Systematic review

WHAT INTERVENTIONS IMPROVE OUTCOMES FOR KINSHIP CARERS AND THE CHILDREN IN THEIR CARE

Foundations
What Works Centre for Children & Families

Department for Education

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About Foundations, the national What Works Centre for Children & Families

Foundations, the national What Works Centre for Children & Families, believes all children should have the foundational relationships they need to thrive in life. By researching and evaluating the effectiveness of family support services and interventions, we're generating the actionable evidence needed to improve them, so more vulnerable children can live safely and happily at home with the foundations they need to reach their full potential.

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- Understand the evidence base
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GLOSSARY OF TERMS / ABBREVIATIONS & ACRONYMS

Abbreviation / acronym / terms	Description
CASP	Critical Appraisal Skills Programme (checklist used for critical appraisal of individual qualitative studies)
CI	Confidence Interval (95%), the range of values for which we are 95% confident that the true value lies
ENTREQ	Enhancing transparency in reporting the synthesis of qualitative research
GRADE-CERQual	Confidence in the Evidence from Reviews of Qualitative Research (approach for assessing confidence in findings)
PICOS	Population, Intervention, Comparison, Outcomes, Study design
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
PSM	Propensity score matching
RCT	Randomised controlled trial
RoB-2	Risk of Bias 2 tool (used to appraise risk-of-bias for randomised trials)

Abbreviation / acronym / terms	Description
ROBINS-I	Risk Of Bias in Non-randomised Studies – of Interventions (used to appraise risk of bias in non-randomised studies)
SEND	Special educational needs and disabilities
SPIDER	Sample, Phenomenon of interest, Design, Evaluation, Research type
QED	Quasi-experimental design

PLAIN LANGUAGE SUMMARY

Interventions for kinship carers, including help navigating other services, may improve outcomes for carers and the children in their care, but more evidence is needed.

Kinship care is a form of foster care where family or close friends take care of a child rather than the parent. We looked at kinship care where there were concerns for the child around abuse or neglect. This could be formal kinship care – arranged with the involvement of children's services – or informal kinship care where family or friends look after a child without the involvement of children's services.

What is this review about?

Kinship carers are known to have more and different needs than other parents and carers. They are often older and more likely to live in poverty, and they must navigate relationships with the birth parents of the child(ren) they are looking after, and the trauma a child has experienced. We also know that children in kinship care have better outcomes (for example, in children's behaviour, psychiatric disorders, wellbeing, and placement stability) compared to children in non-kin foster care, and kinship carers are often very committed to the children.

We want to know how to support kinship carers better – to understand what works to improve outcomes for both the children and the caregivers from all backgrounds. We also want to explore caregivers' perceptions of what helps them and practitioners' thoughts about how to deliver support programmes.

What is the aim of this review?

There are two aims of this review. We want to understand how effective different interventions are for kinship families. To do this, we aimed to summarise the best available evidence from around the world. We also want to understand what kinship carers and practitioners say they want and their experiences of support programmes in the UK.

Findings from this review will inform the development of a Practice Guide to support kinship carers and the children in their care, which will form part of a set of Practice Guides aimed at supporting the implementation of the Children's Social Care National Framework. The National Framework was recommended by the Independent Review of Children's Social Care to establish the purpose, principles, and outcomes of the children's social care system.

What studies are included?

This review included 36 reports, providing the findings from 27 studies. They included information on kinship support and navigation services, parenting programmes, and others. There were 21 studies about the impact of what works from around the world, and six qualitative studies on carer and practitioner experiences in the UK.

The studies had some weakness that may affect our confidence in their results, but overall, they had strong impact designs.

What are the main findings of this review?

Of the studies we found, 21 looked at the impact of programmes, and six looked at the experiences of kinship families and practitioners in relation to a programme in the UK. Overall, the studies included in this review emphasised that kinship families have unmet needs, and that different types of programmes can meet these needs. These programmes can ultimately help to improve the outcomes for children in care (such as behaviour, wellbeing and placement stability) and kinship carers (such as parenting skills, wellbeing, and access to support).

The wide scope of the programmes and interventions included in the review limited our ability to statistically combine studies (otherwise known as meta-analysis). For Kinship Navigator programmes that help carers 'navigate' services, we were able to conduct one small meta-analysis on the likelihood of children being placed in kinship care, and two small meta-analyses on stability for children in kinship care which demonstrated small positive effects of the programme. For programmes that offer financial subsidies to formal guardians, we conducted a small meta-analysis on the effects of positive permanency outcomes which showed small positive effects of the subsidy. However, we have some concerns about how confident we can be in these findings due to risk of bias. Of the studies not included in the meta-analyses, most reported small or no impacts and there is a lot of variation between studies.

The six studies that looked at the experiences of kinship families and practitioners showed that support designed specifically for kinship families is both needed and welcomed. The research highlighted the value of trust, peer support, and relationship building in programmes for kinship families.

What do the findings of this review mean?

This review adds to growing evidence looking at how best to support kinship carers. The studies of measurable outcomes indicate that programmes specifically designed for kinship families show promise in helping to improve the lives of kinship caregivers, and the children in their care. The evidence suggests that this is particularly true for three types: programmes that help kinship caregivers navigate local and national services; parenting programmes for kinship carers; and financial support guardianship for kinship carers.

To better understand who these programmes work for, and in what contexts, future work should be coordinated to fill gaps in the evidence. Specifically, researchers looking at programmes for wider populations such as foster carers or parents of children with behavioural issues should report outcomes for kinship families separately.

How up-to-date is this review?

The review authors conducted the searches in October 2023 and included literature identified until February 2024, and an updated targeted search of websites and grey literature was conducted in June 2024.

EXECUTIVE SUMMARY

Overview

The number of children and young people placed in the care of family or friends rather than unrelated foster carers is increasing. This form of care, known as kinship or connected care, can lead to better outcomes for children, despite kinship carers facing additional challenges compared to other foster carers (e.g. navigating kin relationships, being more likely to live in poverty).

This review sought to understand the evidence of programmes and policies to improve the outcomes of kinship carers and the children in their care. Where possible, we aimed to understand the elements of effective programmes and look at differential impact for groups of carers. The review also explored carer and practitioner perspectives on how interventions can best serve them. Thus, the review sought to answer the following five research questions:

1. What interventions for kinship families improve the outcomes for children in kinship care (e.g. safety, permanence, and wellbeing) and for kinship carers (e.g. wellbeing, confidence in parenting, relationship with child in care)?
2. Are there interventions/programmes that are particularly effective with different groups of carers and children (e.g. disabled or carers or children from minoritised ethnic backgrounds)?
3. Are there common elements shared by effective interventions?
4. What are the enablers and barriers to successful implementation of interventions for kinship carers and children in kinship care in the UK?
5. What are the perspectives of kinship carers and children in kinship care on the acceptability and usefulness of different interventions in the UK?

Methods

Following established systematic review methods, we identified published and unpublished literature which describe outcomes for children in kinship care and their caregivers from robust impact evaluations of interventions, policies, and programmes using experimental and quasi-experimental designs. We also identified qualitative research answering questions on the implementation and experiences of interventions and programmes in the UK. The systematic review protocol was published on Foundation's website and registered on Open Science Framework.[1] For a small number of studies with similar populations, outcomes, design, interventions, and comparisons, meta-analyses were carried out to examine impact of kinship

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[1] See: https://doi.org/10.17605/OSF.IO/F4Z7G

navigator programmes on placement in kinship care and on placement stability. GRADE was used to assess confidence in findings presented in the meta-analyses. Remaining studies were synthesised narratively. Risk of bias was assessed using the appropriate tools for each study type (Cochrane Risk of Bias 2 and ROBINS-I tool). A separate quality appraisal tool (CASP) was used for qualitative studies. Qualitative studies were coded and synthesised using thematic analysis with the confidence in finding statements assessed using GRADE-CERQual.

Key findings

We identified 29 impact evaluations (from 21 studies) that met our inclusion criteria and 6 qualitative studies. Of the impact studies, 67% presented some/moderate or high concerns around risk of bias. Four qualitative studies were assessed as moderate quality, and two as high quality.

Both the qualitative and impact literature emphasised that kinship families have unmet needs and different programmes and services can meet these needs and improve outcomes for children in care and kinship carers. One prevalent approach was to assist carers to navigate services. A meta-analysis for two of the QED studies for these 'kinship navigator' programmes showed that they had a small, but statistically significant, impact on the likelihood of children being placed in kinship care (low certainty of evidence). Based on the common effects model, two meta-analyses of RCTs and QEDs studies showed small, but significant effects on the likelihood of placement disruption (medium and low certainty of evidence). Other individual studies found positive effects in kinship navigator in terms of reunification rates, permanency (defined as adoption/guardianship and/or reunification), safety, carer wellbeing, parenting skills, knowledge, use and perceptions of services, and on relationship with the child. Two studies which measured enhanced kinship navigator programmes against standard kinship navigator programmes also found some positive impacts, showing that additional supports can improve outcomes above a heightened 'business as usual'.

Another set of studies examined direct financial support to kinship carers who enter legal guardianship for the children in their care. The meta-analysis showed small but statistically significant effect of subsidised guardianship on permanence.

Other studies identified through this review and summarised narratively measured the impact of parenting skills programmes, cognitive behavioural therapy, resourcefulness or self-care practices, and peer-to-peer group support. These programmes and interventions again showed a variety of outcomes – there was no significant impact in some domains but significant positive impacts in others.

The qualitative literature from the UK also emphasised the importance of practitioners building relationships with kinship carers, of peer-support, and of being recipient-centred in both the content and the implementation of interventions, including addressing accessibility.

Recommendations and next steps

The evidence around how best to support kinship carers is limited but continuing to grow, and the evidence base from the US shows the results of investment in research for both evidence-based practice and for understanding what works. The available evidence indicates that interventions for kinship families – especially the kinship navigator approach, which help kinship families to navigate services – show promise and should be invested in along with accompanying evaluation for new contexts. Financial support for kinship carers to enter formal guardianship arrangements shows promise in leading to more positive permanency outcomes for children, but further research is needed to understand how the financial support may lead to other outcomes and understand implementation in the UK.

There were a range of other emerging and potentially promising approaches – particularly parenting programmes for kinship carers – and it is important that research continues to grow to understand best how to improve outcomes for kinship families. Research should take an equity lens, understanding of who is being served by interventions and how to improve equity. Researchers should improve study reporting, including disaggregating populations by kinship carers, to understand if effective approaches for parents or foster carers are effective for them.

Despite limited qualitative literature in the UK around the implementation of interventions for kinship carers, messages were clear for practice, including the importance of trust and of designing interventions to be timely, convenient, and map onto the needs of kinship carers and the children in their care. Kinship carers valued targeted interventions for their specific contexts and needs.

INTRODUCTION

Project background

An increasing proportion of children formally in care in England are being placed in the care of family or close friends, rather than with non-kin foster carers.[2] This is often referred to as kinship care or connected care.[3] From 2015 to 2021, the number of local authority fostering households offering care to a family or friend increased by 7% to 27%, and 58% of newly approved carers in 2021 were kin carers (Ofsted, 2021). This trend has continued in recent years with the number of children placed with a relative or friend foster carer increasing in 2022–23, even as the number placed in foster care decreased (Ofsted, 2023). This number is likely to continue to grow, with the announcement of the government's new strategy to 'improve support and reduce barriers to kinship care' (Department for Education, 2023). There are two primary ways in which a child could be placed in a kinship care arrangement: a child may be placed with an approved formal kinship carer by Children's Services, or the family may make private arrangements, the latter of which is thought to be the more prevalent but is also more difficult to monitor or measure. The increase in these forms of kinship care can be attributed to many factors, including increasing divorce rates and the impact of the rising cost of living (Nandy & Selwyn, 2013; Sacks-Jones, 2022).

A systematic review led by Winokur on the impact of kinship care on children and young people showed that it has a positive impact compared to children placed in non-kinship foster care on several outcomes including behaviour, psychiatric disorders, wellbeing, and placement stability (Winokur et al., 2014; Winokur et al., 2018). These positive outcomes occur despite kinship carers tending to be older, less educated, and more likely to be single, unemployed, and poor than non-kinship foster carers (Cuddeback, 2004).

The prevalent literature tends to be US-based, with conclusions that are not necessarily relevant to the UK social policy context. For example, the inconsistent use of formal and informal kinship care may disguise the prevalence of informal kinship care among people from Asian and Black backgrounds in the UK, while people from Black backgrounds are overrepresented in formal kinship care in the US (Scannapieco & Jackson, 1996; Schoenwald et al., 2022).

In a landscape where 15% of children in care who live with relatives or friends are in formal kinship care arrangements (Ofsted, 2023), and the rate of kinship care varies between 4–39% across local

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[2] Throughout this work, we do refer to children being placed and placements for comprehension in alignment with the literature and practice, but we recognise that these are important decisions and homes for children.
[3] As well as kinship care, we also refer to 'relative care' and 'relative caregivers' as these terms are often used interchangeably within the literature and practice, with both terms describing when a child is looked after by kin (i.e. family or close friends).

authorities (Schoenwald et al., 2022), it is vital to know how best to support the carers and children involved to have the best outcomes. This requires understanding of the variation in promotion of kinship care across local authorities, as well as the influence of policies such as regulation and payment on the use and stability of kinship placements (Shlonsky & Berrick, 2001). There is also room for further investigation into the support kinship carers need, including the specific needs of carers from Black and Asian backgrounds, and those in circumstances that make caring more challenging such as living with a disability, poor finances, or single adult fostering (Lin, 2014; Selwyn et al., 2013). The review aims to look at interventions to improve outcomes for children in kinship care and their carers.

Previous systematic reviews

A previous review of group interventions for kinship carers found promising indications that carer outcomes can be improved by kin-specific interventions (Rabassa & Fuentes-Peláez, 2023). They sought to identify effective components of such interventions and found that caregivers benefited from group interventions which focused on parenting skills, with small group sizes and regular sessions. Wu et al. (2020) previously reviewed the effectiveness of parenting programmes for kinship caregivers and Lin (2014) looked at a range of services including kinship navigator programmes and financial assistance. These reviews similarly identified probable benefits to caregiver and child outcomes. However, these previous reviews included studies which employed non-experimental designs such as pre- and post-test comparisons which limit confidence in their conclusions. Moreover, the qualitative findings presented predominantly represented US-based populations.

The strength and applicability of previous review findings to the UK context is limited by the quality and type of evidence available, the range of interventions that purport to support kinship families, the range of outcomes reported, restricted geographies, and publication bias. To address these issues, this review looked exclusively at impact evaluation study designs including randomised controlled trials and quasi-experimental designs, which involve a comparison group. We also searched for grey and unpublished literature to identify unpublished research. Furthermore, we complemented the quantitative review with a qualitative synthesis to identify perspectives on the implementations of interventions for kinship carers specific to the UK children’s social care context, to further our understanding of how to improve the quality of kinship care that children experience, including placement stability.

Design and aims

Following established systematic review methods, we identified published and unpublished literature which describes robust evaluations of interventions, policies, and programmes using experimental designs (randomised controlled trials) and quasi-experimental designs as well as qualitative process evaluations. Based on the extraction of their information, we described and synthesised study findings using meta-analysis, where possible, as well as narratively – including subgroups of kinship carers or children in kinship care with different characteristics.

Objectives

Research objectives

The objective of this systematic review is twofold: to assess the effectiveness of programmes that aim to improve outcomes for kinship carers and the children in their care and to understand the implementation considerations involved in delivering such programmes. This review is intended to support the identification of promising and effective policies, programmes, and interventions and to inform our understanding of how to improve the quality of kinship care within the UK.

Findings from this review will inform the development of a Practice Guide to support kinship carers and the children in their care, which will form part of a set of Practice Guides aimed at supporting the implementation of the Children's Social Care National Framework. The National Framework was recommended by the Independent Review of Children's Social Care to establish the purpose, principles, and outcomes of the children's social care system.

Research questions

This review aimed to answer five research questions:

1. What interventions for kinship families improve the outcomes of children in kinship care (e.g. safety, permanence, and wellbeing) and for kinship carers (e.g. wellbeing, confidence in parenting, relationship with child in care)?
2. Are there interventions/programmes that are particularly effective with different groups of carers and children (e.g. disabled or carers or children from minoritised ethnic backgrounds)?
3. Are there common elements shared by effective interventions?
4. What are the enablers and barriers to successful implementation of interventions for kinship carers and children in kinship care?
5. What are the perspectives of kinship carers and children in kinship care on the acceptability and usefulness of different interventions?

While all five questions examine the same population and outcomes of interest, questions one to three focus on impact and are answered by high-quality impact evaluations, whereas questions four and five explore qualitative perspectives and experiences from qualitative and mixed-methods literature. As such, our search methodology involved one overarching literature search with two sets of inclusion and exclusion criteria for Q1-3 and Q4-5. Using this approach, we provide a mixed-methods synthesis which suits the purpose of this review to support decision makers with both evidence of impactful interventions and considerations at the deliverer and recipient level.

The research questions for this systematic review explore what works in kinship care (RQ1), for whom (RQ2), and how and why (RQ3) by analysing quantitative impact research studies. Furthermore, they explore the processes around implementation (RQ4) and beneficiary perspectives (RQ5) using qualitative perspectives and experiences.

In exploring these questions, we sought to understand whether interventions or policies work differently for kinship carers or children in kinship care with different characteristics including by ethnic or cultural group, by age, by type of caring relationship (sibling, grandparents), by type of kinship care (formal or informal), level of education, socioeconomic status, and so on.

As part of the permanency outcomes included in research question 1, we included outcomes relating to the type of placement a child was placed into. The presence of sufficient support for kinship caregivers may influence the number of children being placed into care in general, and the proportion of those being placed in kinship homes. The authors included this outcome as we consider this an important outcome for children and consequence of kinship support to assess when implementing programmes and policy in this sector. Implications of these findings are presented in the Discussion section.

For the purposes of this review, we define formal kinship care as cases in which the child or children have been removed from their parental home and placed with close friends or family by the relevant child protection service. Depending on the geography, that will mean the kinship carer is licensed or unlicensed and has undergone assessment to different extents. Informal kinship care is defined here as cases in which there is a private arrangement between the children's parents and the kinship caregiver, and there may or may not be child protection involvement. We acknowledge that informal kinship caregivers are therefore less likely to be accessing the included interventions, and that the reasons for a child being in informal kinship care are not systematically recorded, so we cannot guarantee that they fulfil the inclusion criteria of being in kinship care for reasons of child maltreatment, neglect or risk of child maltreatment, relinquishment or lack of provision of support. Several of the studies included in the review also include kinship families where the child has been adopted or there is a guardianship arrangement in place.

We used the PICOS framework to structure the inclusion and exclusion criteria for research questions 1–3 and the SPIDER framework for research questions 4 and 5.

METHODS

Protocol registration and ethical review

This systematic review followed a review protocol, published on the Foundations website[4] and registered with the Open Science Framework.[5] Initially, there were no significant departures from the protocol; however, after completing a first draft, it was decided to do a targeted update of the search (as explained in the search section), and timelines were expanded to accommodate and ensure up-to-date grey literature was detected and incorporated in a transparent manner.

In order to ensure transparency, this report follows reporting guidelines including the Cochrane Handbook for Systematic Review (Higgins & Thomas, 2023), the PRISMA guidelines for reporting systematic reviews (Page et al., 2020), and, for qualitative synthesis, GRADE-CERQual and ENTREQ transparency in reporting the synthesis of qualitative research.

Given the nature of the review, the research team and Foundations determined that no ethical review processes were needed, but the review would consult with a Kinship Advisory Group, assembled by Foundations, during protocol development and with preliminary findings. Together, the research team and Foundations ensured that the Advisory Group represented a breadth of experience and expertise (including those with lived experience). The research team then ensured that there were terms of reference in place, worked to enable an environment where technical language was limited and where Advisory group members would feel comfortable to decide what to share and could share through written or verbal feedback, and offered 1-to-1 discussions with Advisory Group members.

Eligibility criteria

Tables 1 and 2 show the inclusion and exclusion criteria for questions 1–3 and then 4 and 5.

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[4] See: https://foundations.org.uk/wp-content/uploads/2023/10/kinship-care-systematic-review-research-protocol.pdf
[5] See: https://doi.org/10.17605/OSF.IO/F4Z7G

Table 1. Inclusion and exclusion criteria for quantitative papers to answer research questions 1–3

PICOS domain	Inclusion criteria	Exclusion criteria
Population	• Children and young people (aged 0 to 21 years) in formal or informal kinship care for reasons of child maltreatment, neglect or risk of child maltreatment, relinquishment or lack of provision of support. • Relative caregivers responsible for the care of a child or young person (aged 0 to 21 years) in formal or informal kinship care. Studies of wider populations were included if they reported outcomes separately for these populations.	• Young people in kinship care for reasons other than maltreatment, neglect or risk of child. maltreatment, relinquishment, or lack of provision of support. • Young people in unrelated foster care. • Unrelated foster carers. • Studies of wider populations that do not report kinship carer/child outcomes separately.
Intervention	Interventions, programmes, or services that support kinship caregivers or the children in their care (or both).	Other interventions, programmes, or services such as interventions around the decision-making process.
Comparison	Treatment as usual, another intervention, no intervention, or wait-list control.	Studies that use an undefined or inappropriate comparison group.

PICOS domain	Inclusion criteria	Exclusion criteria
Outcomes	*Child-level outcomes:* • Safety • Permanence • Wellbeing, quality of life, behaviour • Educational attendance, achievement, attainment. *Kinship carer outcomes:* • Wellbeing or quality of life • Capacity to provide quality care (e.g. parenting skills) • Knowledge or use of other support services or resources • Relationship between carers and children.	Studies looking at other outcomes. Studies which use unvalidated measures of wellbeing, quality of life, relationships, or behaviour.
Study design	Controlled experimental and quasi-experimental designs which include a valid counterfactual (such as a parallel group or highly controlled time-series).	Studies that do not use these designs.

