or more incentives.</p>	<p>55 children – assuming an attrition rate of up to 10%, which would provide a minimum sample of 50 children (or equivalent recruitment rate per month) or fewer can be recruited to the trial.</p>
Ethics	<p>Research is unlikely to have</p>	<p>Concerns that research has negative impact on involved</p>	<p>Research is likely to have a negative</p>



Criterion Logic	Go: Advance to pilot RCT	Amend: Develop the design further	Stop: Do not proceed to pilot RCT
Research principle of doing no harm.	negative impact on involved local authorities, carers and children.	local authorities, carers, and children – e.g. through research burden, but it is possible to address these through changes to the design/outcome measures/communication or incentives.	impact on involved local authorities, carers, and children – e.g. through research burden or withholding support.
Acceptance of evaluation among delivery staff A positive attitude of delivery staff towards their work being evaluated will contribute to the smooth running of the evaluation.	70% or more of delivery staff agree to their work being evaluated.	50–70% agree to their work being evaluated.	Less than 50% agree to their work being evaluated.
Delivery			
Fidelity The extent to which delivery is consistent across actors and as intended.	Practitioners will be able to deliver the intervention with fidelity.	There is evidence that practitioners struggle to deliver the intervention with fidelity, but this can be addressed (for example through booster training).	Practitioners will not be able to deliver the intervention with fidelity.
Changes to programme All participants should receive the same programme. Changing the programme during delivery, while the pilot RCT is running, will bias results.	No programme changes imminent.	Changes to programme planned but can either be fully implemented before pilot RCT starts or be postponed until after pilot RCT.	Changes to programme imminent.
Feasibility of delivery The programme can be delivered for the trial period. Considerations might be budget and	Sufficient resources to deliver the programme in the trial period.	Scarce resources that can be addressed in time before the programme needs to be rolled out for the trial – e.g. additional funding can be	Serious shortage of funding and/or workforce endangers rollout of the programme in the trial period.