PICOS domain	Inclusion criteria	Exclusion criteria
Geography	Research conducted in high-income countries with similar child protection systems to the UK, including England, Wales, Scotland, Northern Ireland, US, Canada, Australia, New Zealand, France, Germany, Sweden, Finland, Norway, Denmark, Netherlands, and Ireland.[6]	Research conducted outside of these countries or where the child protection system is not similar to the UK (e.g. non-functioning systems of child protection, possibly due to war or other factors)

Table 2. Inclusion and exclusion criteria for qualitative papers to answer research questions 4 & 5

SPIDER domain	Inclusion criteria	Exclusion criteria
Sample	• Children and young people (aged 0 to 21 years) in formal or informal kinship care for reasons of child maltreatment, neglect or risk of child maltreatment, relinquishment or lack of provision of support. • Relative caregivers responsible for the care of a child or young person (aged 0 to 21 years) in formal or informal kinship care. • In addition to voices from children and kinship carers, professionals working in kinship care in the United Kingdom. Studies of wider populations were included if they reported outcomes separately for these populations.	Young people in kinship care for reasons other than maltreatment, neglect or risk of child maltreatment, relinquishment, or lack of provision of support. Young people in unrelated foster care. Unrelated foster carers that were not connected carers. Studies of wider populations that do not report kinship carer/child outcomes separately.

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[6] While the listed countries present some variation in social care systems, this limit was specified to exclude countries without a functioning care system or operational foster care.

SPIDER domain	Inclusion criteria	Exclusion criteria
Phenomena of interest	Experiences of general and kinship-specific services, programmes and interventions from a recipient and practitioner perspective.	Other phenomena including perceptions of services in general or gaps in services.
Design	Any methods reflecting the experiences and perspectives of interventions in kinship care (e.g. qualitative studies, process evaluations, surveys about interventions).	Studies that do not use appropriate methods.
Evaluation	• Enablers and barriers to successful implementation of interventions for kinship carers and children in kinship care. • The perceived acceptability and usefulness of different interventions to kinship carers and children in kinship care.	n/a
Research type	• Phenomenology • Grounded theory • Case study.	n/a
Geography	Research conducted in the UK.	Research conducted outside of the UK.

We interpreted the outcome of a kinship support service on placement into kinship care to be a ‘child-level outcome’ falling under the broad domain of permanence and stability (e.g. effects on the amount of time placed with kinship or initial placement with kinship carers) but separated out for clarity from other permanence and stability outcomes (e.g. disruption, reunification, adoption, guardianship). We excluded studies focused on policies or interventions about the decision-making process around placement (e.g. tools or policy changes to emphasise placement with kin).

Publication restrictions

The following publication restrictions were applied during the screening process:

- Language – In order for the research team to extract and interpret findings, we restricted the language of studies to either be published in English, available in an English translation, or in a language that one of the research team can read (e.g. French).
- Study type – For studies reporting on quantitative findings, we restricted study design to controlled experimental and quasi-experimental designs which include a valid counterfactual. For studies reporting on qualitative findings, there were no restrictions on study design (i.e. we included any methods reflecting the experiences and perspectives of interventions in kinship care).
- Publication period – No restriction was placed on the publication period.
- Publication status – No restrictions on publication status, though all studies were assessed for risk of bias.
- Information sources.

The following databases were searched for studies published up to October 2023 (from the inception of each database):

- PsycINFO
- SCOPUS
- Ovid MEDLINE
- ERIC
- Social Sciences Citation Index (SSCI)
- Conference Proceedings Citation Index – Social Science and Humanities (CPCI-SH).

In addition to searches of the databases outlined above, we conducted searches for unpublished grey literature from the websites listed below. This list of sites was selected based on expertise within the study team and consultation with the study Advisory Groups.

- Australian Institute of Family Studies (https://aifs.gov.au/)
- California Evidence-Based Clearinghouse for Child Welfare (https://www.cebc4cw.org/)
- Chapin Hall at the University of Chicago (https://www.chapinhall.org/)
- Washington State Institute for Public Policy (https://www.wsipp.wa.gov/)
- Office of Planning, Research, and Evaluation, US Administration for Children and Families (https://www.acf.hhs.gov/opre)
- Foundations / What Works for Children's Social Care (https://foundations.org.uk/ / https://whatworks-csc.org.uk/)
- Kinship – Research, evaluations and surveys (https://kinship.org.uk/for-professionals/resources/)
- Kinship care: Advice Service for Scotland (https://kinship.scot/)

- Northern Ireland Kinship care (https://kinshipcareni.com/)
- Rees Centre (https://www.education.ox.ac.uk/rees-centre/)
- CASCADE: Children's Social Care Research and Development Centre (https://cascadewales.org/)
- CELCIS: Centre for Excellence for Children's Care and Protection (https://www.celcis.org/)
- Title IV-E Prevention Services Clearinghouse (https://preventionservices.acf.hhs.gov/)
- Children's Bureau, An Office of the Administration for Children & Families (https://www.acf.hhs.gov/cb)

Additionally, we had a call for studies advertised online and with direct approaches. Authors of relevant primary studies and relevant reviews were contacted by email to ascertain if they were aware of any supplemental, additional and/or unpublished literature. We also asked the Advisory Group to share papers or contact authors of any relevant literature they were aware of, and we screened the references of relevant systematic reviews, key literature, and grey literature identified during the search process.

Search strategy

One overarching literature search was undertaken, after which studies were screened against inclusion and exclusion criteria relevant to the two sets of research questions. The initial search combined both sets of search terms to ensure that all relevant papers were identified without duplication. An example search in SCOPUS database can be found in Appendix B. The database searches were conducted on 12 October 2023.

An extension to the initial search took place between 6–18 June 2024. This search targeted specific sources of grey literature known to the review team, screening the references of additional reviews and relevant papers, and contacting key individuals, to ensure that this systematic review included key texts relevant to research questions 1–3.

Search terms

The database search was conducted by combining the following search terms into one search, to ensure we identified quantitative studies for questions 1–3 and qualitative studies based in the UK for questions 4 and 5 without duplication.

The terms were combined as follows: (1 AND 2 AND 3) OR (1 AND 2 AND 4 AND 5)

1. Search terms related to kinship care, relevant to RQs 1–5:
    - Kin or kinship care*
    - Kin or kinship foster*
    - Kin or kinship placement*
    - Friend* and family care*

  - Connected care*
  - Family or families foster*
  - Family or families placement*
  - Relative* foster*
  - Relative* care*
  - Custodial grandparent*.
2. Search terms related to population, relevant to RQs 1–5:
   - Child* or adolescent* or baby or babies or infant* toddler* or school age* or girl or boy or teen* or preteen* or pre teen* or youth or young person or young people.
3. Search terms related to quantitative study design, relevant to RQs 1–3:
   - Affect* or effect*
   - Comparison group*
   - Experiment*
   - Impact*
   - QED or quasi-experimental or quasi-experimental
   - RCT or random or random* control* trial
   - Treatment group or intervention group
   - Control group.
4. Search terms related to qualitative study design, relevant to RQs 4 & 5:
   - Qualitative
   - Survey
   - Questionnaire*
   - Interview*
   - Focus group*
   - Process evaluation.
5. Search terms related to qualitative study location, relevant to RQs 4 & 5:
   - United Kingdom
   - UK
   - Great Britain
   - British Isles
   - England
   - Scotland
   - Wales
   - Northern Ireland.

Selection process

Identified records were filtered for inclusion in the review across two phases: title and abstract screening and full text review.

A total of three reviewers were involved in the title and abstract screening stage (AH, IT, EW). Every record was screened twice, and reviewers were blind to each other's decision based on the population, presence of an intervention, study design, geography, and language. Conflicts were resolved in a meeting between all three reviewers. At this stage, reviewers took the approach of 'if uncertain, put it through the full text review' to ensure that any ambiguous information could be fully assessed.

The same three reviewers then reviewed the full texts of papers using all eligibility criteria and each paper was again screened twice by reviewers who were blind to each other's decision. Conflicts were resolved in a meeting between all three reviewers. If a resolution was not reached, a fourth reviewer (EO) was provided with the context and made the final decision. In cases where there were multiple reasons for exclusion, a hierarchy was used (Table 3).

Table 3. Hierarchy of exclusion reasons

Ranking	Exclusion reason
1st	Kinship outcomes not reported separately
2nd	Wrong study population
3rd	Wrong study location
4th	No control/comparison group
5th	Not an intervention
6th	Study results not reported
7th	Reported outcomes not in review scope
8th	Wrong language

Data collection process

A data extraction template was created in Excel to manage data across the five research questions. Study and intervention details were extracted for all studies. Quantitative data on outcome measures was extracted for the QED and RCTs in a separate sheet. This extraction template spreadsheet was developed by the research team and piloted by two team members (AH and IT) for a subset of two studies. The form was refined based on this early piloting before formal data extraction commenced, to ensure full topic coverage and useability. Data was extracted independently, blind to the other extractor. A total of four reviewers were involved in the extraction process (AH, IT, PV, KY). All papers were extracted by two reviewers, and conflicts were resolved in a meeting between two of the reviewers. Two authors (EO, KY) offered training, answered queries around data extraction, and quality-assured data extraction.

A practice elements framework was developed in consultation with experts on common elements, building off existing frameworks for coding elements found within parenting interventions and other delivery elements in general, and deductively by including additional elements mentioned within intervention descriptions within the review. The framework was implemented in Microsoft Excel. Intervention manuals were identified where possible, and one researcher coded intervention elements across all studies (IT).

Qualitative studies were coded using thematic analysis in Dedoose, a qualitative data organisation and analysis tool. Codes were developed inductively from the data before being categorised under descriptive and analytical themes. All studies were double coded by four of the researchers, blind to the others' coding (AH, IT, GM, EO).

In two cases, further information about the analysis or results was sought from the corresponding authors by email.

Data management and processing

Citations (authors, year of publication, publisher, title, abstract) identified in the database searches, the call for studies, and snowballing from existing reviews were imported into the online systematic review software, Covidence. The screening process (duplicate identification, title and abstract screening, full text review) was carried out on Covidence to ensure that accurate records were kept of the screening process.

The screening of papers and reports identified through website searches was managed in Excel, with separate spreadsheets per reviewer to ensure blind screening.

Data items

The following data items were extracted and recorded for all included papers:

- Reference
    - First author
    - Other authors
    - Publication year
    - Publication title
    - Publication type (journal article, dissertation, report)
    - Journal title
    - Funder

- Study details
  - Study location (country)
  - Intervention name
  - Year intervention start
  - Year intervention end
  - Year study start
  - Year study end
  - Recruitment period
  - Population (e.g. Grandparents, by ethnicity, SEND, Adolescents)
  - Inclusion criteria
  - Exclusion criteria
  - Form of Kinship care (formal, informal, both)
  - Setting
- Sample size
  - Total sample size
  - Intervention sample size
  - Control sample size
- Demographics (N, %)
  - Gender: Total sample, Intervention, Control
  - Ethnicity: Total sample, Intervention, Control
  - Total sample
  - Disability
  - SEND: Total sample, Intervention, Control
  - Legal status: Total sample, Intervention, Control (e.g. guardianship, informal)
  - Other notable Description: Total sample, Intervention, Control
  - Description of children in their care if not recipients of intervention
- Intervention
  - Developers/Origin
  - Short description
  - Recipients: Carers or Children
  - Type (Financial/subsidy, Kinship navigator, Peer support group, Therapeutic service – caregiver, Mentoring – children, Training – self-care/resourcefulness, Training – parenting skills, Case management)
  - Intervention components
  - Delivery medium (online, face to face, materials provided)
  - Deliverer (profession/qualifications)
  - Referral mechanism
  - Incentive
  - Duration of intervention (in months)
  - Dosage (number, frequency and duration of sessions)

  - Cost (if applicable)
- Summary
  - Summary of overall findings
  - Study limitations
- Critical appraisal
  - CASP checklist for qualitative studies
  - ROBINS-I for QEDs
  - ROB-2 for RCTs.

The following data items were collected for quantitative studies:

- Comparison
  - Comparison type (business as usual (BAU), other service, no service, other)
  - Comparison activities description
- Evaluation design
  - Study method (RCT or QED)
  - Unit of randomisation
  - Unit of analysis
  - Timepoints measured
  - Main statistical analysis method
- Children's outcomes (separate for safety, permanency, wellbeing and behaviour, education)
  - Outcome description
  - Measure name
  - Measure detail (scoring approach, direction of travel, clinical cut-offs, duration, alpha, other validation information)
  - Sample size
  - Reported result – intervention group
  - Reported result – control group
  - Effect size and confidence intervals
  - Significance (p-value)
- Carers' outcomes (wellbeing, parenting, use and knowledge of services, relationship with child)
  - Outcome description
  - Measure name
  - Measure detail (scoring approach, direction of travel, clinical cut-offs, duration, alpha, other validation information)
  - Sample size
  - Reported result – intervention group
  - Reported result – control group
  - Effect size and confidence intervals

    - Significance (p-value)
- Differential impacts reported
    - Disabled children or carers
    - Children or carers from ethnic minorities
    - Children involved in the criminal justice system
    - Children or carers with SEND.

The following data items were collected for qualitative studies:

- Data collection methods (e.g. interviews, focus groups)
- Analysis methods (e.g. thematic, phenomenological)
- Outcomes of interest (implementation outcomes; acceptability and usefulness).

Risk of bias assessment

Risk of bias for the included studies was assessed and reported at the study level. Risk of bias assessments provide an indication of the likelihood that the design or methods employed by a given study may produce misleading results. Bias can occur in favour of the intervention or control group, or both within the same study. When a study is assessed as having a 'high risk of bias', it does not necessarily imply that the findings are not reliable, or that the study was poorly conducted, but it does mean that we have less confidence in the findings they present.

For the studies included in this review, the following tools were used:

- **Randomised controlled trials:** assessed using the Cochrane Risk of Bias 2 (RoB-2) tool (Sterne et al., 2019)
- **Non-randomised studies:** assessed using the Risk of Bias in Non-Randomized Studies – of Interventions (ROBINS-I) tool (Sterne et al., 2016)
- **Qualitative studies:** assessed using the Critical Appraisal Skills Programme (CASP) tool.[7]

The RoB-2 assesses risk of bias across five domains plus for overall risk. The domains are randomisation process, deviations from intended interventions, missing outcome data, measurement of the outcome, and selection of the reported result (see Appendix C for more information on the RoB-2 bias domains). Each study is rated as:

- Low risk of bias – the study is judged to be at a low risk of bias for all domains.
- Some concerns – there are some concerns regarding at least one domain and there are no 'high risk' assessments for any domains.

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[7] See https://casp-uk.net/wp-content/uploads/2018/01/CASP-Qualitative-Checklist-2018.pdf

- High risk of bias – the study is considered to be at 'high risk' in at least one domain or there are concerns across multiple domains that reduce confidence in the study's findings.

The ROBINS-I tool assesses risk across seven domains: confounding, selection of participants into the study, classification of interventions, deviations from intended interventions, missing data, measurement of outcomes, selection of the reported result (see Appendix D for more information on the ROBINS-I bias domains). Each study is rated as:

- Low risk of bias – the study is considered low risk across all domains.
- Moderate risk of bias – the study is considered low or moderate across all domains.
- Serious risk of bias – at least one domain is considered to be at serious risk, but none are at critical risk.
- Critical risk of bias – at least one domain is considered to be at critical risk; the study should not be included in synthesis.
- No information – there is not enough information to make a judgement about risk of bias.

Reasons for a study using quantitative methods being assessed as presenting a high risk of bias included:

- Outcomes measures being assessed by practitioners or researchers who were aware of the individual's treatment group (i.e. whether or not they had received the intervention)
- Authors not using or reporting on using the methods used to control for relevant confounding domains
- Authors not reporting sufficient information to assess domains such as how participants were randomised, whether outcomes data was available for all participants, and whether there was a pre-specified analysis plan in place.

The Critical Appraisal Skills Programme (CASP) Checklist for Qualitative Studies is a series of 10 prompts to systematically reflect on whether the results of a study are valid, what the results are, and whether they help (locally) in this synthesis.

Reasons for a study using qualitative methods being assessed as presenting a high risk of bias, and therefore low quality, included:

- The sampling method is not appropriate for the research questions or lacked transparency in the selection process
- Authors not reporting sufficient information to assess the appropriateness of analysis methods.

Three reviewers completed the risk of bias assessments (AH, IT, PV), and each study was assessed by one reviewer, with input from a second reviewer (EO, KY, AH) where criteria were unclear. Conflicts were resolved in a meeting between two of the reviewers.

Effect measures

Given the heterogeneity of measures and outcomes, effect measures are presented as reported in the papers. They were transformed for running specific meta-analyses as discussed below.

Synthesis methods

We described and synthesised study findings narratively, including studies of kinship carers or children in kinship care with different characteristics. The data from each included study was used to build summary of findings/evidence tables including an overall description of included studies. Studies were grouped by intervention type, and results synthesised by outcome domain, stratified by study design, and population.

Given that there were sufficient papers identified with outcomes that could be synthesised (the level of statistical heterogeneity was low or could be accounted for using random effects models; the differences in populations, interventions, comparisons, outcomes or study designs did not make statistical synthesis inadvisable), three meta-analyses were conducted, and the data synthesised following guidance in Harrer et al. (2021). Meta-analyses were carried out in R version 4.2.2 (R Core Team, 2024).

Where possible, we meta-analysed reported Cohen's *d* effect sizes (where necessary, we transformed reported odds ratios into Cohen's *d* values [d = log (OR)*(sqrt(3)/pi); Borenstein, Hedges, Higgins & Rothstein, 2009]). Cohen's *d* effect sizes were subsequently transformed into Hedges' *g* due to its better properties for small sample sizes (using the effect size computation (esc) for meta-analysis package in R); and standard errors were estimated from reported p values (using the se.from.p function in the dmetar package in R). These effect sizes were meta-analysed using the metagen function (meta package in R). For the analysis of RCTs of placement disruption, effect sizes were not reported, so raw values of outcomes (placement disruption/no placement disruption) were meta-analysed instead using the metabin function in (meta package in R). Fixed effects models were used unless there was statistical significance between study heterogeneity, in which case random effects models were used.

There are currently no universally accepted guidelines to direct the conduct of qualitative evidence synthesis (Campbell et al., 2019; Noyes, n.d.). Given our wide-ranging research questions, we used thematic synthesis (Braun & Clarke, 2006) and managed coding in the software Dedoose. The approach taken to analysis was both deductive, in that the codes was guided by the research questions and carried out with reference to existing theory and evidence from the field of implementation science, but also inductive in so far as the authors explored the data to identify themes and insights that appeared important to participants – including themes that are not reflected in the literature or that might contradict existing evidence. The results and analyses of the papers were coded using line by line coding and then descriptive themes were developed, and higher order analytical themes. Themes were developed into finding statements.

The findings were discussed with the Advisory Group, with particular attention to co-creating some of the points in the implications section to maximise relevance for stakeholders.

Synthesis of practice elements

As previously discussed, the researchers developed a practice elements framework, building off existing frameworks for coding elements found within parenting interventions and other delivery elements in general, and deductively by including additional elements mentioned within intervention descriptions of studies included in the review. The practice elements from the 21 quantitative studies were brought together in a sortable 196-line Excel spreadsheet giving elements and higher-order categories of elements. Given the heterogeneity in the quantitative studies – and various concerns around risk of bias – the synthesis of practice elements was descriptive in nature. Intervention manuals were identified where possible, and one researcher coded intervention elements across all studies.

Reporting bias assessment in the synthesis

The presence of publication bias arising due to missing results was assessed by examining the distribution of results in a funnel plot (Appendix J). We created a funnel plot for each meta-analysis and visually examined these for effect size distributions. The funnel plot is challenging to interpret with two studies per meta-analysis. As there are not enough studies to assess the symmetry, we cannot make any conclusions around publication bias (Borenstein, Hedges, Higgins & Rothstein, 2009).

Certainty assessment

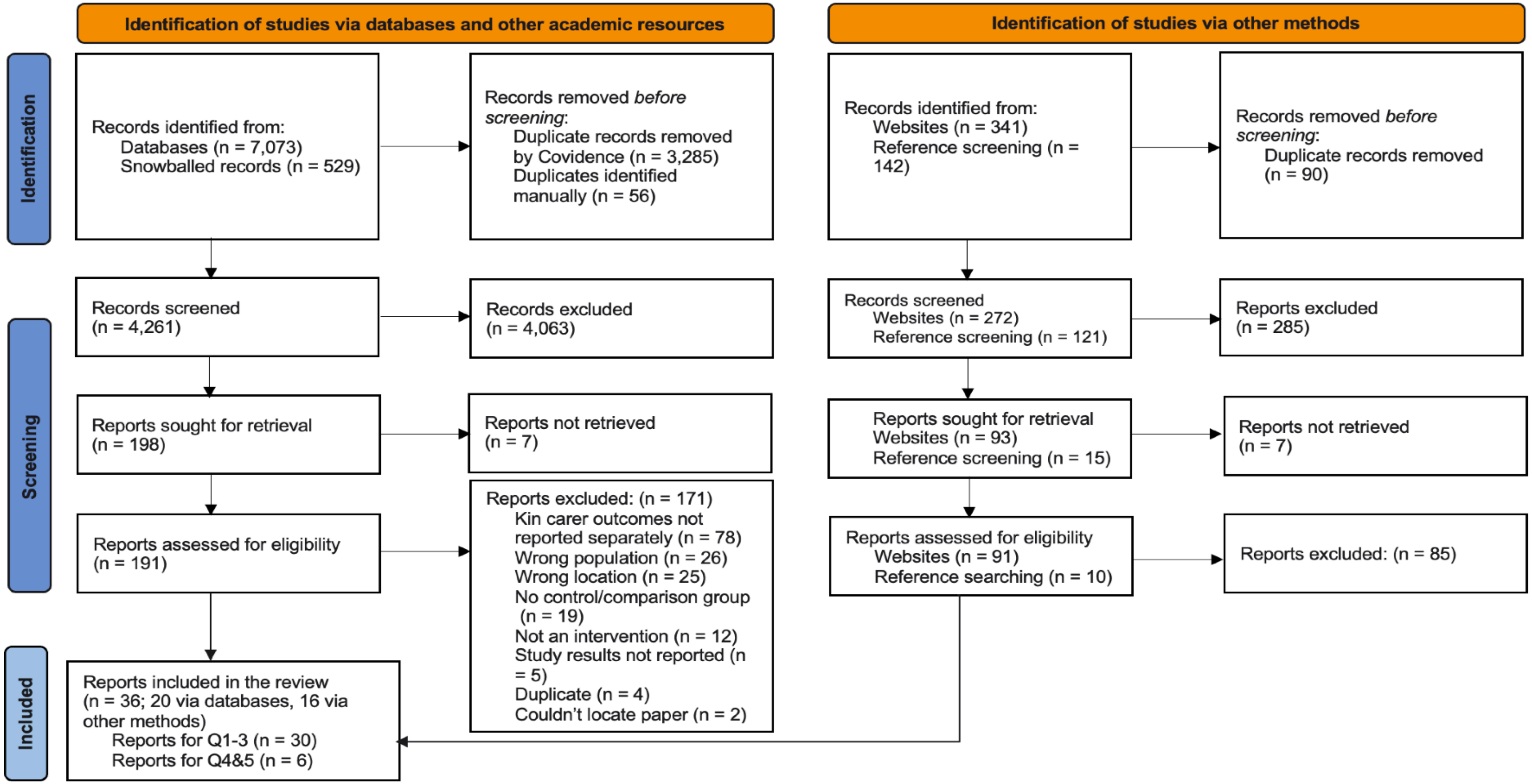
GRADE (Schünemann et al., 2013) was used to assess the confidence in cumulative evidence for meta-analyses. GRADE-CERQual (Lewin et al., 2018) was used to assess the confidence of findings from the qualitative evidence syntheses.

FINDINGS

Study selection

Figure 1 presents the PRISMA flow diagram for the selection of studies. Across academic databases, websites, and other sources, there were 8,085 records found and 4,654 records screened after de-duplication. From these, 292 full-text reports were screened for eligibility. This review includes synthesis of a total of 36 papers and reports which present findings from 27 individual studies.

Figure 1. PRISMA flow diagram (go to accessibility text)



Characteristics of included studies

A full reference list of included studies can be found in Appendix A.

Quantitative studies

The review identified 30 papers reporting on 21 studies using quantitative methods to include to address research questions 1–3. Eight of these papers used a non-randomised (QED) design and 22 used a randomised (RCT) design. This included three dissertations, 13 peer-reviewed journal articles, and 14 reports published outside of traditional academic journals.

An overview of all included papers for research questions 1–3 can be found in Table 5.

Some studies – i.e. individual evaluations or investigations – were reported in multiple papers identified through the search methods. Lead papers (see Table 4) were selected as the peer reviewed paper, which was also the most recently published in all cases. Results of the lead papers only have been reported in the narrative synthesis, unless otherwise specified due to additional reported outcomes, to ensure that the findings of individual studies were not over-weighted in the analysis.

Of the included studies, 19 studies (28 papers) were conducted in the United States of America, one was conducted in Australia, and one was conducted in the Netherlands.

The included studies can be broadly categorised into eight intervention types. Some studies fit into more than one category: kinship navigator programmes (10), caregiver training: parenting skills (6), caregiver training: resourcefulness (2)/therapy (1), peer support groups (2), financial support/subsidy (4), mentoring for children in kinship care (1), and case management (without kinship navigator service) (1).

The inclusion criteria were designed to include studies which offer universal services, or services for children in all kinds of foster care, that also report on outcomes specifically for kinship carers or the children in their care. However, no studies of this type were identified, meaning the included papers represent the literature on interventions that specifically target kinship families.

Similarly, the scope of this review was intended to include studies which report child-level outcomes. Only one study reported outcomes as reported directly by children, though several present caregiver-reported child outcomes.

Table 4. Lead papers for studies with multiple papers

Papers	Lead paper
Fowler, Day, Wollen and Vanderwill (2023); Day et al. (2024)	Day et al. (2024)
CHS of NJ (2012); Feldman and Fertig (2013)	Feldman and Fertig (2013)
N'Zi, Stevens and Eyberg (2016); N'Zi (2012); Stevens (2011)	N'Zi, Stevens and Eyberg (2016)
Hong (2006); Mandell (2001)	Hong (2006) – However, reported separately at times because of distinct subgroups.
Testa (2002); Testa, Cohen and Smith (2003)	Testa, Cohen and Smith (2003)
Forehand, Alessi and Winokur (2022); Forehand, Alessi, Butler and Winokur (2023)	Forehand, Alessi, Butler and Winokur (2023)
Wheeler et al. (2016); Wheeler et al. (2017); Wheeler et al. (2020)	Wheeler et al. (2020)
Littlewood, Cooper and Pandey (2020); Littlewood, Cooper, Yelick and Pandey (2021); Pandey (2016)	Reported separately in the synthesis because distinct subgroups and outcomes are reported in each paper

The scope of the included studies varied significantly, from a small-scale pilot study with 12 participants to a large-scale area level QED with 11,294 participants. The mean number of participants was $N = 1309$. Figure 2 shows a histogram presenting the prevalence of study sizes across studies.

Figure 2. Histogram to show sample sizes across impact evaluation studies (go to accessibility text)

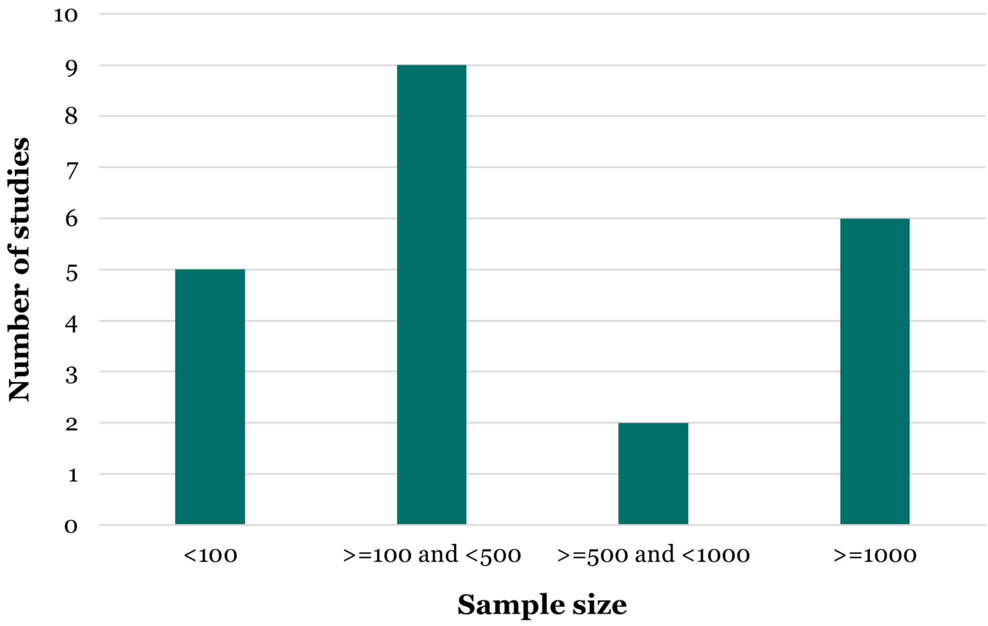


Table 5. Summary of included impact evaluation papers

Reference	Study design	Population	Intervention name	Comparison condition	Sample size (n)	Outcomes reported – children	Outcomes reported – caregivers	Follow-up period*	Setting
CHS of NJ* *(2012)	RCT	Kinship caregivers	Kinship Cares – enhanced kinship navigator programme	Standard kinship navigator	437	Safety – referrals to child welfare Permanency – attainment of legal guardianship Wellbeing – health	Wellbeing – parental stress	Post intervention	In-home
Day* et al. *(2024)	RCT	Kinship caregivers	Washington State Enhanced Kinship Navigator Program	Standard kinship navigator	252	n/a	Wellbeing Knowledge and use of services – service utilisation	6 months	By phone

Reference	Study design	Population	Intervention name	Comparison condition	Sample size (n)	Outcomes reported – children	Outcomes reported – caregivers	Follow-up period*	Setting
***Feldman* and *Fertig* (2013)**	RCT	Informal kinship carers	Enhanced kinship navigator programme	Standard kinship navigator	437	Safety – child welfare system involvement Permanency Wellbeing – health	Wellbeing – stress; social support Knowledge and use of services	Post intervention	In-person and videoconference
***Forehand*, *Alessi* and *Winokur* (2022)**	RCT	Kinship caregivers	Colorado Kinnected – kinship navigator program	BAU	371	Permanency	n/a	Post intervention	In-home
***Forehand*, *Bulter*, *Alessi* and *Winokur* (2023)**	RCT	Kinship caregivers	Colorado Kinnected – kinship navigator program	BAU	402	Permanency	n/a	6 months	In-home

Reference	Study design	Population	Intervention name	Comparison condition	Sample size (n)	Outcomes reported – children	Outcomes reported – caregivers	Follow-up period*	Setting
Fowler, Day, Wollen* and *Vanderwill (2023)	RCT	Kinship caregivers	Washington State Kinship Navigator	BAU	252	Safety – allegations of abuse, ER visits Permanency – placement stability Wellbeing – health Education	Knowledge and use of services	6 months	Phone, email or in-person meetings
Hong (2006)	QED (from a RCT sample)	Relative caregivers who received relevant payments	Maryland Guardianship Assistance Demonstration Project (GAP)	BAU	424	Permanency – placement stability	n/a	Post intervention	n/a (financial support)

Reference	Study design	Population	Intervention name	Comparison condition	Sample size (n)	Outcomes reported – children	Outcomes reported – caregivers	Follow-up period*	Setting
Littlewood, Cooper* and *Pandey (2020)	RCT	Relative caregivers	1) Standard Kinship Navigator Program 2) Kinship Navigator Program with Innovations 3) Kinship Navigator Program with Peer to Peer Only	BAU	240	Safety – maltreatment Permanency – placement stability	n/a	12 months	In-person and online
Littlewood, Cooper, Yelick* and *Pandey (2021)	RCT	Kinship caregivers	1) Peer to Peer Kinship Navigator Plus 2) Peer to Peer Kinship Navigator Only 3) Traditional Kinship Navigation	BAU	1,551	n/a	Wellbeing – protective factors Parenting – various Knowledge and use of services	12 months	In-person and online

Reference	Study design	Population	Intervention name	Comparison condition	Sample size (n)	Outcomes reported – children	Outcomes reported – caregivers	Follow-up period*	Setting
Mandell (2001)	RCT	Relative caregivers who received relevant payments	Maryland Guardianship Assistance Demonstration Project (GAP)	BAU	1,755	Permanency – placement stability	n/a	Post intervention	n/a (financial support)
McCallion, Janicki* and *Kolomer (2004)	RCT	Grandparent caregivers of at least one child with a developmental disability or delay.	Case management plus support groups	Case management only	97	n/a	Wellbeing – depressive symptoms, strain Parenting – various Knowledge and use of services Relationship with child	1 month	In-home and community setting

Reference	Study design	Population	Intervention name	Comparison condition	Sample size (n)	Outcomes reported – children	Outcomes reported – caregivers	Follow-up period*	Setting
Montoro-Rodriguez, Hayslip, Ramsey **and** ***Jooste (2021)***	RCT	Grandparent caregivers	No name – Selection, Optimization, and Compensation programme	No intervention	52	n/a	Wellbeing – depressive symptoms Parenting	3 months	Face-to-face in community centres
N'ZI (2012)	RCT	Grandmothers and great-grandmother caregivers of children between 3 and 7	Child Directed Interaction Training	No intervention	12	n/a	Wellbeing – depressive symptoms, stress Parenting – interactions	3 months post intervention	Face-to-face in community centres

Reference	Study design	Population	Intervention name	Comparison condition	Sample size (n)	Outcomes reported – children	Outcomes reported – caregivers	Follow-up period*	Setting
***N'Zi, Stevens* and *Eyberg* (2016)**	RCT	Grandmothers and great-grandmothers caregivers of children between 3 and 7	Child Directed Interaction Training	No intervention	14	Behaviour	Wellbeing – depressive symptoms, stress Parenting – interactions Relationship with child	3 months post intervention	Face-to-face in community centres
***Pandey et al.* (2016)**	RCT	Grandmother caregivers aged over 55 years	1) Standard Care 2) Peer-to Peer Care Only 3) Full Kin Tech Care	BAU	506	n/a	Wellbeing – protective factors Parenting Knowledge and use of services Relationship with child – attachment	12 months	Community based

Reference	Study design	Population	Intervention name	Comparison condition	Sample size (n)	Outcomes reported – children	Outcomes reported – caregivers	Follow-up period*	Setting
***Pasalich*, *Moretti*, *Hassalla* and *Curcio* (*2021*)**	RCT	Kinship caregiver for a child aged 8-16	Connect for Kinship Parents	BAU	26	Permanency – placement changes Behaviour – regulation and emotional adjustment	Wellbeing – caregiver strain Parenting – caregiver competence Relationship with child – attachment	6 months	Face-to-face in community venues
***Preston* (*2021*)**	QED	Formal kinship carers	Clark County Nevada's Foster Kinship Navigator Program	No intervention	1,116	Permanency – placement disruption	Knowledge and use of services – becoming a licensed foster carer	Post intervention	Face-to-face
***Rhodes*, *Haight* and *Briggs* (*1999*)**	RCT	Adolescents in relative care aged 10-16	Big Brothers-Big Sisters	No intervention	180	Wellbeing – relationships with peers	n/a	18 months	Face-to-face

Reference	Study design	Population	Intervention name	Comparison condition	Sample size (n)	Outcomes reported – children	Outcomes reported – caregivers	Follow-up period*	Setting
Schmidt and Treinen (2021)	QED	Kinship caregivers	Arizona Kinship Support Services	BAU	11,294	Permanency - various	n/a	12 months	Face-to-face
Schoemaker et al. (2020)	QED	Kinship foster carers	Video-feedback Intervention to promote Positive Parenting for Foster Care	Attention control – dummy intervention	15	n/a	Parenting practices	3 months post intervention	In-home
Smith, Hayslip, Hancock and Strieder (2018)	QED	Custodial grandmothers	1) Behavioural parent training 2) CBT	Attention control – relevant reading on relevant topics	343	Wellbeing/behaviour	Wellbeing – depressive symptoms Parenting practices	6 months	Face to face in community agencies

Reference	Study design	Population	Intervention name	Comparison condition	Sample size (n)	Outcomes reported – children	Outcomes reported – caregivers	Follow-up period*	Setting
Smith et al. (2023)	RCT	Custodial grandmothers	Online social intelligence training	Attention control – healthy living information sessions	349	Behaviour	Wellbeing – Various Relationship with child - attachment	9 months	Online
Stevens (2011)	RCT	Relative caregivers of pre-school aged children	Child Directed Interaction Training	No intervention	12	Behaviour	Relationship with child - attachment	3 months	Community venue
Testa (2002)	RCT	Relative and foster carers	Illinois Subsidized Guardianship	BAU	6,520	Permanency - legal permanence and placement stability	n/a	Post intervention	n/a (financial support)

Reference	Study design	Population	Intervention name	Comparison condition	Sample size (n)	Outcomes reported – children	Outcomes reported – caregivers	Follow-up period*	Setting
Testa, Cohen* and *Smith (2003)	RCT	Relative and foster carers	Illinois Subsidized Guardianship	BAU	7,467	Safety – reports of abuse and neglect Permanency - legal permanence and placement stability	n/a	Post intervention	n/a (financial support)
Testa (2008)	RCT	Relative carers	Tennessee Subsidized Guardianship	BAU	566	Permanency	n/a	12 months	n/a (financial support)
Wheeler et al. (2016)	QED	Children in kinship placements	ProtectOHIO	BAU	4,479	Safety – Re-reports of maltreatment Permanency – various	Wellbeing – needs	Post intervention	Face-to-face in the community

Reference	Study design	Population	Intervention name	Comparison condition	Sample size (n)	Outcomes reported – children	Outcomes reported – caregivers	Follow-up period*	Setting
Wheeler et al. (2017)	QED	Children in kinship placements	ProtectOHIO	BAU	6,350	Safety – Re-reports of maltreatment Permanency – various	Wellbeing – needs	Post intervention	Face-to-face in the community
Wheeler et al. (2020)	QED	Children in kinship placements	ProtectOHIO	BAU	1,610	Permanency – various	Wellbeing – needs	Post intervention	Face-to-face in the community
Zauszniewski, Musil, Burant* and *Au (2014)	RCT	Grandmother caregivers	Resourcefulness Training	Attention control	102	n/a	Wellbeing – depressive symptoms, stress	3 months post intervention	Face-to-face

*Where multiple follow-up periods were reported, the closest to 12 months has been included in this review.

Qualitative studies

An overview of all included studies for research questions 4 and 5 can be found in Table 6.

Six qualitative papers were included in this study. Two were journal articles, and four were reports resulting from the grey literature search. As it formed part of the selection criteria, all qualitative studies were conducted in the United Kingdom, and included research from three different regions in the UK: England, Wales, and Scotland.

In the papers informing the qualitative results of this review, a spectrum of kinship carers' perspectives was captured, reflecting diversity in age, geographical location, and caregiving needs. None of the papers identified for this review included the perspectives of children in kinship care placements; often interventions were specifically working with carers, so this is to be expected. The sample sizes (excluding non-kin foster carers where applicable) in qualitative studies ranged from three to 23.

The types of intervention differed from the quantitative studies in that we did not identify any qualitative studies discussing kinship navigator programmes. This reflects the service landscape in the UK, where formal kinship navigator programmes have not yet been introduced. However, two papers report on kinship caregivers' experiences of Kinship Connected, which incorporates many practice elements that are typical in kinship navigator programmes, such as advocacy, referrals, supporting access to grants, and more general support. Included studies reported on a range of interventions: an adoption support fund; resourcefulness, wellbeing, and relationship support programmes; a parenting skills programme; Kinship Connected; and a parallel child and carer therapy support service.

Table 6. Summary of included studies for questions 4 and 5

Reference	Population	Intervention	Sample size (of kinship carers) (n)	Phenomena reported	Setting	Study design	Qualitative data collection method(s)	Analysis approach
Schroer and Samuels (2019)	Kinship carers without a Special Guardian Order	Adoption Support Fund	13	Acceptability and usefulness	n/a (financial support)	Qualitative	Observations, focus groups and semi-structured interviews	Thematic analysis
Hartley, McAteer, Doi and Jepson (2018)	Kinship carers of teenage children identified as in need of extra support	CARE	12	Implementation experiences Acceptability and usefulness	Face to face sessions held in a community setting	Qualitative	Stakeholder consultations, semi-structured interviews, advisory group consultations and focus groups	Thematic analysis
Channon et al. (2020)	Kinship carers	Fostering Changes	3	Implementation experiences	Held in a variety of community settings	Mixed methods	Interviews and focus groups	Not specified

Reference	Population	Intervention	Sample size (of kinship carers) (n)	Phenomena reported	Setting	Study design	Qualitative data collection method(s)	Analysis approach
Starks and Whitley (2020)	Kinship carers	Kinship Connected	14	Acceptability and usefulness	Face-to-face in community setting, over the phone and email	Mixed methods	Case studies and interviews	Not specified
Whitley, Fischer, Van Zanten and Kelson (2023)	Kinship carers	Kinship Connected	23	Implementation experiences Acceptability and usefulness	Face-to-face in community setting	Qualitative	Focus groups	Not specified
Welch (2018)	Kinship carers and children in kinship care	Notre Dame support service for kinship families	Not reported	Implementation experiences Acceptability and usefulness	Face-to-face in community setting	Qualitative	Survey	Not specified

Excluded studies (qualitative and quantitative)

As described in the methods section, when reviewing papers at full text stage, a hierarchy of exclusion reasons was used where multiple reasons applied. Table 7 presents the number and reason of exclusions for papers identified via databases. Two papers were also identified for possible inclusion but could not be included in analysis as we could not gain access to the papers.

Table 7. Reasons for exclusion for papers screened at full text stage through Covidence

Reason for exclusion	Number of papers excluded
Kin carer outcomes not reported separately	78
Wrong study population	26
Wrong study location	25
No control/comparison group	19
Not an intervention	12
Study results not reported (intervention description/protocol, review)	5
No access to paper after contacting author	2

Table 8 presents the number of papers and reason for exclusions for papers identified via the grey literature searches. One paper was also identified for possible inclusion but could not be included in analysis as we could not gain access to the papers.

Table 8. Reasons for exclusion for grey literature papers screened at full text stage

Reason for exclusion	Number of papers excluded
Kin carer outcomes not reported separately	53
Wrong study population	4

Reason for exclusion	Number of papers excluded
Wrong study location	1
No control/comparison group	6
Not an intervention	18
Study results not reported (intervention description/protocol, review)	2
No access to paper after contacting author	1

The majority of papers from database and grey literature searches were excluded because they reported on universal interventions and did not report outcomes for kinship carers (and/or children in kinship care) separately from the overall cohort. In addition, a high number of papers from database searches were excluded because the study design, population, or location did not meet the inclusion criteria.