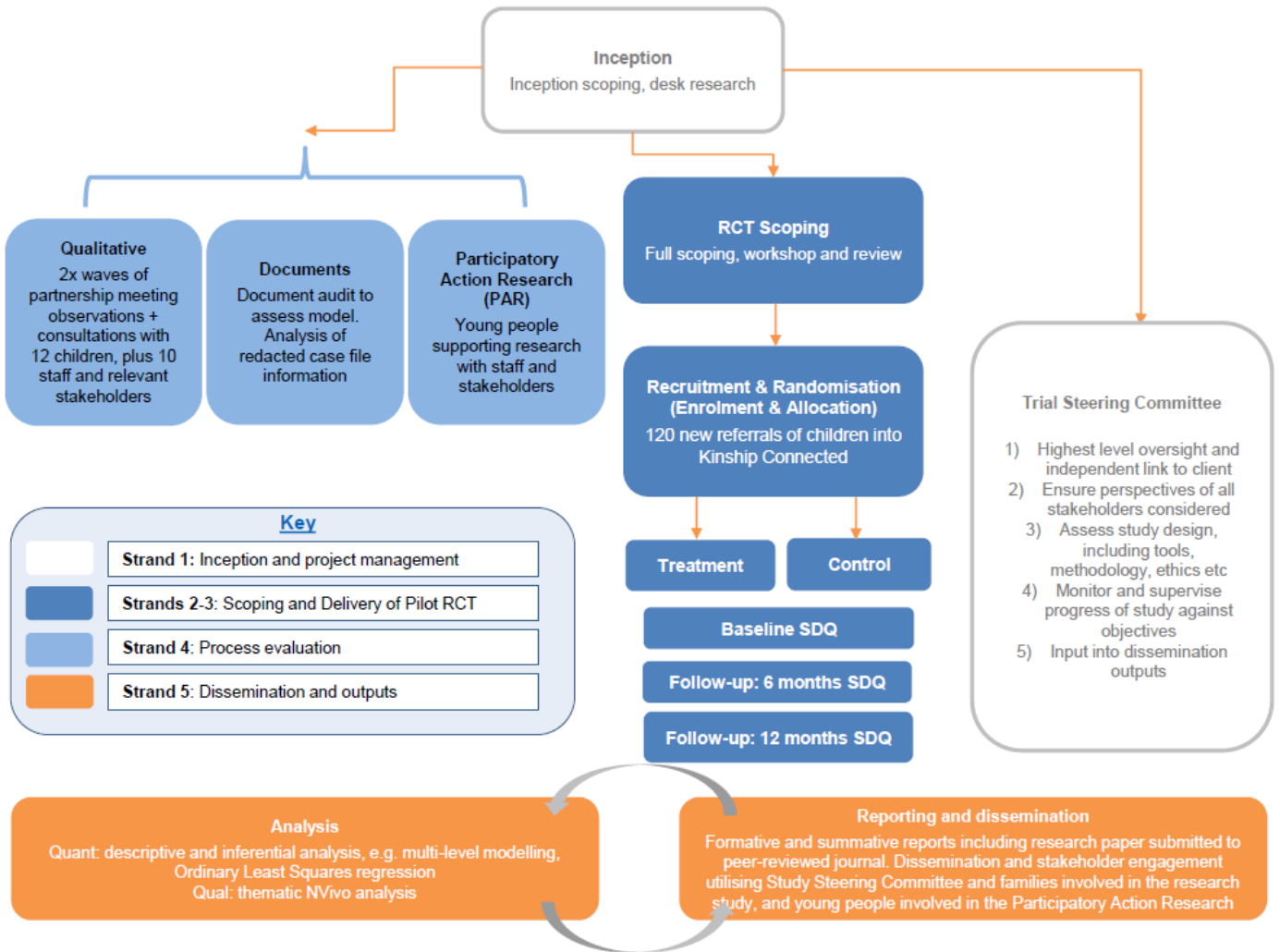


Criterion Logic	Go: Advance to pilot RCT	Amend: Develop the design further	Stop: Do not proceed to pilot RCT
workforce capacity/availability.		secured, additional Kinship workers can be recruited.	
Retention	Attendance records/case completion files indicate that target audience usually stays engaged in the programme – i.e. usually receives all of the support.	Attendance records/case completion files indicate that target audience mostly stays engaged in the programme – i.e. usually receives most of the support.	Attendance records/case completion files indicate that target audience members drop out after one or two initial sessions.

An example study outline is provided in Figure 4.2. It is proposed that the scoping and delivery of the proposed pilot RCT is complemented with inception and project management, process evaluation and dissemination and outputs strands. For example, context and triangulation for the pilot RCT would also be provided from the qualitative interviews undertaken as part of the process evaluation.



Figure 4.2: Example study outline





5. Limitations

Limitations were considered and mitigated from the outset of the study, which was approved by the Ecorys Ethics Committee. **The main limitation with this feasibility study is its limited scope.** Five focus groups were conducted with 23 participants, including three focus groups with 13 kinship carers in total (including one with Kinship's Kinship Carer Advisory Group), and two focus groups with 10 Kinship and local authority staff in total. **Findings from these focus groups provided valuable qualitative insight but may not be representative** of all kinship carers – whether supported by Kinship Connected or not – or Kinship staff or local authority staff, due to the numbers involved and because they were recruited by Kinship and had taken part in one of their programmes. In addition, no children were involved in the focus groups. In agreement with Kinship, it was felt that consultation with children would be too technical (even at older ages), and at that point there was high likelihood that the proposed questionnaires would be undertaken by kinship carers and not children. This was confirmed by the views expressed in the focus groups.

A range of outcomes measurement tools were considered, though it is possible that some were missed in the review. However, given the importance of recognition and use of the SDQ (the recommended measure) in a range of settings, it is unlikely that any measurement tool that was missed in the review would match up to the SDQ in that way.

The merits and feasibility of process and economic evaluations of Kinship Connected or support for kinship carers or the children they care for have not been considered in this report.



6. Recommendations and next steps

The objective of this feasibility study was to answer the question: **Is it possible to run a pilot RCT of the Kinship Connected intervention and what are the key design features of such a pilot?** The pilot RCT would establish the potential for running a full-scale RCT.

The short answer is that **it is possible to run a pilot RCT.**

Running the pilot RCT in local authority areas not currently offering Kinship Connected, and offering the control group business as usual care, would likely address some of the ethical, practical and logistical challenges that a study of this type typically offers. Overcoming these challenges will be crucial to involve a sufficient number of local authorities as well as kinship carers, the children they care for, project staff and local authority staff in any future study. In particular, with kinship carers experiencing a range of challenges and frequently being in crisis, they require any study to be as least burdensome as possible. We therefore recommend a stepped wedge design. Local authorities seeking to commission Kinship Connected would consent to have the timing of their commissioning randomised, meaning that local authorities would be randomised into the treatment at staggered time points. Information on the characteristics, circumstances and levels of need of families before and after commissioning would be collected in all local authorities.