However, five papers were initially included but were then excluded during the extraction process as further details were identified and discussed within the research team.

These papers were:

- Carter et al. (2023) – this paper used an RCT design to assess a self-care toolkit plus kinship navigator service to kinship navigator only. However, the outcomes were measured using an unvalidated wellbeing measure and was subsequently excluded.
- Smith, Strieder, Greenberg, Hayslip and Motoro-Rodriguez (2016) – reported on the patterns of enrolment and engagement for an RCT, rather than the outcome results of the RCT itself.
- Ranzato, Austerberry, Besser, Cirasola and Midgley (2021) – a qualitative examination of foster carer's goals before starting the Reflective Fostering Programme intervention, which does not report kinship carers' perspectives separately.
- Boswell (2011) – reports on participants' qualitative experiences of the Kinship Care Support Service. However, children were in kinship care due to parents being incarcerated rather than due to maltreatment or neglect.
- Nelson-Dusek and Gerrard (2012) – this paper describes a QED of a Kinship Navigator Project in Minnesota. The comparison group for this study would have needed further statistical work to be a true counterfactual.

Risk of bias in studies

Quantitative studies

Risk of bias assessments were used to inform understanding of the strength of evidence and the appropriateness of a meta-analysis of the quantitative studies. For the assessment of impact studies (RoB-2 and ROBINS-I[8]), we used the flexibility in the guidance to override non-blinding as a cause of concern; unlike in the medical field, it is very hard for kinship carers to not know if they are getting a particular service or parenting programme and non-blinding to treatment or in data analysis was assessed not to be of concern, and all studies assessed as 'high risk' from this one domain would overshadow differences in risk of bias from other domains. However, there may still be biases from the inability to blind.

We consider there to be a moderate to serious level of risk of bias across the included quantitative papers – 67% of RCTs and QEDs presented some to high concerns or moderate to serious risk of bias. Figure 3 and Figure 4 display the full results of the RoB-2 and ROBINS-I by domain and overall. Where multiple papers reported on the same study, only the lead paper has been reported, to avoid overrepresenting the risk of bias. In most cases all papers on the same study had the same risk of bias rating, apart from the Littlewood, Cooper, Yelick and Pandey (2021) study, which have been reported separately due to the subgroup selection and reporting. For full RoB-2 and ROBINS-I assessments, see Appendix F and Appendix G.

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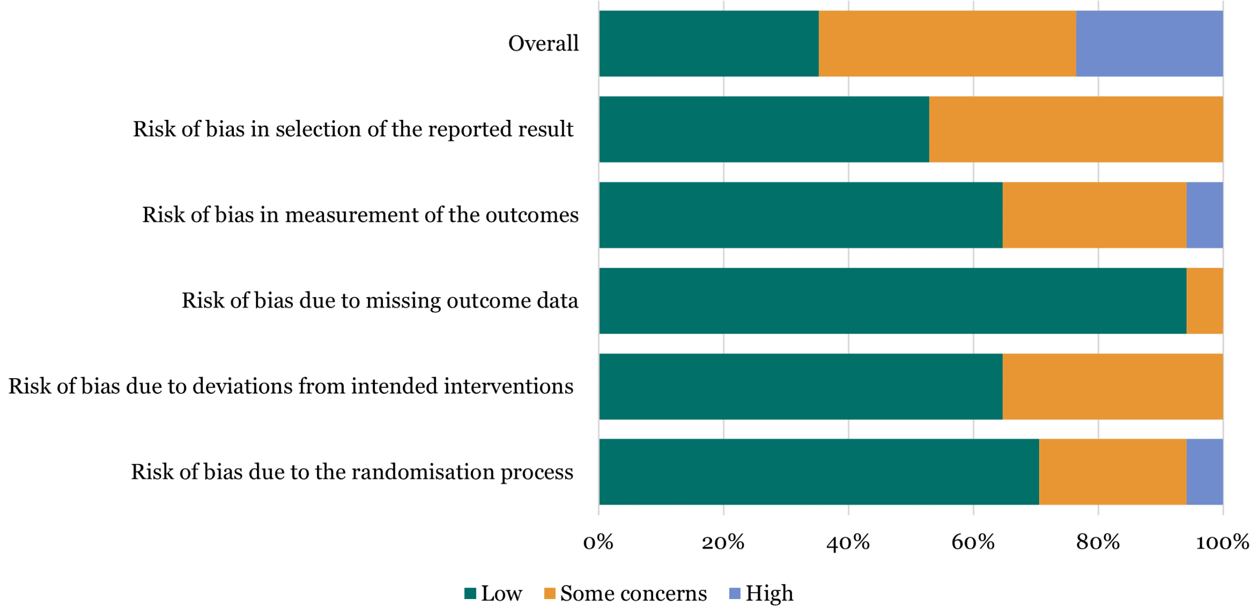
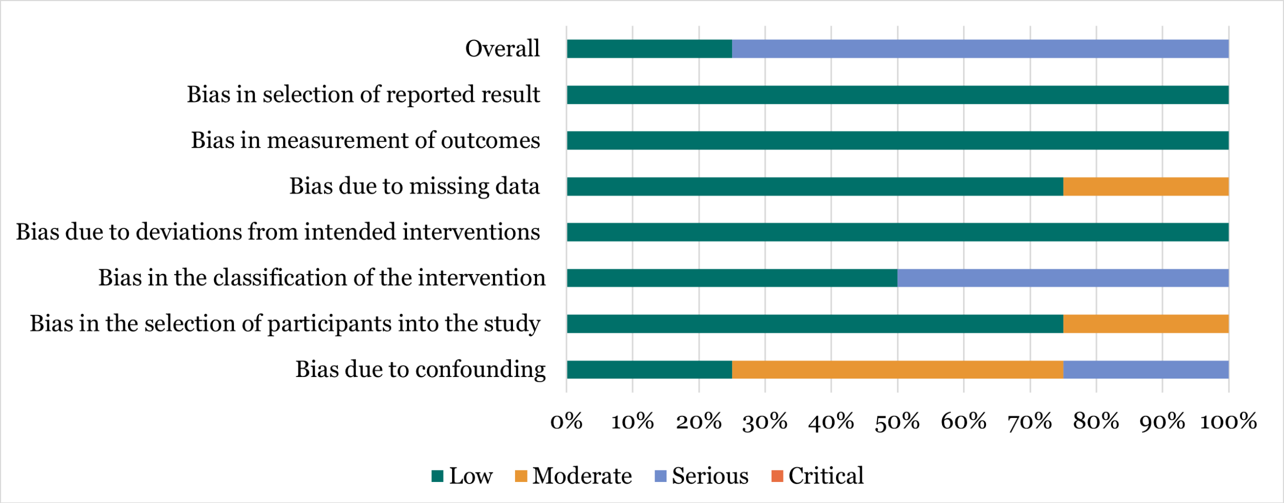
[8] More information about the risk of bias assessments can be found in the methods section.

Figure 3. Summary of RoB-2 assessments for included RCTs (go to accessibility text)



Number of studies assessed = 17; Littlewood, Cooper and Pandey (2020); Littlewood, Cooper, Yelick and Pandey (2021); and Pandey (2019) assessed separately due to subgroup selection

Figure 4. Summary of ROBINS-I assessments for included QEDs (go to accessibility text)



Number of studies assessed = 4

Qualitative studies

The quality of reporting of all the included qualitative studies was found to be acceptable for inclusion in the review. Using the Critical Appraisal Skills Programme (CASP) Checklist tool, we found that the quality of reporting in studies ranged from moderate to high (see Table 9). Two studies were of high quality (Channon et al., 2020; Whitley, Fischer, Van Zanten & Kelson, 2023), and four were of moderate quality (Hartley, McAteer, Doi & Jepson, 2019; Welch, 2018; Starks & Whitley, 2020; Schroer & Samuels, 2019).

Four of the included qualitative studies were grey literature reports, which sometimes have less systematic reporting on design, sampling, and methods than peer-reviewed academic articles. However, these reports were assessed for quality and relevance for this study and were judged to be appropriate for inclusion. The evidence is also representative of the sector and provides insights into programmes and interventions which are often delivered by third sector organisations. Therefore, on balance, we judged all six studies to be of sufficient quality to analyse as part of this review.

The authors of all but one study articulated that they had taken steps to ensure the appropriateness of data collection tools. Methodological quality was compromised most often with respect to describing participant recruitment, data analysis and considerations relating to the relationship between the researchers and the intervention recipients. For the full CASP assessment, see Appendix H.

Table 9. Critical appraisal results for included studies using the Critical Appraisal Skills Programme (CASP) Checklist

Study	Quality judgement
Channon et al (2020)	High
Hartley, McAteer, Doi and *Jepson (2019)*	Moderate
Welch (2018)	Moderate
Starks and *Whitley (2020)*	Moderate
Whitley, Fischer, Van Zanten and *Kelson (2023)*	High
Schroer and *Samuels (2019)*	Moderate

RQ 1: What interventions for kinship families improve the outcomes of children in kinship care and for kinship carers?

In order to structure the outcomes relevant for research question 1, we have categorised the studies into intervention categories. The primary categories are kinship navigator programmes, caregiver training; parenting skills, and caregiver training; resourcefulness/therapy and subsidised guardianship. The remaining interventions were not sufficiently frequent to summarise, and so have been presented individually (peer support groups, financial support, mentoring for children in kinship care, and case management). For each intervention category, we provide a summary of the evidence for each of the child and caregiver-level outcomes.

Kinship navigator programmes

Kinship navigator programmes provide the specialist personnel, information, and infrastructure to support kinship caregivers to learn about and access the support to which they are entitled, both to meet the needs of the children they are raising and their own needs as caregivers. These programmes also usually promote effective partnerships among public and private agencies to ensure kin caregiver families are served effectively.[9] This section reports the findings for each outcome type: Child outcomes on permanency (e.g. reunification, guardianship, adoption), placement stability, and safety; and caregiver outcomes for caregiver wellbeing, parenting skills, knowledge and use of services, and relationship with the child.

Child outcomes

Likelihood of being placed in kinship care

Two (n = 2) QED studies (Wheeler et al., 2016; Schmidt & Treinen, 2021) assessed whether the presence of kinship navigator programmes had an effect on the likelihood that, if a decision was made to place children in out-of-home care, they would be placed in kinship care.

Outcomes for these two studies were combined in a fixed-effects meta-analysis ($I^2 = 0$, $p = .43$, indicating low study heterogeneity, in which case fixed-effects analyses are recommended; Deek et al., 2023). Only one of the two studies (Wheeler et al., 2016) had a statistically significant effect favouring kinship navigator, as shown in Figure 5. The other study (Schmidt & Treinen, 2021) had a positive effect, but confidence intervals spanned the line of no effect (0 on the x-axis), indicating it was not statistically significant. The combined effect size was positive and statistically significant,

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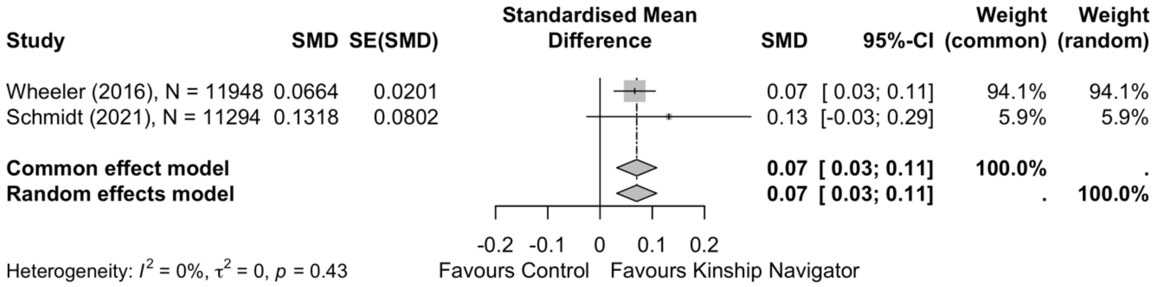
[9] More information on kinship navigator programmes is available at: https://www.casey.org/what-are-kinship-navigators/#:~:text=Kinship%20navigator%20programs%20assist%20kin,their%20own%20needs%20as%20caregivers.

but with a small effect size (SMD = 0.07). Results suggest that Kinship Navigator programmes had a small but significant impact on the likelihood of being placed in kinship care, as measured in these studies. Although effect sizes were small, data were obtained from large, population-based samples, indicating that this finding is generalisable.

Figure 5. Forest plot for QEDs: likelihood of being placed in kinship care (go to accessibility text)



Note: *Given there are only two studies, both fixed and random effects models were calculated for completeness, however as the heterogeneity was 0, results are identical (see Deeks et al., 2023).*

Table 10. GRADE assessment of likelihood of being placed in kinship care: Kinship navigator programmes

Outcomes	Anticipated absolute effects * (95% CI)		Number of participants (studies), follow-up	Certainty of the evidence (GRADE)	Comments
	Estimated risk in comparison group	Estimated risk in intervention group			
Likelihood of being placed in kinship care	The proportion of children who entered kinship care was on average 0.07 SDs 95% CI: [0.03; 0.11] higher in the intervention areas relative to the comparison areas.		23,242[10] (2), ≤12 months	Low	Based on the common-effects model estimate

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[10] Wheeler et al. (2016) reports a sample size of 11,948 for the likelihood of being placed in kinship care. They report a smaller sample size for other outcomes.

See Appendix E for the full GRADE assessment.

Narrative summary on additional placement in kinship care outcome

In addition to Wheeler et al. (2016) assessing the effect of having the kinship navigator programme more structurally on the likelihood of children within intervention areas being placed initially with kin (presented above), the study also assessed the odds of kinship care being their predominant placement (having more than 90% of their time in care being in kinship care). Children in areas with the kinship navigator programme were more likely to be placed predominately with kin (OR = 1.126, Wald $\chi 2(1) = 10.46$, $p < .01$).

Schmidt and Treinen (2021) incorporated several assessments of permanency for young people by looking at their placements while in the custody of Arizona's Department of Child Safety and upon exit, including being placed in kinship care, other foster care placement, or permanent placement (reunification, guardianship, adoption). In this QED, there was a small significant effect of the intervention on being placed in kinship care while in care (OR = 1.27, $p < .01$).

Permanency and stability

Six of the studies reporting on kinship navigator programmes reported permanency and stability outcomes at the child level, four of which are QEDs. The papers reported on in this section are Feldman and Fertig (2013); Forehand, Alessi and Winokur (2022); Forehand, Bulter, Alessi and Winokur (2023); Fowler, Day, Wollen and Vanderwill (2023); Littlewood, Cooper and Pandey (2020); Preston (2021); Wheeler et al. (2016), Wheeler et al. (2007), and Wheeler et al. (2020).

These studies measured permanency outcomes by using administrative data and surveys across several different metrics, and many papers report on more than one permanency outcome. These metrics fall into two broad categories: moving into a permanent placement; and the stability of kinship placements. In this section, we present three meta-analyses and two narrative summaries of permanency and stability outcomes.

Meta analyses of placement disruption outcomes

Placement disruption refers to situations in which a child's placement in a kinship home breaks down or ends for a non-planned reason, for example if the kinship caregiver no longer wishes to care for the child (Preston, 2021).

Two (n = 2) RCTs assessed the impact of Kinship Navigator programmes on the likelihood of placement disruption. Outcomes were combined in a fixed-effects meta-analysis ($I^2 = 57\%$, p = .13, indicating low study heterogeneity, in which case fixed-effects analyses are recommended; Deek et al., 2023). All studies had effects favouring Kinship Navigator, as shown in Figure 6.[11] The

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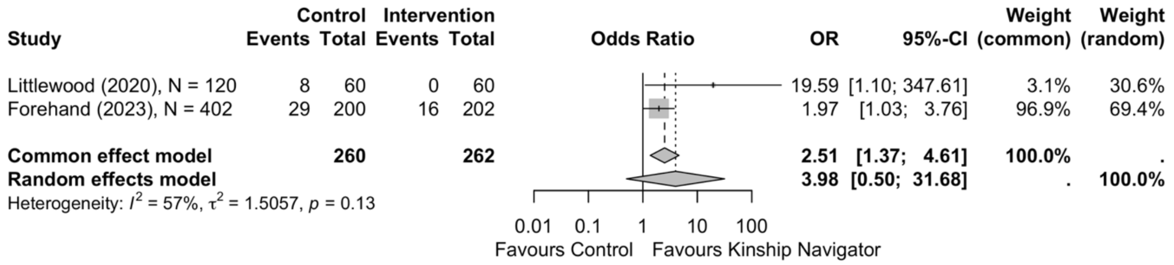
[11] The Odds Ratio was calculated from the raw data for Littlewood, Cooper and Pandey (2020). This estimate is uncertain because of the 0 in the numerator. We have gone ahead with this meta-analysis as it is not weighted highly, and we used two different effect size calculators but got similar results.

combined effect size was positive and was statistically significant in the fixed-effects model, but not in the random-effects model (due to the wider confidence interval in the random effects model aiming to account for greater between-study heterogeneity). These analyses suggest that there may be a small effect of Kinship Navigator on the likelihood of placement disruption, as measured in these studies. However, the small number of studies and substantial between-study heterogeneity present cause for caution in the interpretation of these effects.

Figure 6. Forest plot for RCTs: placement disruption (go to accessibility text)



Note: *Given there are only two studies, both fixed and random effects models were calculated for completeness. The fixed (common) effect model was estimated using the Mantel–Haenszel method, and random-effects using the inverse variance method. A continuity-correction of 0.5 was automatically applied to studies with zero cell frequencies.*

Table 11. GRADE assessment of placement disruption: Kinship navigator programmes (RCTs)

Outcomes	Anticipated absolute effects * (95% CI)		Number of participants (studies), follow up	Certainty of the evidence (GRADE)	Comments
	Estimated risk in comparison group	Estimated risk in intervention group			
Placement disruption	The likelihood of experiencing placement disruption was on average 2.51 times higher 95% CI: [1.37; 4.61] higher in the comparison group relative to the intervention group.		522[12] (2), ≤ 12 months	Moderate	Based on the common-effects model estimate

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[12] Littlewood, Cooper and Pandey (2020) includes four treatment groups, with a total sample size of 240. In the meta-analysis, only two groups are included (n = 60 each).

See Appendix E for the full GRADE assessment.

Two (n = 2) QED studies which assessed the impact of Kinship Navigator programmes on the likelihood of placement disruption were combined in a random-effects meta-analysis (I^2 = 70%, p = .07, indicating significant study heterogeneity, in which case random-effects analyses are recommended; Deek et al., 2023). Both the studies had statistically significant effects favouring kinship navigator, as shown in Figure 7. The combined effect size was positive and was statistically significant in the random-effects model (as well as in a fixed-effects model, run for completeness). These analyses suggest that there may be a small effect of Kinship Navigator on the likelihood of placement disruption, as measured in these studies. However, the small number of studies presents cause for caution in the interpretation of these effects.

Figure 7. Forest plot for QEDs: placement disruption (go to accessibility text)

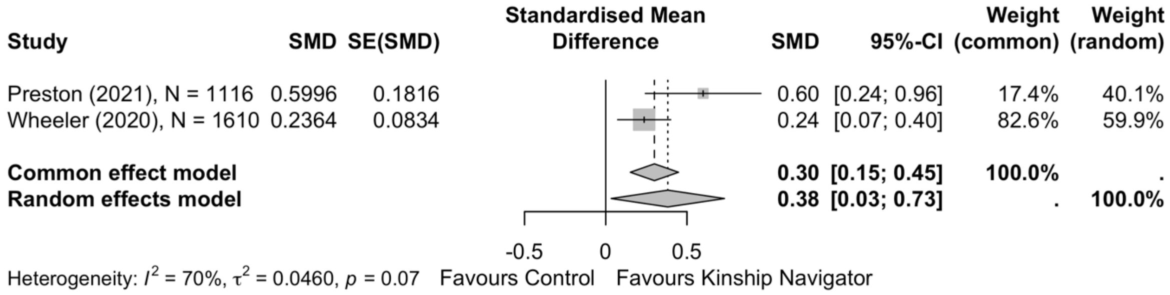

Table 12. GRADE assessment of placement disruption: Kinship Navigator programmes (QEDs)

Outcomes	Anticipated absolute effects (95% CI)		Number of participants (studies), follow up	Certainty of the evidence (GRADE)	Comments
	Estimated risk in comparison group	Estimated risk in intervention group			
Placement disruption	The likelihood of experiencing placement disruption was on average 0.38 SDs 95% CI: [0.03; 0.73] higher in the comparison areas relative to the intervention areas.		2,726 (2), post intervention	Low	Based on the random-effects model estimate

See Appendix E for the full GRADE assessment.

Narrative summary of placement disruption outcomes

- Feldman and Fertig (2013) present on the same RCT as CHS of NJ (2012), but with numbers that are one off each other. Of the 604 or 603 children in the study, only a small number have a 'placement event' of entering into care again after kinship services is completed (5 children total according to Feldman and Fertig (2013) – 1 in the enhanced kinship navigator services and 4 in the control standard kinship navigator services (p. 57) and 6 children according to CHS of NJ – 1 in the enhanced services, and 5 in the control (p. 60). No statistics were performed on this outcome, and there is insufficient information to clearly interpret the finding. Once they leave kinship care, children are unlikely to return whether they receive an enhanced navigator service or not.
- Fowler, Day, Wollen and Vanderwill (2023) used a propensity score matched QED to compare service recipients to comparison counties. They used caregiver surveys to identify the number of young people leaving placements and to measure the reasons for leaving, then analysed rates of leaving due to placement instability (rather than other reasons such as aging out, reunification with parents, or adoption). There was a large, significant effect of the intervention on leaving the kinship home due to instability (OR = 0.1, 95% CI [0.1-0.5], $p < .001$); children in the comparison counties have nine times the odds of leaving their placement due to disruption.
- As reported in the meta-analysis: Littlewood, Cooper and Pandey (2020) report on an RCT using administrative data to measure placement stability by using a binary outcome to indicate whether or not a kinship placement had been disrupted, excluding placements disrupted due to reunification with biological parents. They report a statistically significant effect of the intervention on placement stability. The authors of this paper calculated the Odds ratio from the raw data presented, as included in the meta-analysis (OR = 19.59, 95% CI [1.10-347.61], $p < .001$).[13]
- As reported in the meta-analysis: Forehand, Alessi and Winokur (2023) reported stability via the likelihood of placement disruptions leading to non-relative foster care and to congregate care placement (residential care or group homes). The data from these two measures were combined in the meta-analysis at 6 months post-kinship placement, but the effect of disruption to congregate care was less common and not significant by itself (OR = 1.520, $p = 0.421$), while the disruption to a non-relative foster care placement was significant (OR = 1.512, $p = 0.023$).
- As reported in the meta-analysis, Preston (2021) used administrative data for a matched sample QED to measure placement stability in a similar way, by using a binary outcome to indicate whether a kinship placement had been disrupted, excluding placements

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[13] Note that this OR is particularly large given the reported 0% placement disruptions in the intervention group, which may lead to an unreliable estimate.

disrupted due to reunification with biological parents. They report a medium effect of treatment on placement disruptions (Cohen's $d = .6$, $p < .001$)

- Finally, in their QED, Wheeler et al. (2016, 2017, 2020) assessed placement stability using administrative data through four measures 1) the number of placement moves experienced by children in kinship arrangements (in the meta-analysis), 2) experiencing a move for children in kinship care in their first episode of care, 3) time in the kinship placement, and 4) re-entry into care after the first episode of children placed in a kinship relationship. A higher percentage of children with kinship carers in the areas with the kinship navigator programmes experienced no placement moves during their first care episode than matched children with kinship carers in comparison communities (85% vs 73% in Wheeler et al., 2017; 85% vs 78% in Wheeler et al., 2016), and they experienced fewer placements on average (average of .19 to .24, partial eta squared = .003, $p = .037$) (Wheeler et al., 2020).[14] The 'discharge from placement' for kinship carers also occurred more quickly in the areas with the kinship navigator programmes (the adjusted median days in care was 285 days vs 323 days for children placed with kinship carers in comparison areas, $p < .001$) (Wheeler et al., 2020).[15] For those discharged from care, there were no statistically significant differences in the rate of re-entry into care within 6, 12, and 24 months of the end of their first episode in care for children placed with kinship carer in kinship navigator and comparison counties ($p = .60$, $p = .43$, and $p = .453$, respectively) (Wheeler et al., 2020).

Narrative summary of permanency outcomes

Two studies reported on permanency outcomes:

- Forehand, Alessi, Butler and Winokur (2023) and Forehand, Alessi and Winokur (2022) reported the rate at which permanency had been achieved, either via reunification with parents or through adoption or guardianship – both of which were considered positive outcomes. This RCT reported small, statistically significant effects favouring the intervention group on reunification with parents (OR 1.57, $p = .032$), and the likelihood of placement disruptions to a non-relative foster care placement (OR 1.51, $p = .023$)[16] (Forehand, Alessi & Winokur, 2022). Looking at 6-months post kinship placement end, children in the intervention group were 2.13 times less likely to enter into foster or congregate (residential) care within that period (OR = 0.47, $p = 0.024$,) (Forehand et al., 2023). There was no significant effect of intervention on moving into guardianship/adoption (Forehand, Alessi & Winokur, 2022).
- Schmidt and Treinen (2021) looked at young people's placements while in the custody of the Department of Child Safety and upon exit, including permanent placements

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[14] The paper reported $m = .16$, $SD = .51$ for the intervention vs $m = .24$, $SD = .51$ for the control, $\chi^2 = 13.986$.

[15] Partial eta squared = .009.

[16] 95% confidence intervals not reported.

(reunification, guardianship, adoption). They found an effect in favour of the intervention on moving into a permanent status including guardianship, reunification, or adoption at exit from children services (verses being emancipated, runaway, or deceased at exit from care) (OR = 1.72, $p < .01$).[17]

We identified 'some' to 'serious' concerns with risk of bias in these studies, which undermine confidence in the significance of the small to medium effect sizes reported. However, these results were found consistently across studies with similar designs and large sample sizes, meaning these results may be real and meaningful.

Safety

Three studies – Feldman and Fertig (2013);[18] Fowler, Day, Wollen and Vanderwill (2023); and Littlewood, Cooper and Pandey (2020) – report safety outcomes for children in kinship care. Both Fowler, Day, Wollen and Vanderwill (2023), and Littlewood, Cooper and Pandey (2020) report instances of allegations and substantiations of abuse or maltreatment, Feldman and Fertig (2013) report on referrals to child welfare services after kinship services are completed, and Fowler, Day, Wollen and Vanderwill (2023) also report emergency room visits.

- Feldman and Fertig (2013) reported referrals to child protection services after kinship cases were closed. Of the 211 protection related referrals, 47% were from the enhanced kinship navigator services and 53% were from the comparison regular kinship navigator services. The difference was reported as not statistically significant, but statistics were not given (p. 57). The paper also noted a very low number of substantiated cases.
- Fowler, Day, Wollen and Vanderwill (2023) used a caregiver survey to compare emergency room visits between children in the comparison and intervention counties and found fewer visits, with a medium effect size (OR = 0.4, 95% CI [0.2-0.9], $p = .02$). They also investigated allegations and substantiations of abuse. However, there were extremely low instances of either during the trial, and there were no statistically significant results between the two groups.[19]
- Littlewood, Cooper and Pandey (2020) used administrative data to measure safety outcomes using a binary indicator of whether a family had experienced a substantiation of child abuse or neglect. They report a significant effect of the intervention on safety ($p < .001$), but do not present raw data or an effect size.

The risk of bias present in these papers, plus the limited instances of abuse and unavailability of effect sizes limits our confidence in these findings.

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[17] 95% confidence intervals not reported.

[18] Also reported in CHS of NJ (2012).

[19] Neither group had any substantiations of abuse, and there was one allegation of abuse in the intervention group and four in the control group ($p = .28$).

Caregiver outcomes

Wellbeing

Four of the kinship navigator studies (five papers) – all RCTs – report outcomes on carer wellbeing. The papers are CHS of NJ (2012), Day et al. (2024), Feldman and Fertig (2013), Littlewood, Cooper, Yelick and Pandey (2021), and Pandey et al. (2016). Wellbeing outcomes were measured using a variety of caregiver surveys. Three of these papers report on enhanced kinship navigator programmes compared to 'standard' kinship navigation programmes, while the remaining two looked at several types of enhancements compared to 'business as usual' child support services.

- Feldman and Fertig (2013) (and CHS of NJ, 2012) measured levels of stress, caregiver health and perceived social support. They found no effect of intervention on overall parenting stress (Parental Stress Index (PSI), and Stress Index for Parents of Adolescents (SIPA)) compared to standard kinship navigator services but did find a benefit to service users when only considering scores above clinically significant levels at Time 1 ($p < .05$, no effect size reported). They report no significant differences between groups in terms of physical health on the Rand Medical Outcomes Study Social Support Survey or perceived social support.
- Day et al. (2024) measured caregiver wellbeing using four items from the Family Empowerment Questionnaire and found a small significant effect of the enhanced kinship navigator program compared to standard kinship navigator services (OR = 1.8, 95% CI [1.4-2.3], $p < .001$).
- Littlewood, Cooper, Yelick and Pandey (2021) used the Protective Factors survey to measure perceived social support – and this domain is comprised of three items. There was no difference between the intervention group (three levels of kinship navigator service) and the BAU comparison group on this outcome.
- Pandey et al. (2016) used the same measure of perceived social support but report a benefit of the intervention compared to BAU, though the effect size is not reported ($p < .001$).

While two of these papers (on one study) were assessed as having low risk of bias (Feldman & Fertig, 2013; CHS of NJ, 2012), the study findings present no effects of the intervention. The remaining papers were considered to have some concerns of bias which, combined with the small or no effect sizes (and insufficient data to transform into effect sizes) reported, undermines our confidence in the evidence for kinship navigator programmes improving carer wellbeing.

Parenting skills

Two papers (Littlewood, Cooper, Yelick & Pandey, 2021; Pandey et al., 2016) report on parenting outcomes, both using the Protective Factors survey to assess knowledge of parenting and child development across five items.

- Littlewood, Cooper, Yelick and Pandey (2021) found a significant effect of group ($p = .02$) on knowledge of parenting and child development, but do not report an effect size or identify which comparison was significant (usual care, traditional kinship navigator, peer-to-peer kinship navigator or a peer-to-peer kinship navigator plus specialist services).
- Pandey et al. (2016) also found a significant effect of group on knowledge of parenting and child development ($p < .001$) but also did not specify any effect size or significant comparisons (the four conditions were usual care, standard care, peer-to-peer care, or the full peer kinship navigator programme).

For the included papers, some concerns about risk of bias and the lack of specificity in reporting on outcomes means it is difficult to conclude whether there is an effect of kinship navigator programmes on parenting skills or knowledge.

Knowledge, use, and perceptions of services

Six of the kinship navigator papers, five of which are RCTs (Preston, 2021 being the QED), report outcomes on carers' use and knowledge of services. The papers are Day et al. (2024); Feldman and Fertig (2013); Fowler, Day, Wollen and Vanderwill (2023); Littlewood, Cooper, Yelick and Pandey (2021); Pandey et al. (2016); and Preston (2021). The two methods of assessment for this outcome are 1) perceptions of service support, and 2) utilisation of specific services, such as financial support.

- Day et al. (2024) and Fowler, Day, Wollen and Vanderwill (2023) reported on both of these methods: they used administrative data to measure utilisation of services and benefits and a survey to assess participants' satisfaction with said services. The study compared enhanced kinship navigator services with standard kinship navigator services. They found no effect of the intervention on overall service utilisation or uptake of Kinship Caregiver Support Program services but did find a large significant effect on the attendance at kinship care support groups (OR = 9.4, 95% CI [1.7 to >100], $p = .02$). They also identified a small significant effect of the intervention on utilisation of Temporary Assistance for Needy Families (TANF) benefits (OR = 1.9, 95% CI [1.1-3.2], $p = .02$). However, they found no effect of the intervention on satisfaction with their kinship navigator (OR = 1.1, 95% CI [0.8-1.6], $p = .49$)
- Feldman and Fertig (2013) reported on the results of the Family Needs Scale which measures the intensity of needs in regard to several areas, including concrete and financial needs, educational needs, and support for the child. They identified a statistically significant benefit of the intervention on the intensity of needs (no effect size reported, $p < .01$).
- Littlewood, Cooper, Yelick and Pandey (2021) measured perceived access to concrete services using the Protective Factors Survey. They report a significant effect of intervention by time ($p < .001$) but do not report an effect size or identify which

comparison was significant (usual care, traditional kinship navigator, peer-to-peer kinship navigator or a peer-to-peer kinship navigator plus specialist services).

- Pandey et al. (2016) also measured perceived access to concrete services using the Protective Factors Survey. They report a significant effect of intervention by time ($p < .001$) but also did not specify and effect size or significant comparisons (the four conditions were usual care, standard care, peer-to-peer care, or the full peer kinship navigator programme).
- Preston (2021) measured service uptake by identifying which carers became licensed foster carers in the duration of the study. They found a medium to high sized significant effect of the kinship navigator service on licensure (Cohen's $d = .68$, $p < .001$).

The heterogeneity in measurement approaches regarding the perceptions, knowledge, and use of services makes it difficult to assess the likelihood that kinship navigator programmes have an impact. The moderate risk of bias and number of null effects add to this difficulty.

Relationship with child

Two papers (Littlewood, Cooper, Yelick & Pandey, 2021; Pandey et al., 2016) report on relationships with children, both using the Protective Factors survey to assess nurturing and attachment and family functioning.

- Littlewood, Cooper, Yelick and Pandey (2021) found a significant effect of group on both nurturing and attachment ($p < .001$) and family functioning ($p < .001$), but do not report an effect size or identify which comparison was significant (usual care, traditional kinship navigator, peer-to-peer kinship navigator or a peer-to-peer kinship navigator plus specialist services).
- Pandey et al. (2016) also found a significant effect of group on both nurturing and attachment ($p < .001$) and family functioning ($p < .001$) but also did not specify effect size or significant comparisons (the four conditions were usual care, standard care, peer-to-peer care, or the full peer kinship navigator programme).

As with the parenting outcomes, moderate concerns about risk of bias and the lack of specificity in reporting on outcomes means it is difficult to conclude whether there is an effect of kinship navigator programmes on kinship caregivers' relationships with the children in their care.

Caregiver training: parenting skills

Caregiver training in parenting skills refers to interventions which mainly involve structured programmes, workshops, or sessions designed to equip caregivers with the knowledge and techniques necessary to effectively nurture and support children in their care. Parenting skills typically cover a range of topics, including child development, behaviour management strategies, communication techniques, and methods designed to improve parent–child interaction and the overall quality of parenting that a child receives.[20] The parenting skills training included in this review cover Child Directed Interaction Training, the use of solution-oriented strategies, training in attachment and trauma, social intelligence, and resourcefulness.

Child outcomes

Wellbeing/behaviour

Two of the studies reporting on caregiver training in parenting skills reported child-level outcomes, all of which were regarding child wellbeing or behaviour – N'Zi, Stevens and Eyberg (2016) and Stevens (2011) for one study and Smith, Hayslip, Hancock and Strieder (2018) for the other. These papers use caregiver reports of child behaviour across three domains: internalizing behaviour, externalizing behaviour, and prosocial behaviour.

- N'Zi, Stevens and Eyberg (2016) used the Caregiver report of the Child Behaviour Checklist to assess externalising and internalising behaviour problems for the children in their care. They found a large statistically significant effect of the parenting programme on externalising behaviours (Cohen's $d = 1.04$, $p = .03$) but no effect on internalising behaviours (Cohen's $d = 0.22$, $p = .97$). Using the Reliable Change Index to determine if the magnitude of change exceeds the range of measurement error, the authors report that there was a clinically significant change for the majority of participants for externalising behaviours.
- Smith, Hayslip, Hancock and Strieder (2018) used the caregiver report Strengths and Difficulties questionnaire to measure externalising and internalising behaviours of children. The parent behaviour training yielded positive results in both domains when compared with an information only control. Externalising behaviours (standardised ES = -.66, $p = .03$) and internalising behaviours (standardised ES = -.51, $p = .05$) were both improved by the intervention compared to a matched comparison group. It is unclear from the paper how to interpret the standardised effect sizes reported.

The two studies reported here presented a low risk of bias (N'Zi, Stevens & Eyberg, 2016; Smith, Hayslip, Hancock & Strieder, 2018). Despite the low risk of bias and large effect sizes reported, the small sample sizes also reduce confidence in the findings, particularly in N'Zi, Stevens and Eyberg (2016).

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[20] WHO guidelines on parenting interventions to prevent maltreatment and enhance parent–child relationships with children aged 0–17 years. Geneva: World Health Organization, 2022. Licence: CC BY-NC-SA 3.0 IGO.

Caregiver outcomes

Wellbeing

Three of the studies representing four of the papers reporting on parenting programmes provided outcomes for caregiver wellbeing, reported in N'Zi (2012) and N'Zi, Stevens and Eyberg (2016); Smith, Hayslip, Hancock and Strieder (2018); and Smith et al. (2023). A meta-analysis was not appropriate for this outcome given the heterogeneity in intervention characteristics. There was also heterogeneity in outcomes within this theme, with depressive symptoms and stress reported most commonly, as well as prosocial behaviour, anxiety, loneliness, and self-esteem.

- N'Zi, Stevens and Eyberg (2016) measured caregiver depression using the Beck Depression Inventory-II (BDI-II), a self-report questionnaire and stress using the PSI. They found a large significant effect of the intervention on parenting stress (Cohen's $d = 1.51$, $p = .005$) and a medium to large effect on depressive symptoms (Cohen's $d = 0.78$, $p = .02$). Using reliable change, the authors report a clinically significant change in the majority of participants in the intervention conditions for the PSI but not for the BDI-II.
- Smith, Hayslip, Hancock and Strieder (2018) measured psychological distress using the Centre for Epidemiological Studies – Depression Scale (CES-D), a self-report questionnaire capable of identifying clinical levels of depression and the Overall Anxiety Severity and Intensity Scale. They found a marginally statistically significant effect of the parenting behaviour training on psychological distress (standardised ES = -.64, $p = .05$).
- Smith et al. (2023) explored the effect of grandmothers attending a Social Intelligence Training programme on their depressive symptoms, anxiety symptoms, loneliness, self-esteem and prosocial behaviour, using the CES-D, Medical Outcomes Study Mental Health Inventory, Loneliness Scale, Rosenberg Self-Esteem Scale and the Values in Action Inventory of Strengths. They found significant effects for anxiety symptoms (standardised ES = 0.28, $p = .02$) and prosocial behaviour (standardised ES = 0.20, $p = .01$), but do not provide an interpretation of the size. The intervention was reported to have no effect on the remaining outcomes.

In order of reporting, the studies reporting on caregiver wellbeing outcomes for parenting interventions present low, low and high risk of bias. The small sample size presented in N'Zi, Stevens and Eyberg (2016) and inconsistency in results on depressive symptoms further undermine confidence in the otherwise large effect sizes reported.

Parenting

Three studies report on parenting outcomes for parenting interventions: N'Zi, Stevens and Eyberg (2016); Schoemaker et al. (2020); and Smith, Hayslip, Hancock and Strieder (2018). Both the heterogeneous intervention types and outcome measures made meta-analysis inappropriate for this theme.

- N'Zi, Stevens and Eyberg (2016) incorporated two measures of parenting skills: a caregiver report and observations. The caregiver report assessed the presence of critical verbal force, non-critical verbal force, and limit setting using the Parent Daily Report and the Daily Discipline Inventory. Large significant effects were found for critical verbal force (Cohen's $d = 1.61$, $p = .03$) and limit setting (Cohen's $d = 1.26$, $p = .05$) but no effect was reported for non-critical verbal force. Regarding the observational outcomes, they report large significant effects for both 'positive following' and 'negative leading' parenting behaviours – an increase in the former and a decrease in the latter (Cohen's $d = 4.68$, $p < .001$; Cohen's $d = 2.50$, $p < .001$)
- Schoemaker et al. (2020) measured parenting outcomes in three ways: observations to measure parental sensitivity, observations of parental sensitive discipline, and a questionnaire of attitudes towards parenting. No significant effect of group was identified.
- Smith et al. (2023) measured parenting outcomes in response to behavioural parenting training using the self-report Parenting Practices Inventory; they found no statistically significant findings regarding coercive discipline (standardised ES = -.24, $p = .26$), ineffective discipline (standardised ES = -.40, $p = .11$), or nurturance (standardised ES = .23, $p = .26$).

Risk of bias for the reported studies was considered low, but two of the studies identified no result and two of the studies included in this section report on very small sample sizes of 14 and 15 (N'Zi, Stevens & Eyberg, 2016; Schoemaker et al., 2020), meaning these studies do not provide evidence that parenting training improves parenting outcomes for kinship caregivers.

Relationship with child

Two studies of parenting training interventions reported in three papers present findings in relation to kinship caregivers' relationships with the children in their care: N'Zi, Stevens and Eyberg (2016); Stevens (2011); and Smith et al. (2023).

- N'Zi, Stevens and Eyberg (2016) and Stevens (2011) used the Child Parent Relationship Scale (Positive Aspects of Relationship), a caregiver report questionnaire, to assess relationship quality. They report a large but marginally significant effect favouring the intervention group (Cohen's $d = 1.24$, $p = .05$). Furthermore, they explored child attachment behaviours using the Parent Attachment Diary. They report no effect of the intervention on secure, resistant or avoidant attachment behaviours.
- Smith et al. (2023) measured grandchild attachment behaviours differently, using the Experience with Close Relationships questionnaire. There was no difference reported between groups in either avoidant attachment or anxious attachment. They also measured relationship quality with grandchild – but found no effect.

The limited number of studies available for this outcome, lack of significant effects, and moderate risk of bias mean we cannot conclude that there is an effect of parenting training interventions on relationships with the children in kinship care.

Caregiver training: resourcefulness or therapy

Caregiver training in resourcefulness refers to interventions which mainly involve programmes, workshops, or sessions designed to equip caregivers with the necessary knowledge and skills to effectively support their own emotional wellbeing, seek help when needed, and cope with the challenges associated with caregiving (Montoro-Rodriguez, Hayslip, Ramsey & Jooste, 2021; Zauszniewski, Musil, Burant & Au, 2014). This type of training recognises the importance of caregivers prioritising their own mental health and self-care practices in order to better support the individuals under their care. Therapy based interventions which specifically aim to support caregivers' wellbeing (cognitive behavioural therapy) have also been included in this grouping.

Three studies (Montoro-Rodriguez, Hayslip, Ramsey & Jooste, 2021; Smith, Hayslip, Hancock & Strieder, 2018; and Zauszniewski, Musil, Burant & Au, 2014) reported on the outcomes of resourcefulness or therapy programmes for caregivers. Unsurprisingly, the focus of these studies were caregiver-level outcomes.