Delivery staff and kinship carers viewed individual randomisation of participants as challenging, with consequences of delaying access to effective support, particularly for a programme where its impact on kinship carers is established, albeit at a lower standard of evidence (Level 3 or lower on the Maryland Scientific Methods Scale (Sherman et al., 1998)) than an RCT or QED. To address this, as a minimum, **any control group should be able to access business as usual services from the local authority, and if there is a risk that participants may have no access to any resources at all, then they can be signposted to information and advice on resources should they reach crisis point and to support them in their caring role.**

A QED approach was seen as preferable to an RCT by delivery staff and kinship carers, as mitigating some of the ethical challenges in particular posed by an RCT, whilst still offering a high standard of evidence (Level 3 or 4, out of 5 on the Maryland Scientific Methods Scale (Sherman et al., 1998)). However, Kinship Connected is not currently commissioned in 90% of local authorities in England and Wales. This mitigates some of the concerns expressed by stakeholders already benefiting from the programme about withholding it to control group participants, given that it is effectively withheld in 90% of local authorities anyway. **It would be possible to exploit the future rollout of Kinship Connected as a means of running an RCT** (or indeed a QED); for example, by taking advantage of natural lags in the commissioning process via a natural stepped wedge or waiting list design for programmes rolled out in a staggered way. Randomisation in local authorities where Kinship Connected has not already been commissioned may be the most appropriate route to randomisation, although it would require set-up costs in the new areas so may be deemed expensive, and collecting data for the control group may prove challenging. It would, however, maintain the highest standard of evidence (Level 5 out of 5 on the Maryland Scientific Methods Scale (Sherman et al., 1998)).

The mental health of children in kinship care was identified as the key outcome of interest for the pilot RCT, because of the paucity of existing research evidence and also through Kinship Connected's



theory of change and logic model (see Figure 1.1). **We suggest that the Strengths and Difficulties Questionnaire (SDQ) is the most appropriate tool for measuring children and young people’s mental health outcomes** in this context. The SDQ was generally viewed fairly positively by kinship carers. We recommend that kinship carers complete the SDQ on behalf of children aged 2–18 involved in the study. For the pilot RCT, we recommend that a broad age range can be considered (Kinship Connected supports kinship carers of children aged 0–18), in order to test efficacy for a full RCT. A hybrid approach offering both paper and online completion was favoured by kinship carers. Practical and emotional support for kinship carers and children before, during and after completing the questionnaires is vital, and staff were happy to provide this in-person or remotely. Offering both methods would remove barriers to kinship carers accessing this support if they had a need or preference for either method. Kinship carers also expressed that any study should provide a more holistic assessment than purely focused on a questionnaire – for example, involving qualitative research. Subject to funding, it may also be worth including a measure of impact on kinship carers (or additional children’s measures such as behaviour or attachment) to widen the possibility of change being observed.

This research will generate vital new knowledge. The under-researched nature of this cohort provides a clear evidence gap. Kinship care has not received the same levels of research as other care options for children. The evidence that does exist rarely links to mental health outcomes, particularly of the children cared for, nor meets the same standard of evidence from an RCT or QED. Though there has been some research into kinship carers’ outcomes, there is no primary evidence on the impact the Kinship Connected programme has on children, and historically there has been little primary research on the impact of kinship care on UK children more generally (Winokur et al., 2014). Getting this knowledge will ensure that the support offered to kinship families improves children’s lives. If a positive impact is found, it will further strengthen the case for local authorities to “invest-to-save” in kinship care as a way to secure permanence and improve outcomes for children who are unable to live with their parents. It will also provide transferable learning for mental health services in dealing with children in kinship, adoptive and foster care.

There is likely to be considerable interest in this research, and particularly so given the estimated economic benefits of kinship care. The positive results of support services for kinship carers provide a solid basis for wider uptake, and there has been further attention to this area following the independent review of children’s social care (MacAlister, 2022). There is interest from HM Treasury and the Department for Education in building a robust case for investment in effective approaches to children’s social care, including kinship care, in securing better outcomes for children. At a time of unprecedented financial challenge, kinship care becomes an increasingly cost-effective option, with a cost–benefit analysis showing that for every £1 invested in the programme, £1.20 of benefits were estimated to be generated for local authorities (Starks & Whitley, 2020). There is the potential for multi-million-pound savings to central government from placing children from local authority care into kinship care, resulting from improved health and educational outcomes, and reduced homelessness, crime and anti-social behaviour (Nicol Economics, 2020). Similarly, although not considered in this report, process and economic evaluations of Kinship Connected or support for kinship carers or the children they care for may have merit, and particularly economic evaluation which would present the case for funding.

The pilot RCT protocol provides further technical detail on study design, including research questions and analysis. The protocol is available on the OSF website: osf.io/qxdt7



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¹¹ Please note that this source refers to Residence Orders for what are now Child Arrangement Orders.



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