Child outcomes

Wellbeing

One study that reported on a therapeutic programme for caregivers reported on child-level wellbeing outcomes.

- Smith, Hayslip, Hancock and Strieder (2018) used the caregiver report Strengths and Difficulties questionnaire to measure externalising and internalising behaviours of children. The cognitive behavioural therapy (CBT) yielded positive results in both domains when compared an information only control. Externalising behaviours (standardised ES = -.98, p = .002) and internalising behaviours (standardised ES = -.66, p = .01) were both improved by the intervention compared to a matched comparison group. It is unclear from the paper how to interpret the standardised effect sizes reported.

Further research would be required to replicate this study finding and provide supportive evidence. However, the study was assessed as having a low risk of bias and used a fairly large sample, showing evidence of promise in this domain.

Caregiver outcomes

Wellbeing

All three studies (Motoro-Rodriguez, 2021; Smith, Hayslip, Hancock & Strieder, 2018; Zauszniewski, Musil, Burant & Au, 2014) that reported on resourcefulness training or therapy for caregivers reported on caregiver wellbeing outcomes, using homogenous outcomes – namely depression – though one paper used this to create a composite measure.

- Montoro-Rodriguez, Hayslip, Ramsey and Jooste (2021) measured depressive symptoms in grandparents using the CES-D questionnaire and found a statistically significant group by time interaction in which grandparents in the intervention group experienced a reduction in depressive symptoms ($p < .01$) but did not report an effect size.
- Smith, Hayslip, Hancock and Strieder (2018) measured psychological distress using the Centre for Epidemiological Studies – Depression Scale (CES-D), a self-report questionnaire capable of identifying clinical levels of depression and the Overall Anxiety Severity and Intensity Scale. They found no effect of the CBT on psychological distress (standardised ES = -.16, $p = .33$).
- Zauszniewski, Musil, Burant and Au (2014) measured caregivers' wellbeing using three different scales: the Perceived Stress Scale, CES-D, and the Quality of Life Short-Form 12. Significant group by time interactions were reported for perceived stress ($p < .001$), depressive symptoms ($p < .05$) and quality of life ($p < .01$). No effect sizes were reported, though they state that the study was powered to detect an effect size of .15.

The Montoro-Rodriguez, Hayslip, Ramsey and Jooste (2021) study presented a high risk of bias while the other papers were considered to have a low risk of bias. The strength and significance of findings also varies significantly across studies. For these reasons, while there is some evidence of promise in this domain, we do not have high confidence in these findings.

Parenting

Only two studies reported on parenting outcomes for this intervention type and measured them differently – one reported caregivers' perceptions of parental efficacy while the other used self-reported parenting behaviours.

- Montoro-Rodriguez, Hayslip, Ramsey and Jooste (2021) measured parental efficacy using a self-report scale and found a significant group by time interaction ($p < .01$), in which small benefits were found for the intervention group but they do not report an effect size.
- Smith, Hayslip, Hancock and Strieder (2018) measured parenting outcomes in response to CBT using the self-report Parenting Practices Inventory; they found no statistically significant findings regarding coercive discipline (standardised ES = -.40, $p = .09$), but significant benefits of the programme for the intervention group in ineffective discipline (standardised ES = .73, $p = .005$), and nurturance (standardised ES = .39, $p = .07$).

No conclusions beyond the individual results can be drawn in this domain, given the variance in intervention approach and outcome measures.

Knowledge and use of services

One paper reported on the influence of resourcefulness training on caregivers' knowledge and use of available support services.

- Montoro-Rodriguez, Hayslip, Ramsey and Jooste (2021) explored the extent to which grandparents' needs were met over time, and they found an increase for the intervention group and a decrease for the waiting list control group, but this finding did not reach significance (p = .06).

The high risk of bias present in this study and lack of statistically significant results mean that further research is required to provide evidence for the benefits of this kind of intervention on the uptake of services.

Guardianship subsidy

Five papers across three studies reported on the effect of a financial subsidy for guardianship (Hong, 2006; Mandell, 2001; Testa, 2002; Testa, Cohen & Smith 2003; and Testa 2008). One of these papers reported on three guardianship waivers in Wisconsin, Tennessee, and Illinois (Testa, 2008), but it was only clear that Tennessee was a substantial majority of kinship carers (all kinship carers). All these papers reported from a programme in the US ('guardianship waivers') which allowed states to offer financial subsidies for relative caregivers taking out guardianship until the child was 18 (or sometimes 21 if in education). The financial subsidies were modest amounts. In Maryland, there was a $300 monthly subsidy to relative caregivers who assume guardianship of the child in their care; this was $112 more per month than unlicensed kinship carers receiving welfare payments, and half the average payment for kinship carers licensed and receiving foster care payments ($600/month). Three states were represented in these studies: Maryland (Hong, 2006, Mandell, 2001); Illinois (Testa 2002; Testa, Cohen & Smith 2003; Testa 2008); and Tennessee (Testa, 2008). Hong (2006) presented a QED analysis from an RCT study, and the remaining papers present RCTs.

Child outcomes

Permanency and stability

Four (n = 4) RCT samples (from three studies) assessed the impact of guardianship subsidy on permanency. Outcomes were combined in a fixed-effects meta-analysis ($I^2 = 55\%$, $p = .08$, indicating non-statistically significant study heterogeneity, both fixed-effects and random effects models were calculated anyway for completeness). All studies had effects favouring guardianship subsidy, as shown in Figure 8. The combined effect size was positive and was statistically significant in both the fixed-effects and random-effects models. These analyses suggest that there may be a small effect of the guardianship subsidy on permanence, as measured in these studies. However, the small number of studies present cause for caution in the interpretation of these effects.

Figure 8: Forest plot for subsidised guardianship: permanence (go to accessibility text)

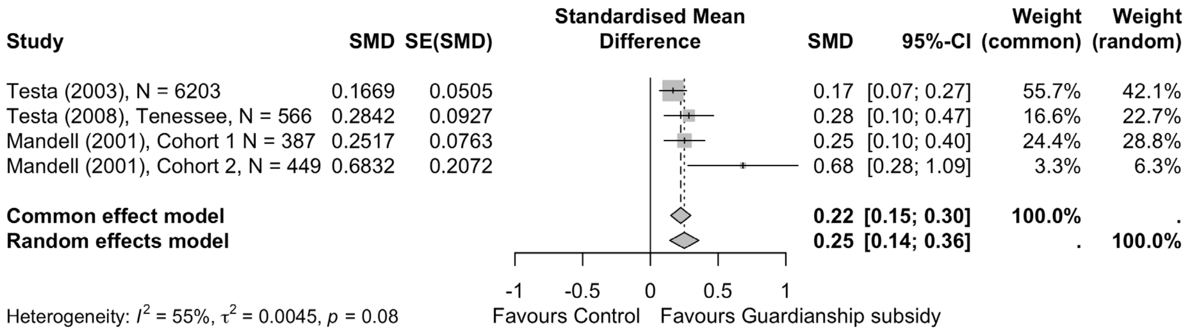

Table 13. GRADE assessment of permanence: Subsidised guardianship

Outcomes	Anticipated absolute effects (95% CI)		Number of participants (cohorts), follow-up	Certainty of the evidence (GRADE)	Comments
	Estimated risk in comparison group	Estimated risk in intervention group			
Placement disruption	The likelihood of experiencing placement disruption was on average 0.22 SDs 95% CI: [0.15; 0.30] higher in the comparison areas relative to the intervention areas.		7.605 (4), various	Low	Based on the common-effects model estimate

See Appendix E for the full GRADE assessment.

One question that arises across the studies is whether one type of permanency (guardianship) acts as a substitution for another permanency (adoption). We have selected measures for all studies which combine permanency outcomes considered positive (guardianship and adoption and reunification at a minimum, and generally also living with other relatives). Whilst there are indications that those in the control group may be more likely to adopt their children (Testa, Cohen & Smith, 2003), the overall net 'positive' permanency favours the intervention group that were offered the guardianship subsidies.

Another question that arises is whether the subsidies positively affect adoption and guardianship alone, without considering reunification. In Appendix K, a sensitivity analysis was conducted on just adoption and guardianship outcomes using Testa, Cohen and Smith (2003) and Testa (2008).

Outcomes were combined in a fixed-effects meta-analysis ($I^2 = 67\%$, $p = .08$, indicating non-significant study heterogeneity, both fixed-effects and random effects models were calculated for completeness). Both studies had effects favouring the guardianship subsidy, as shown in Figure 7 in Appendix K. The combined effect size was positive and statistically significant in both the fixed-effects model and random-effects models. These analyses suggest that there may be a small effect of guardianship subsidy on permanence, measured as the rates of children moving into adoption and guardianship. However, the small number of studies present cause for caution in the interpretation of these effects.

Hong (2006) conducted a further subgroup analysis using propensity score matching to examine different placement outcomes,[21] distinguishing between children who remain in kinship care, move into restricted foster care, exit care via guardianship, and are reunified. They also found no harm to these subgroups. An additional analysis by Mandell (2001) also notes that the current level of the subsidy ($300/month) appears enough to affect the permanency for children who are placed with kinship care providers, it does not appear large enough to affect the rate at which formal, licensed foster carers ('Restricted Foster Carers' receiving $600 per month) take up guardianship.

Two studies looked at stability. Hong (2006) found that the majority of young people in both the intervention and control groups did not experience a placement disruption, but there was a significant effect of the intervention on placement stability in which the intervention reduced the likelihood of disruption ($p = .006$). Though some concerns were identified around potential bias in randomisation, this was because the randomisation procedure was not described. Otherwise, the study was considered to have a low risk of bias, which combined with the large sample implies these findings are genuine, but replication and more information regarding effect sizes is required to draw conclusions. Testa (2002) evaluated the Illinois guardianship programme and presented percentages of children still living in the kinship home (including adopted or with a guardianship order) and those who moved from the home: 70.3% of the intervention group were still in the kinship home compared to 69.4% of the control group; this finding was not statistically significant.

Safety

One study reported on safety. Testa, Cohen and Smith (2003, p. 54) reported on reports of abuse and neglect for those randomised to subsidised guardianship or services as usual (whether or not they took up the subsidised guardianship). No statistical tests were presented, but 16.4% of the subsidised guardianship demonstration group (3.3% of the group had substantiated reports) and 16.7% of the control group had been reported for abuse and neglect prior to 1999 (4.3% had substantiated reports). Indicated reports were the lowest for those who had taken up guardianship. This study was assessed to have a low risk of bias, but we cannot determine confidence in this finding from a single study.

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[21] Hong (2005) used propensity score analysis to examine the possibility of negative effects in the absence of the guardianship study.

Other intervention types

The following papers reported on intervention types that were too heterogeneous to meaningfully summarise.

Two papers reported on the effect of peer support groups (Pasalich, Moretti, Hassalla & Curcio, 2021; McCallion, Janicki & Kolomer, 2004).

Pasalich, Moretti, Hassalla and Curcio (2021) reported results for nine caregiver and child outcomes, all reported here. The outcomes cover child wellbeing and behaviour, caregiver wellbeing, relationship between caregivers and the children in their care, placement changes and parenting competence:

- Child behavioural and emotional difficulties, and prosocial behaviour were measured using the caregiver report SDQ. They found no effect on behavioural and emotional difficulties (ηp2 = 0.05, 95% CI [0.00-0.23], *p* = .288) or prosocial behaviours (ηp2 = 0.13, 95% CI [0.00,0.33], *p* = 0.076).
- Child affect regulation (suppression and dyscontrol) was measured using the caregiver-report Affect Regulation Checklist. A small significant effect was found for suppression (ηp2 = 0.22, 95% CI [0.02, 0.42], p = 0.019) but no effect was identified for dyscontrol no effect (ηp2 = 0.03, 95% CI [0.00, 0.19], p = 0.428).
- Child attachment insecurity (anxiety and avoidance) was measured using the caregiver report of the Adolescent Attachment Anxiety and Avoidance Inventory. No effect was found for anxiety or avoidance (ηp2 = 0.03, 95% CI [0.00, 0.20], p = 0.398; ηp2 = 0.05, 95% CI [0.00, 0.23], p = 0.285).
- Placement changes was measured using administrative data regarding the number of placement moves during the study. There were no unplanned placement moves in the intervention group and no effect of the intervention found (p = .48).
- Caregiver strain was measured using the Caregiver Strain Questionnaire-Short Form. They found a small significant effect of the intervention on reducing strain (ηp2 = 0.25, 95% CI [0.03, 0.45], p = 0.011).
- Caregiver competence was measured using the Parenting Sense of Competence Scale. No effect was identified (ηp2 = 0.04, 95% CI [0.00, 0.21], p = 0.363).
- Caregiver psychological aggression was measured using a modified version of the Conflict Tactics Scale. No effect was identified (ηp2 = 0.04, 95% CI [0.00, 0.22], p = 0.316).

This paper was thought to have some concerns for risk of bias, used a fairly small sample and reports many comparisons, which diminish our confidence in the veracity of its findings.

The intervention presented in McCallion, Janicki and Kolomer (2004) incorporated both peer support groups and case management elements but without full kinship navigator services. The outcomes cover caregiver wellbeing and parenting ability, but effect sizes were not reported and could not be calculated from available data:

- They measured caregivers' depressive symptoms using the CES-D self-report survey. They found a significant effect (p < .05).
- Three measures of empowerment were reported, all of which were found to benefit from the intervention: family (p < .05), services (p < .05) and community (p < .01).
- Caregiver mastery was reported to benefit from the intervention (p < .01).

One paper reported on the effect of mentoring for children in kinship care (Rhodes, Haight & Briggs, 1999). Children in relative foster placements made up 78 of the 90 participants, so the results are reported combined and considered relevant for this review. They reported on peer relationships and found an effect of treatment on prosocial support and self-esteem over time (*p* < .05; *p* < .01).

RQ 2: Are there interventions/programmes that are particularly effective with different groups of carers and children?

This research question aims to explore the relative benefits and potential unintended effects of the interventions identified through this review on different populations of carers and children, depending on characteristics such as race and ethnicity, age, gender, relation to child, and on carers or children with a disability.

It is important to understand how different populations of kinship carers and children in kinship care experience and benefit from interventions, as previous reviews have shown that kinship caregivers are more likely to be older, less educated, and more likely to be single, unemployed and poor than non-kinship foster carers (Cuddeback, 2004). The responsible parties for policymaking, intervention design, and implementation must be cognisant of the disparities in contextual factors effecting these populations at various and intersecting levels.

Our ability to answer this research question is limited, as the included studies provided no or minimal specific insights into the differential effectiveness of interventions for subgroups of participants (e.g. disabled or minoritised carers or children). While there is a lack of specific evidence on the effectiveness of interventions for different subpopulations, this review identified important demographic and contextual factors within the included studies.

Grandparents – specifically grandmothers – are well documented as the most common form of kinship carer. The majority of kinship caregivers across all studies were women (mean = 95.4%, *SD* = 19.9) and the majority of those were grandmothers. Two studies only included grandparents (McCallion, Janicki & Kolomer, 2004; Montoro-Rodriguez, Hayslip, Ramsey & Jooste, 2021), a further four papers only included grandmothers and great-grandmothers (N'Zi, Stevens & Eyberg, 2016; Smith, Hayslip, Hancock & Strieder, 2018; Smith et al., 2023; Zauszniewski, Musil, Burant &

Au, 2014), and grandmother was the most common relationship, where reported in the remaining studies.

Kinship navigator programmes were generally open to both informal and formal caregivers, though some studies only reported findings for formal caregivers due to the availability of official statistics for comparison.

Several of the included studies reported on populations with notable characteristics. The majority (more than 60%) of the caregivers belonged to people of the global majority in eight of the included studies (Feldman & Fertig, 2013; Hong, 2006; McCallion, Janicki & Kolomer 2004; Montoro-Rodriguez, Hayslip, Ramsey & Jooste 2021; Rhodes, 1999; Testa, Cohen & Smith, 2003; Testa, 2008; Zauszniewski, Musil, Burant & Au, 2014). As these studies were conducted in the USA, the ethnicities and races represented were predominantly Black/African American, Hispanic or Latino, and Indigenous American. These studies reported positive impacts on a range of caregiver outcomes: caregiver depression, caregiver stress, caregivers' relationships with children, parental efficacy and caregiving, and service needs.

Similarly, in six of the included studies (Feldman & Fertig, 2013; Forehand, Alessi, Butler & Winokur, 2023; Hong, 2006; Littlewood, Cooper & Pandey, 2020; Rhodes, Haight & Briggs, 1999; Testa, Cohen & Smith, 2003), the majority of the children were reported as Black/African American, Hispanic/Latino, or Indigenous, again all from US-based studies.[22] Positive outcomes for children in these studies were reported for: reunification, exiting to guardianship and children's relationships with peers and others.

Although no studies reported on differences in effectiveness of the interventions for disabled and non-disabled children, in one study (McCallion, Janicki & Kolomer, 2004) all participants were caregivers of a child with a developmental disability or delay. They reported caregiver outcomes for depression, empowerment and caregiving mastery – all significantly improved by the support group intervention. This demonstrates that peer support can be effective for carers facing particularly complicated caring responsibilities.

When looking at Overall Waiver Impact on permanency for children in foster care (i.e. the effect of all interventions delivered as part of the funding, not reported specifically on kinship families), Wheeler et al. (2016) found that certain factors predicted the speed at which children exit foster care to permanency or reunification. Unless drug or alcohol abuse is identified as a risk factor, being older or being black is associated with a quicker exit. Developmental risk (physical, cognitive, or social development) predicted a slower exit to permanency or reunification include. However, these results are not specific to kinship families and cannot be extrapolated without further analysis.

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[22] In Forehand, Alessi, Butler and Winokur (2023), the population of children in the study was over 60% 'racial/ethnic minority,' predominately Hispanic or Black. Like many studies, this is an overrepresentation of these populations compared to the demographics of these areas.

The included studies represent a broad range of populations, with regard to race and ethnicity, age, gender, relationship to child, disability, and socioeconomic status, and demonstrate the ability of interventions to effect positive change in a variety of communities. However, this review is unable to provide evidence for *differential* impacts on children and their caregivers depending on different characteristics.

RQ 3: Are there common elements shared by effective interventions?

Practice elements were extracted direct from the paper and/or programme manual including their definition and then categorised at three different levels. Where multiple papers reported on the same intervention, that intervention was only coded once so that they are not overrepresented in the data. Often an understanding of the intervention was taken from multiple papers and sources of information. The data below represents 21 different interventions reported across the 30 included papers.

The first level differentiates between two categories: content elements and process elements. Content elements are the general principles or approaches driving practice, while process elements are about the implementation methods (i.e. delivery method, delivery support, or practitioner's approach). This roughly follows other approaches (Garland et al., 2008; McLeod et al., 2017; Tan et al., 2021). The second level consists of general techniques – for example, case management or proactive parenting. The third level consists of specific operationalisations of the general techniques, such as screening and family needs assessments for case management, and rule setting and managing conflict for proactive parenting.

At the second level, process elements fell into three main categories: delivery method, practitioner approach, and delivery support. Examples of third-level operationalisations are below.

- Delivery method – e.g. modelling, roleplay, homework sheets
- Practitioner approach – e.g. emotional and social support
- Delivery support – e.g. general community engagement, programme oversight.

A full list of process elements can be found in Appendix L.

The content elements were much more varied, as shown in Table 14. For example, case management included operationalisations such as family needs assessment, family safety planning, tailored intervention navigation, goal setting, general information and referrals, and navigating peer-led support.

For both process and content elements, a total of 18 general techniques and 85 different operationalisations were identified in the included quantitative studies. The frequency of the general techniques across studies can be seen in the following table.

Table 14. Frequency of general techniques across studies

General technique (level 2)	Frequency of operationalisations (level 3)	Frequency of general technique across interventions
Case management	48	14
Delivery method	24	8
Psychoeducation	19	5
Skills for parents themselves	19	6
Relationship enhancement/promoting sensitivity	15	6
Peer learning groups	11	1
Caregiver education (system)	10	4
Delivery support	6	4
Access to wider teams/agencies	8	5
Incentives	5	3
Practitioner's approach	4	3

General technique (level 2)	Frequency of operationalisations (level 3)	Frequency of general technique across interventions
Positive reinforcement	4	3
Proactive parenting	4	3
Activities	4	3
Financial resources	5	5
Nonviolent disciplining	3	2
Peer support groups	3	3
Caregiver education (practical)	2	1

Determining effectiveness

The heterogeneity in study designs, outcome domains, outcome measures, and reporting conventions across studies, meant that determining whether each intervention approach was or was not effective was not possible. There are many metrics by which a study could be considered to be effective, including implementation and presence of statistically or clinically significant outcomes. There are also questions around relevance of a particular approach in a new context.

In Table 15, we present each intervention with its corresponding practice elements and indicate the outcome areas in which a significant outcome favouring the intervention was reported, and where there was no effect reported.

Summary of findings

Interpretation of the frequency of practice elements in relation to effective interventions is limited due to the variety of elements incorporated in the heterogeneous included studies and the imbalance in their frequency. For example, one might presume that case management is an element common to studies with positive outcomes for children and caregivers in kinship arrangements. However, that is because it is such a prevalent feature of the interventions included – namely of kinship navigator programmes – and other elements may be more efficacious, but less frequently evaluated in this context. Without comparing their presence or absence in one study versus another, we cannot say that any individual element is effective, nor can any causal inference be drawn from specific combinations of elements. We can only report on their presence within effective interventions. The summary presented in **Error! Reference source not found.** must therefore be interpreted with caution.

Case management is a content element and was the most commonly used practice element – present in 14 of the interventions, showing that it is a commonly used practice beyond the seven kinship navigator programmes included in this review. Case management comprises several operationalisations, including screening and eligibility, family needs assessments, providing information, referrals, and peer-led system navigation. Case management is thought to benefit kinship families by providing ongoing and personal support from a specialised worker, assessing families' needs and connecting them to the relevant services.

Delivery method, the second most common practice element across the included studies, is a process element and refers to the activities involved in the delivery of the intervention, including the use of home visits, at home practice, physical materials, use of video guidance, and role plays. The medium through which an intervention is delivered is a key area for future research, particularly in the context of the qualitative findings which suggest that the accessibility of delivery methods is a crucial determinant of engagement with support services for kinship carers and their children.

Psychoeducation, a content element, is the third most commonly employed practice element in the included studies, and aims to increase caregivers' knowledge of various areas, including children's development, attachment styles, the impacts of trauma, and conflict management. This element was most frequent in the parenting training interventions and is thought to benefit caregivers by both improving their knowledge of relevant issues and strategies to mitigate them.

A full understanding of the relative contributions of practice elements to different outcomes necessitates different statistical techniques, such as a network meta-analysis or meta-regression approaches (e.g. Lipsey, 2009; Leijten, Melendez-Torres, et al., 2021; Pompoli et al., 2018; Taylor et al., 2023), or qualitative comparative analysis (e.g. Melendez-Torres et al., 2019). These analyses are generally undertaken with a larger number of studies and are beyond the scope of this review.

Table 15. Relationship between practice elements and presence of statistically significant outcomes favouring the intervention

⊖ This symbol indicates that the practice element had no effect on the reported outcome.

✓ This symbol indicates that the practice element had a positive effect on the reported outcome.

☐ This symbol indicates that the outcome was not reported.

Reference	Practice elements (level 2)	Child outcomes				Caregiver outcomes			
		Safety	Permanence	Wellbeing/ behaviour	Education	Wellbeing	Parenting	Knowledge /use of services	Relationship with child
Day* et al. *(2024)	Case management. Delivery support. Financial resources. Peer support groups. Caregiver education (system).	☐	☐	☐	☐	✓	☐	✓	☐

Reference	Practice elements (level 2)	Child outcomes				Caregiver outcomes			
		Safety	Permanence	Wellbeing/ behaviour	Education	Wellbeing	Parenting	Knowledge /use of services	Relationship with child
Feldman and Fertig (2013)	Case management. Caregiver education (system). Financial resources. Activities. Peer support groups.	☐	☐	☐	☐	⊖	☐	✓	☐
Forehand, Alessi, Butler and Winokur (2023)	Case management. Delivery method. Practitioner’s approach.	☐	✓	☐	☐	☐	☐	☐	☐

Reference	**Practice elements (level 2)**	**Child outcomes**				**Caregiver outcomes**			
		Safety	**Permanence**	**Wellbeing/ behaviour**	**Education**	**Wellbeing**	**Parenting**	**Knowledge /use of services**	**Relationship with child**
Hong (2006)	Financial resources.	☐	✓	☐	☐	☐	☐	☐	☐
Littlewood, Cooper and Pandey (2020)	Case management. Delivery support. Access to wider teams/agencies. Practitioner’s approach.	✓	✓	☐	☐	☐	☐	☐	☐

Reference	Practice elements (level 2)	Child outcomes				Caregiver outcomes			
		Safety	Permanence	Wellbeing/ behaviour	Education	Wellbeing	Parenting	Knowledge /use of services	Relationship with child
Littlewood, Cooper, Yelick and Pandey (2021)	Case management. Delivery support. Access to wider teams/agencies.	☐	☐	☐	☐	⊖	✓	✓	✓
McCallion, Janicki and Kolomer (2004)	Case management. Peer learning groups.	☐	☐	☐	☐	✓	✓	✓	☐

Reference	**Practice elements (level 2)**	**Child outcomes**				**Caregiver outcomes**			
		Safety	**Permanence**	**Wellbeing/ behaviour**	**Education**	**Wellbeing**	**Parenting**	**Knowledge /use of services**	**Relationship with child**
Montoro-Rodriguez, Hayslip, Ramsey and Jooste (2021)	Case management. Delivery method. Psychoeducation. Skills for parents themselves.	☐	☐	☐	☐	✓	✓	⊖	⊖
N'Zi, Stevens and Eyberg (2016)	Delivery method. Relationship enhancement/ promoting sensitivity. Positive reinforcement.	☐	☐	✓	☐	✓	✓	☐	✓

Reference	Practice elements (level 2)	Child outcomes				Caregiver outcomes			
		Safety	Permanence	Wellbeing/ behaviour	Education	Wellbeing	Parenting	Knowledge /use of services	Relationship with child
Pandey et al. (2016)	Case management. Delivery support. Access to wider teams/agencies.	☐	☐	☐	☐	✓	✓	✓	✓

Reference	**Practice elements (level 2)**	**Child outcomes**				**Caregiver outcomes**			
		Safety	**Permanence**	**Wellbeing/ behaviour**	**Education**	**Wellbeing**	**Parenting**	**Knowledge /use of services**	**Relationship with child**
Pasalich, Moretti, Hassalla and Curcio (2021)	Delivery method. Relationship enhancement/ promoting sensitivity. Psychoeducation. Skills for parents themselves. Incentives. Proactive parenting.	☐	☐	✓	☐	✓	⊖	☐	⊖

Reference	Practice elements (level 2)	Child outcomes				Caregiver outcomes			
		Safety	Permanence	Wellbeing/ behaviour	Education	Wellbeing	Parenting	Knowledge /use of services	Relationship with child
Preston (2021)	Case management. Psychoeducation. Caregiver education (system). Skills for parents themselves. Proactive parenting. Caregiver education (practical).	☐	✓	☐	☐	☐	☐	✓	☐

Reference	Practice elements (level 2)	Child outcomes				Caregiver outcomes			
		Safety	Permanence	Wellbeing/ behaviour	Education	Wellbeing	Parenting	Knowledge /use of services	Relationship with child
Rhodes, Haight and Briggs (1999)	Case management. Activities	☐	☐	✓	☐	☐	☐	☐	☐

Reference	Practice elements (level 2)	Child outcomes				Caregiver outcomes			
		Safety	Permanence	Wellbeing/ behaviour	Education	Wellbeing	Parenting	Knowledge /use of services	Relationship with child
Schmidt and Treinen (2021)	Case management. Caregiver education (system). Access to wider teams/agencies. Activities. Peer support groups. Practitioner's approach.	☐	✓	☐	☐	☐	☐	☐	☐

Reference	Practice elements (level 2)	Child outcomes				Caregiver outcomes			
		Safety	Permanence	Wellbeing/ behaviour	Education	Wellbeing	Parenting	Knowledge /use of services	Relationship with child
Schoemaker et al. (2020)	Relationship enhancement/ promoting sensitivity. Psychoeducation. Skills for parents themselves. Positive reinforcement. Nonviolent disciplining.	☐	☐	☐	☐	✓	☐	☐	☐

Reference	**Practice elements (level 2)**	**Child outcomes**				**Caregiver outcomes**			
		Safety	**Permanence**	**Wellbeing/ behaviour**	**Education**	**Wellbeing**	**Parenting**	**Knowledge /use of services**	**Relationship with child**
Smith, Hayslip, Hancock and Strieder (2018)	Case management. Delivery method. Relationship enhancement/ promoting sensitivity. Skills for parents themselves. Positive reinforcement. Incentives. Proactive parenting. Nonviolent disciplining.	☐	☐	✓	☐	✓	✓	☐	☐

Reference	**Practice elements (level 2)**	**Child outcomes**				**Caregiver outcomes**			
		Safety	**Permanence**	**Wellbeing/ behaviour**	**Education**	**Wellbeing**	**Parenting**	**Knowledge /use of services**	**Relationship with child**
Smith et al. (2023)	Delivery method. Delivery support. Relationship. enhancement/ promoting sensitivity. Psychoeducation. Incentives.	☐	☐	✓	☐	✓	☐	⊖	☐
Wheeler et al. (2020)	Case management. Delivery method.	☐	✓	☐	☐	☐	☐	☐	☐

Reference	**Practice elements (level 2)**	**Child outcomes**				**Caregiver outcomes**			
		Safety	**Permanence**	**Wellbeing/ behaviour**	**Education**	**Wellbeing**	**Parenting**	**Knowledge /use of services**	**Relationship with child**
Zauszniewski, Musil, Burant and Au (2014)	Delivery method. Skills for parents themselves.	☐	☐	☐	☐	✓	☐	☐	☐
Testa, Cohen and Smith (2003)	Financial resources. Access to wider teams/agencies. Relationship enhancement/ promoting sensitivity. Case management.	☐	✓	☐	☐	☐	☐	☐	☐

Reference	Practice elements (level 2)	Child outcomes				Caregiver outcomes			
		Safety	Permanence	Wellbeing/ behaviour	Education	Wellbeing	Parenting	Knowledge /use of services	Relationship with child
Testa (2008)	Financial resources.	☐	✓	☐	☐	☐	☐	☐	☐

RQ 4 and RQ 5: Implementation, acceptability, and usefulness

Research questions addressed in this section:

What are the enablers and barriers to successful implementation of interventions for kinship carers and children in kinship care?

6. What are the perspectives of kinship carers and children in kinship care on the acceptability and usefulness of different interventions?

Summary of findings

The research team identified 10 key findings reported in the qualitative papers, summarised in Table 16.

Table 16. Finding statements for research questions 4 & 5

Finding statement	Summary	Research questions addressed
1	An intervention's distinction from statutory services is perceived to facilitate engagement, favourable experiences, and positive outcomes	4 & 5
2	Providing carers with access to a network of peers enhances an intervention's acceptability and usefulness	5
3	Carers find that consistent and intensive interactions with practitioners facilitate positive relationships which promote engagement	4
4	Practitioners' interpersonal skills are key to building positive, supporting, trusting relationships with kinship carers	5
5	Programme developers found codesign and incorporation of evidence-based frameworks effective when developing new interventions	4 & 5

Finding statement	Summary	Research questions addressed
6	Kinship carers view specialised support as highly acceptable and useful due to their unmet needs and the gaps in statutory services	5
7	Carers find interventions that incorporate referrals and liaise with other services useful	5
8	Kinship carers are more likely to engage with and enjoy interventions that actively address the accessibility of the services	4 & 5
9	Being recipient-centred is an important element for a programme's acceptability	5
10	Caregivers and practitioners perceive a broad range of positive outcomes as a result of targeted kinship interventions	5

Narrative summary of qualitative findings

After analysing the six qualitative studies included in this review, the research team identified several factors that facilitated or hindered the implementation of interventions for kinship carers and children in kinship care and identified particular elements valued by kinship carers. These findings have been summarised in 10 statements discussed in detail in this section. While these findings inevitably contribute to and overlap with each other, they each capture specific features of effective support for kinship families. The interventions reported on in this section are: an adoption support fund; resourcefulness, wellbeing and relationship support programmes; a parenting skills programme; Kinship Connected; and a parallel child and carer therapy support service.

Determinants of implementation include the role of the intervention provider, the accessibility of the intervention, and the relationships established with practitioners. Intervention design elements that influence kinship carers' perceptions of interventions' acceptability and usefulness include incorporating existing evidence-based frameworks and prioritising accessibility. Additionally, specific intervention delivery features – such as peer support groups, facilitation of referrals to services, and flexibility in delivery methods – were perceived as effective among kinship carers. Overall, both caregivers and practitioners reported a diverse range of positive outcomes resulting from targeted kinship interventions.

Summaries of each finding statement are provided below, along with specific examples drawn from the qualitative studies.

Finding 1: An intervention's distinction from statutory services is perceived to facilitate engagement, favourable experiences, and positive outcomes

Contributing papers:

- Welch (2018)
- Starks and Whitley (2020)
- Whitley, Fischer, Van Zanten and Kelson (2023)
- Schroer and Samuels (2019)

Kinship carers felt more positively about support from non-statutory services due to prior negative experiences. Kinship carers expressed their frustration with the lack of understanding and support they had previously received from statutory services, particularly from local authorities and children's services. They reported experiencing a closed-door approach when contacting local authorities for information or support on aspects of caregiving (such as managing challenging behaviour), which reinforced their sense of isolation and increased their levels of stress. One study also reported that some kinship carers felt anxious about contacting social workers due to the fear that the child might be removed.

> *"I haven't had any practical support from my local authority from day one. I have never had any of the terms explained to me, never had any advice, nothing." (Kinship carer; Starks & Whitley, 2020, p. 66)*

> *"No support by LA just persecution and lack of understanding." (Kinship carer; Schroer & Samuels, 2019, p. 34)*

When kinship carers did receive support from local authorities, it was viewed as too intermittent or too late to be effective. In one paper, caregivers described their engagement with social workers as sporadic and unreliable, with sessions often being cancelled at short notice (Welch, 2018). As a result, kinship carers felt undervalued and disregarded in their caregiving role. These negative experiences led to apprehension of, and distrust towards, engaging with statutory services. As a result, the position of delivery organisations as distinct from local authority services played a role in facilitating participant engagement and trust with third sector interventions.

> *"Having weekly sessions, same time, same place, it makes them feel valued, we're never late. Where maybe social workers turn up late for their appointment, things are cancelled … here I think that uninterrupted time for you, it goes a long way to making that relationship and to feel we're very reliable." (Professional; Welch, 2018, p. 32)*

Third sector organisations were seen as being able to offer more targeted and tailored support for kinship carers, as the interventions were designed to deal with the specific complexities of kinship families. Carers felt that third sector providers, compared to statutory services, had the autonomy and capacity to adapt components of the intervention based on the needs and feedback of recipients, which enhanced engagement and acceptability. For instance, modifying session content and delivery to align with immediate caregiver concerns (Welch, 2018). In addition, the responsiveness offered by interventions running independently from statutory services emerged as important for usefulness. Interventions delivered by third sector organisations were perceived by caregivers and professionals as operating with fewer budgetary and procedural constraints compared to local authorities, enabling them to address the needs of kinship carers earlier and more effectively.

> *"Kinship Connected can often step in earlier than social care can, which is needed when families are in crisis … in those cases Kinship Connected can be lifelines for people." (Professional; Whitley, Fischer, Van Zanten & Kelson, 2023, p. 26)*

Kinship carers also found third sector interventions to be acceptable due to the practitioners' understanding of their experiences and needs. Third sector professionals were seen by kinship carers as more attuned to the nuanced challenges faced by kinship carers, offering tailored support and a more empathetic approach.

Confidence in finding 1: High

Finding 2: Providing carers with access to a network of peers enhances an intervention's acceptability and usefulness

Contributing papers:

- Welch (2018)
- Starks and Whitley (2020)
- Whitley, Fischer, Van Zanten and Kelson (2023)

Kinship carers valued and enjoyed the opportunity to access a network of peers presented by some support services. They emphasised the importance of connecting with other caregivers who shared similar experiences, finding solace, understanding, and practical support within peer support groups and networks. They highlighted that being a part of these groups diminished feelings of isolation, increased connectedness and fostered a profound sense of belonging within a community of peers facing similar challenges.

> *"Before I got involved in all of this, I had no idea what a kinship carer was. I thought it was just me. To meet other people in the same situation is just a godsend. I really don't know where I'd have been without this support." (Kinship carer; Starks & Whitley, 2020, p. 66)*

The composition of peer support groups could increase carers' sense of belonging and community, if they saw themselves reflected in other members of the group, in terms of their age and relationship to the child(ren) in their care. However, this could also be alienating for less common kinds of kinship carers, as in the case of one caregiver who was an older sister. She reported feeling disconnected from her peer support group due to significant age differences (Starks & Whitley, 2020). The extent to which recipients identify with, and relate to, their peers influences the perceived value of belonging to a support network of kinship carers.

In addition to perceived improvements in connectedness, kinship carers reported that these peer support groups served as a safe and supportive environment where they could freely express their frustrations, discuss challenges they were facing, and grow in confidence in their caregiving abilities.

> *"We trust each other, it's a total release, we can shout and bawl and scream and cry and no one judges us." (Kinship carer; Starks & Whitley, 2020, p. 47)*

Caregivers also emphasised how participation in peer support groups led to increases in confidence regarding caregiving roles, as well as a sense of empowerment. These peer-focused environments facilitated reciprocal learning, as caregivers shared insights, strategies, and resources to navigate the challenges they faced. Specifically, caregivers highlighted notable improvement in their parenting skills, such as managing challenging behaviour, as a result of peer support (Starks & Whitley, 2020).

Kinship carers emphasised the importance of accessibility when assessing the effectiveness and usefulness of support groups, particularly emphasising the significance of location and timing in relation to in-person sessions. They stressed that for engagement with the group to be successful, the timing and location must align with the caregiver's lifestyle and commitments; for instance, ensuring that meetings do not overlap with typical school pick-up times (Starks & Whitley, 2020). Some caregivers valued online groups and forums, such as those on WhatsApp or Facebook, due to their convenience. These online platforms allowed kinship carers to stay connected with their peers and access advice and encouragement at any time, irrespective of geographical or time constraints. They also played a role in providing support to caregivers during periods when access to professional assistance was limited, such as evenings and weekends.

Confidence in finding 2: High

Finding 3: Carers find that consistent and intensive interactions with practitioners facilitate positive relationships which promote engagement

Contributing papers:

- Welch (2018)
- Starks and Whitley (2020)

- Whitley, Fischer, Van Zanten and Kelson (2023)
- Schroer and Samuels (2019)

Throughout the included studies, kinship carers emphasised that developing trusted relationships is achieved through consistent, reliable, and intensive support from practitioners. Participants also reported that positive, supportive, and trusting relationships with practitioners is a central facilitator to engagement with interventions.

Caregivers identified the frequency of sessions as a factor influencing their relationship with professionals. Specifically, they found regular weekly sessions with practitioners to be effective in establishing and nurturing relationships (Welch, 2018). While practitioners acknowledged the substantial commitment involved attending weekly sessions (in terms of time and effort), kinship carers valued the depth of engagement these weekly sessions offered. They emphasised that weekly contact was pivotal in fostering positive relationships, as it provided them with the necessary time and space for their needs to be thoroughly explored and addressed.

> *"We spent a lot of time talking about my situation. I felt she understood what I was going through … it felt good to have her on board." (Kinship carer; Starks & Whitley, p. 44).*

As well as the frequency of support, the dependability of support was also a factor in developing trusting relationships with practitioners (such as having sessions scheduled at the same time and at the same place). Practitioners who act on their assurances were particularly valued by carers. This made caregivers feel prioritised, supported, and valued, and contrasted with the inconsistent support they had received from local authorities (as referenced in Finding 1).

> *"Really frequent compared to other places. Yeah, that it's once a week and they know that they're getting that. [Knowing] that they're being kept in mind, that you're seeing them every week. (Professional; Welch, 2018, p. 32)*

The format of service delivery was described as shaping relationship dynamics between kinship carers and practitioners. Caregivers favoured intensive, one-to-one needs-based support, and perceived individualised approaches as enabling deeper and more meaningful rapport with practitioners, which in turn encouraged long-term engagement and facilitated positive impact.

Confidence in finding 3: Moderate

Finding 4: Practitioners' interpersonal skills are key to building positive, supporting, trusting relationships with kinship carers

Contributing papers:

- Welch (2018)
- Starks and Whitley (2020)
- Whitley, Fischer, Van Zanten and Kelson (2023)

- Schroer and Samuels (2019)

Kinship carers emphasised the importance of practitioners' interpersonal skills in fostering positive, supportive, and trusting relationships with intervention recipients. Specifically, kinship carers highlighted the significance of practitioners' abilities, such as active listening and empathy in building rapport and addressing their needs effectively within the intervention context. As a result, they reported that practitioners' skills were central to the perceived effectiveness of interventions.

In particular, interviewees identified the importance of active listening for fostering relationships between carers and professionals, as it showed that carers' needs and concerns were being acknowledged and understood (Starks & Whitley, 2020).

> *"Many kinship carers felt, or the first time, that they were being listened to and understood by a professional." (Professional; Starks & Whitley, 2020, p. 9)*

Empathy was another skill that caregivers found valuable. Practitioners that were perceived as empathetic, and knowledgeable about the complex challenges kinship families faced, were more likely to have a positive relationship with intervention recipients. Caregivers felt that practitioners recognised, respected, and cared about kinship families, appreciating their difficulties and acknowledging their commitment to conquer these (Welch, 2018).

Confidence in finding 4: Moderate

Finding 5: Programme developers found codesign and incorporation of evidence-based frameworks effective when developing new interventions

Contributing papers:

- Hartley, McAteer, Doi and Jepson (2019)

In one paper, which included insights into the process of developing the intervention, the authors identified that involving kinship carers in the codesign process and incorporating evidence-based frameworks as contributing to successful intervention implementation and acceptability (Hartley, McAteer, Doi & Jepson, 2019).

They used the Six Steps for Quality Intervention Development framework (6SQuID) (an innovative, collaborative, and co-produced pragmatic framework for designing, implementing, and evaluating an intervention across a range of public policy endeavours) to develop and test an intervention for kinship carers of teenage children in Scotland. The programme developers reported that drawing on an established framework provides a useful methodological underpinning for intervention procedures which could be adapted for the specific population through codesign. This, in turn, was perceived to contribute to successful implementation and acceptability among service users.

By engaging kinship carers in codesign and utilising appropriate evidence-based frameworks, interventions may be more likely to be well received and effectively implemented.

Confidence in finding 5: Low

Finding 6: Kinship carers view specialised support as highly acceptable and useful due to their unmet needs and the gaps in statutory services

Contributing papers:

- Welch (2018)
- Starks and Whitley (2020)
- Whitley, Fischer, Van Zanten and Kelson (2023)
- Schroer and Samuels (2019)

Kinship carers expressed that they had substantial unmet needs due to notable gaps in the support offered by local authorities to kinship families. They struggled with a lack of provision relating to housing, financial assistance, parenting skills and legal rights, as well as children's mental health (Welch, 2018; Starks & Whitley, 2020; Whitley, Fischer, Van Zanten & Kelson, 2023; Schroer & Samuels, 2019). Kinship carers reported that social care and other services frequently underestimated the severity of their needs, lacked appropriate services to address them, or imposed eligibility criteria that families found challenging to meet. Consequently, interventions designed specifically to address kinship needs in these areas were met with acceptance and perceived utility by caregivers.

Kinship carers emphasised the absence of comprehensive parenting support tailored to their unique circumstances. For example, caregivers noted the lack of guidance on effectively supporting children who often present with a variety of complex needs (Starks & Whitley, 2020). Caregivers, particularly grandparents, can experience or be perceived to experience a lack of confidence in their caregiving role, due to the time since caring for their own children and perceived past difficulties with raising children. They may recognise gaps in their parenting capabilities, particularly when confronted with the demands of caring for children who have experienced adverse childhood events. One kinship carer explained that felt underequipped as a caregiver, and didn't know how to handle the behaviours displayed by the child in their care:

> *"When these behaviours first started to show, I had never experienced anything like it before." (Kinship carer; Welch, 2018, p. 14)*

In turn, interventions that provided targeted parenting resources and guidance specifically designed to address the complex challenges inherent in their caregiving role were perceived as useful and effective by kinship carers.

Caregivers also identified gaps in the availability of therapeutic services tailored to meet the needs of the children in their care. For instance, in relation to emotional and behavioural regulation (Welch, 2018). They reported concerns about the limited access to specialised therapeutic interventions designed to address the unique emotional and psychological challenges experienced by children in kinship care. Caregivers therefore welcomed interventions that offered therapeutic support tailored for children in care, filling a critical gap in available support services within the kinship family context.

> *"And I want to get this in, Notre Dame does, and HAS, filled a big gap that's missing out of psychological services for children." (Kinship carer; Welch, 2018, p. 41)*

Carers expressed a strong preference for interventions tailored specifically to address unique challenges faced by kinship families. Targeted interventions were seen as more relevant, practical, and effective in meeting the specific requirements and complexities of kinship caregiving, garnering significant favourability among caregivers.

Confidence in finding 6: High

Finding 7: Carers find interventions that incorporate referrals and liaise with other services useful

Contributing papers:

- Welch (2018)
- Starks and Whitley (2020)
- Whitley, Fischer, Van Zanten and Kelson (2023)

Caregivers expressed challenges in both identifying and accessing available support for kinship families. Consequently, they found interventions that incorporated referrals to third sector services, assisted accessing statutory support/entitlements and advocated on behalf of kinship families to be particularly effective. This finding aligns with the move towards kinship navigator services currently in the US.

Kinship carers reported that interventions which support them to identify what statutory support is available and to access what they are entitled are effective. Kinship caregivers valued interventions that provided support with housing and financial matters. For instance, assistance with liaising with local authorities on the need for housing adaptations to accommodate children with disabilities (Starks & Whitley, 2020). By easing administrative burdens, interventions which supported families to navigate statutory systems were perceived as successful in alleviating caregiver stress.

> *"She's been amazing. Nothing is too much trouble. She has liaised with housing about my debt issues and advised me on so many things. She has said if ever I need help, to ask her." (Kinship carers; Starks & Whitley, 2020, p. 63)*

Interventions that facilitated referrals and directed caregivers to third sector provisions were considered as favourable and effective by kinship carers. They found that this type of provision effectively enabled their ability to access, and benefit from, additional avenues of support: for example, gaining access to early help services, local peer-to-peer support groups, and self-care services (Starks & Whitley, 2020; Welch, 2018). By connecting caregivers with a range of resources and networks, they felt that interventions empowered them to navigate their caregiving journey more confidently and successfully.

Carers also value professional support to navigate specific systems: for example, informal advocacy support, specifically in relation to court appearances. This type of approach provided caregivers with valuable guidance, reassurance, and practical assistance throughout complex legal proceedings, ensuring their voices were heard and their rights were advocated for effectively.

By coordinating with various agencies and organisations, interventions helped caregivers to access comprehensive support in areas such as healthcare, education, social services, and more. This integrated approach was seen as essential in effectively addressing the diverse and interconnected challenges faced by kinship families.

Confidence in finding 7: Moderate

Finding 8: Kinship carers are more likely to engage with and enjoy interventions that actively address the accessibility of the services

Contributing papers:

- Starks and Whitley (2020)
- Whitley, Fischer, Van Zanten and Kelson (2023)

The accessibility of support sessions was highlighted as a factor in enabling successful participant engagement in an intervention. Caregivers stressed the importance of considering indirect costs, modes of delivery, and flexibility in the set-up of an intervention. Addressing these accessibility concerns ensured that kinship carers could consistently engage with interventions, enhancing their overall acceptability.

One intervention offered to reimburse participant's travel expenses to enable their attendance at sessions (Welch, 2018). Kinship carers valued this offer, viewing it as a demonstration of the programme's understanding of the challenges kinship families may face in accessing services. This provision was not only perceived as alleviating a practical barrier to participation, but also underscored the intervention's dedication to ensuring accessibility and inclusivity.

Caregivers also placed value on having the flexibility to engage with the programme through various channels, including face-to-face meetings, video and phone calls, and email correspondence. This flexible approach to engagement allowed caregivers to choose the mode of delivery that best suited their circumstances, ensuring that they could access support and participate in interventions in a way that was appropriate and convenient for them. Consequently, interventions that prioritised accessibility in relation to delivery were met with high levels of acceptance among caregivers.

Confidence in finding 8: Moderate

Finding 9: Being recipient-centred is an important element for a programme's acceptability

Contributing papers:

- Channon et al. (2020)
- Hartley, McAteer, Doi and Jepson (2019)
- Welch (2018)
- Starks and Whitley (2020)

Caregivers particularly liked recipient-centred interventions that prioritised collaboration and flexibility to accommodate their diverse needs. Kinship carers valued interventions that offered flexible approaches, recognising the varying circumstances and challenges faced by kinship families. Specifically, adaptability in session content and delivery times and location allowed caregivers and children to access support and resources in a manner that best suited their individual situations, schedules, and preferences.

Kinship carers valued interventions with a collaborative component: for instance, working closely with professionals to co-produce personal support plans tailored to their specific needs (Starks & Whitley, 2020). Moreover, caregivers favoured interventions that embraced a continuous support model, as opposed to those with discrete, time-limited forms of support. A recipient-centred design ensured ongoing appropriate support, aligning with the evolving needs of kinship carers throughout their caregiving journey.

Caregivers highlighted the value of flexibility in intervention delivery. They appreciated flexibility in scheduling sessions, as well as the ability to adapt content to suit changes in family circumstances: for instance, suspending an intervention's activity whilst families dealt with various issues, and resuming when they were ready (Welch, 2018). Additionally, caregivers valued interventions that supplemented core aspects of delivery, such as structured weekly meetings, with more flexible forms of engagement such as practitioner responsiveness by email. Kinship carers felt that this adaptable approach ensured that interventions could accommodate the evolving needs and preferences of caregivers.

> *"I think we're all really flexible, if they're late or miss a session or something like that, we understand … it's not like 'three strikes and you're out' kind of thing." (Professional; Welch, 2018, p. 30)*

Caregivers appreciated interventions which were designed to enable self-referrals, particularly for support groups. This underscores its significance in a context where they often felt marginalised from accessing other forms of support, such as for kinship carers who cannot access certain statutory support due to a Special Guardianship or Child Arrangements Order (Whitley, Fischer, Van Zanten & Kelson, 2023). Autonomy in seeking and accessing assistance was particularly valued, as it empowered them to actively engage with services and access the support they needed on their own terms.

Moreover, the flexibility of delivery empowered caregivers by providing them with a degree of control over their engagement with interventions. This sense of agency enabled caregivers to take ownership of their support and caregiving journey, fostering a deeper sense of empowerment and self-efficacy.

> *"Kinship carers feel a sense of ownership about this project, they feel it is their place, they have some control over the service, involvement is their choice, it's empowering." (Professional; Welch, 2018, p. 38)*

Confidence in finding 9: High

Finding 10: Kinship carers and practitioners perceive a broad range of positive carer- and child-level outcomes as a result of targeted kinship interventions

Contributing papers:

- Starks and Whitley (2020)
- Welch (2018)
- Hartley, McAteer, Doi and Jepson (2019)

Kinship carers and practitioners perceived numerous and diverse positive outcomes at both the carer and child levels stemming from targeted kinship interventions. This section incorporates several themes presented throughout the other qualitative findings, as successful implementation and high levels of acceptability are associated with better outcomes for programme recipients. The outcomes reported in the included studies span various domains, including improved caregiver wellbeing, enhanced parenting skills, strengthened family relationships and family functioning, social and behavioural outcomes for children, caregiver empowerment, and social connectedness.

Kinship carers underscored the impact of engaging in tailored interventions on their social wellbeing. They expressed a profound improvement in their sense of connectedness, attributing it to the access to a supportive network of peers. Participating in these groups substantially alleviated caregivers' feelings of isolation and fostered a sense of identity and community.

> *"The socialising aspect is very important for us, and for the children … we all get on and we've gone out for lunch together, a little community is developing and it's irreplaceable." (Kinship carer; Starks & Whitley, 2020, p. 59)*

Kinship carers perceived that tailored interventions were effective and enhanced their wellbeing, and alleviated the strain associated with their caregiving responsibilities and lack of other forms of support. Both kinship carers and professionals recognised that tailored interventions provide caregivers with the necessary skills to address the complex needs of the children under their care effectively. Practical assistance, such as facilitating communication and coordination with other essential services or acting as intermediaries and advocates, was thought to significantly improve kinship carers' wellbeing, reduce stress, and increase their knowledge and use of support services.

Caregivers reported that participation in tailored interventions led to significant developments in their parenting skills. Kinship carers often expressed a lack of confidence in their parenting abilities prior to the intervention, particularly in relation to their understanding of trauma and their ability to effectively manage challenging behaviour (Starks & Whitley, 2020). In particular, kinship carers noted improvements in their understanding of child development, attachment styles, and the effects of trauma, which directly informed their parenting practices. They emphasised how interventions provided valuable insights into the unique challenges faced by the children in their care, as well as their own responses to these challenges. By fostering a greater awareness of both the child's needs and their own parenting approach, interventions empowered kinship carers to adapt and refine their parenting skills to better support the child's growth and wellbeing within their unique familial context.

Carers and practitioners also reported a range of positive social outcomes for children in kinship care as a result of targeted kinship interventions, though only one intervention directly supported children. Perceived outcomes for children include various aspects of their social and emotional wellbeing, notably contributing to heightened self-worth and confidence among the children (Starks & Whitley, 2020; Welch, 2018; Hartley, McAteer, Doi & Jepson, 2019). Interventions were described as facilitating improvements in behavioural regulation, enabling the children to function more effectively both at home and in educational settings. Caregivers also stressed how interventions played a pivotal role in promoting and nurturing positive relationships within the familial context, resulting in more secure attachments between the children and their carers. This enhanced sense of security and stability within the caregiving environment contributed to the childrens overall emotional resilience and wellbeing, laying a solid foundation for their continued growth and development.

Confidence in finding 10: High

Confidence in qualitative findings

CERQual was used to assess confidence in each of the finding statements. The evidence profiles indicate that seven of the findings can be viewed with a high degree of confidence, two with a moderate degree of confidence and one with a low degree of confidence (see Table 17). For all of the findings, moderate concerns regarding methodological limitations were identified, along with a few moderate concerns surrounding adequacy. Overall, confidence in all the majority of the findings generated during the review are high as they are well supported from data across studies of reasonable quality. For the full CERQual assessment, see Appendix I.

Table 17. CERQual assessment of confidence in the evidence summary

Finding statement	Summary	CERQual assessment of confidence in the evidence	Explanation of CERQual assessment	Studies contributing to the review finding
1	An intervention's distinct separation from statutory services is perceived to facilitate engagement, favourable experiences, and positive outcomes.	High	This finding was graded as high confidence because of the richness of the data, and there was only moderate concerns regarding methodological limitations, as well as minor concerns regarding relevance.	Studies: Welch; Starks and Whitley (2018); Whitley, Fischer, Van Zanten and Kelson (2023); Schroer and Samuels (2019)
2	Providing carers with access to a network of peers enhances an intervention's acceptability and usefulness.	High	This finding was graded as high confidence because of the richness of the data, and there was only moderate concerns regarding methodological limitations, as well as minor concerns regarding relevance.	Studies: Welch; Starks and Whitley (2018); Whitley, Fischer, Van Zanten and Kelson (2023)
3	Carers find that consistent and intensive interactions with practitioners facilitate positive relationships which promote engagement.	Moderate	This finding was graded as moderate confidence because of the sufficient richness of the data, and the moderate concerns regarding relevance and methodological limitations.	Studies: Welch (2018); Starks and Whitley (2018); Whitley, Fischer, Van Zanten and Kelson (2023); Schroer and Samuels (2019)

Finding statement	Summary	CERQual assessment of confidence in the evidence	Explanation of CERQual assessment	Studies contributing to the review finding
4	Practitioners' interpersonal skills are key to building positive, supporting, trusting relationships with kinship carers.	Moderate	This finding was graded as moderate confidence because of the sufficient richness of the data, and the moderate concerns regarding methodological limitations, as well as the minor concerns regarding relevance and adequacy.	Studies: Welch (2018); Starks and Whitley (2020); Whitley, Fischer, Van Zanten and Kelson (2023); Schroer and Samuels (2019)
5	Programme developers found codesign and incorporation of evidence-based frameworks effective when developing new interventions.	Low	This finding was graded as low confidence because of the lack of richness of the data, and the moderate concerns regarding methodological limitations, and adequacy, as well as the minor concerns regarding relevance.	Studies: Hartley, McAteer, Doi and Jepson (2018)
6	Kinship carers view specialised support as highly acceptable and useful due to their unmet needs and the gaps in statutory services.	High	This finding was graded as high confidence because of the richness of the data, and there was only moderate concerns regarding methodological limitations, as well as minor concerns regarding relevance.	Studies: Welch (2018); Starks and Whitley (2020); Whitley, Fischer, Van Zanten and Kelson (2023); Schroer and Samuels (2019)

Finding statement	Summary	CERQual assessment of confidence in the evidence	Explanation of CERQual assessment	Studies contributing to the review finding
7	Carers find interventions that incorporate referrals and liaise with other services useful.	Moderate	This finding was graded as moderate confidence because of the sufficient richness of the data, and there was moderate concerns regarding methodological limitations.	Studies: Welch (2018); Starks and Whitley (2020); Whitley, Fischer, Van Zanten and Kelson (2023)
8	Kinship carers are more likely to engage with and enjoy interventions that actively address the accessibility of the services.	Moderate	This finding was graded as moderate confidence because of the sufficient richness of the data, and the moderate concerns regarding methodological limitations and adequacy.	Studies: Starks and Whitley (2020); Whitley, Fischer, Van Zanten and Kelson (2023);
9	Being recipient-centred is an important element for a programme's acceptability.	High	This finding was graded as high confidence because of the richness of the data, and there was only moderate concerns regarding methodological limitations, as well as minor concerns regarding relevance.	Studies: Channon et al. (2020); Hartley, McAteer, Doi and Jepson (2018); Welch (2018); Starks and Whitley (2020); Whitley, Fischer, Van Zanten and Kelson (2023);

Finding statement	**Summary**	**CERQual assessment of confidence in the evidence**	**Explanation of CERQual assessment**	**Studies contributing to the review finding**
10	Caregivers and practitioners perceive a broad range of positive outcomes as a result of targeted kinship interventions.	High	This finding was graded as high confidence because of the richness of the data, and there was only moderate concerns regarding methodological limitations, as well as minor concerns regarding relevance.	Studies: Hartley, McAteer, Doi and Jepson (2018); Welch (2018); Starks and Whitley (2020); Whitley, Fischer, Van Zanten and Kelson (2023); Schroer and Samuels (2019)

DISCUSSION

Key findings for the research questions and objectives

This systematic review sought to answer the following five research questions:

What interventions for kinship families improve the outcomes for children in kinship care (e.g. safety, permanence, and wellbeing) and for kinship carers (e.g. wellbeing, confidence in parenting, relationship with child in care)?

7. Are there interventions/programmes that are particularly effective with different groups of carers and children (e.g. disabled or minority carers or children)?
8. Are there common elements shared by effective interventions?
9. What are the enablers and barriers to successful implementation of interventions for kinship carers and children in kinship care in the UK?
10. What are the perspectives of kinship carers and children in kinship care on the acceptability and usefulness of different interventions in the UK?

What works? Interventions to improve the outcomes for children in kinship care and for kinship carers

There were 30 papers of 21 RCTs or QEDs that reported on at least one outcome for children in kinship care and/or their kinship carers. Many studies found positive findings for 'kinship navigator' programmes which help carers to access services, meet goals based on their needs, and provided a variety of other services; caregiver training: parenting skills, and caregiver training: resourcefulness/therapy. The remaining studies focused on peer support groups, financial support, mentoring for children in kinship care, and case management, and they demonstrated varying levels of effectiveness across outcome areas. Only one of the studies included in this review explored the benefits of an intervention that supports children in kinship care directly, so child-level outcomes were achieved indirectly through providing support, skills, and resources to kinship caregivers.

Likelihood of going into a kinship care placement was included in this review, as an important and direct outcome for children of the presence of an intervention. Increased kinship care placements, as a consequence of kinship supports, is interpreted differently by geography and policy stance. The availability of a willing relative caregiver may mean a child is more likely to go into care than if traditional foster care was the only option. While previous reviews (Winokur, 2018) have shown that kinship care leads to better outcomes for children than non-kin foster care, there are other considerations: keeping a child with their parents is widely viewed as the preferred option and more children in care may lead to higher costs for authorities.

Kinship carers, and the children in their care, have well-documented unmet needs and are more likely to be living with a disability, have poor finances, or be single adult carers than non-kinship foster carers. It is not surprising that providing a financial subsidy means that more kinship carers take up guardianship for the children in their care. In line with previous reviews (Lin, 2014; Rabassa & Fuentes-Pelaez, 2023; Wu et al., 2020), it is also not surprising – given the needs of kinship carers – that the included studies found positive impacts of interventions across so many approaches and outcome domains. This review reinforces and builds on previous reviews, by limiting included studies to experimental or quasi-experimental designs and incorporating all intervention types and a broad range of outcomes for children and caregivers. This review also collates UK-context specific experiences of receiving and implementing programmes to support kinship families. In the qualitative work, it was noted that any support is better than none, indicating that 'simple' interventions like peer support can have a significant impact.

This is also a context where it may be difficult to detect certain outcomes or the impact of a standalone programme compared to existing support, for several reasons.

Firstly, in many studies the comparison group was receiving services as usual, which was similar to the intervention, making it harder to detect improvements in outcomes as the baseline consists of a decent level of support. In the US over recent years, the quality of 'standard care' has vastly improved, through the roll-out of kinship navigator programmes. Four papers reporting on two studies (Feldman & Fertig, 2013 and CHS of NJ, 2012; Day et al., 2024 and Fowler, Day, Wollen & Vanderwill, 2023) compared an enhanced version of a kinship navigator programme to the standard kinship navigator programme implemented in the region. Similarly, McCallion, Janicki and Kolomer (2004) measured the effects of Case management + support groups to Case management only, and Forehand, Butler, Alessi and Winokur (2023) compared kinship navigator services to kinship supports, which incorporate some but not all of the features of a standard kinship navigator programme. There are also limitations in the comparability and interpretation of the reported outcomes, particularly the consistency, missing data, and data definitions for administrative datasets used for many studies across different regions of the US, or the sensitivity for measures in specific domains. The generalisability of these findings to the UK context, where there is variation in kinship supports and no standard kinship navigator service, is therefore somewhat limited.

Secondly, there are domain-specific reasons why detecting the outcomes of these interventions may be challenging. For the findings on stability, kinship placements are less likely to break down or disrupt than non-kin foster placements, and so it is often harder to detect an impact within the time frame and scale of evaluations (too few events may occur to be interpretable; a so-called 'floor effect' in statistics). For findings on permanency, these are often influenced by structural factors such as whether areas emphasise legal orders such as guardianship or adoption or return to birth parents as a preferred permanent placement. The interpretation of 'positive outcomes' is also culturally specific – a return to birth parents may be viewed more positively in the US, whereas staying in kinship care may be perceived more positively in the UK as it may present less risk of abuse and neglect. In the UK, we see variation across local authorities in their use of Special Guardianship Orders (SGOs), and there is controversy over whether SGOs should be interpreted as a positive outcome (Simmonds et al., 2019; Smyth et al., 2023).

Lastly, caregivers' often face chronic and structural issues. Health issues are often chronic given the older age of the population, and many are living in poverty with limited economic opportunities given factors such as neighbourhood, age, caregiving responsibility, disability, and education levels. It may also take time to build trust given past family histories with children's services, structural racism, and overrepresentation of certain populations in kinship care. This may limit the ability of an evaluation to detect change such as in wellbeing outcomes over a limited period of time.

For whom? Effective interventions for particular groups of carers and children

There was insufficient evidence reported for subgroups of carers in the included studies to synthesise and draw conclusions on what interventions are effective for particular groups of kinship carers and children in kinship carers. However, the demographics represented within the studies include a wide range of communities, including those often underrepresented or marginalised, and the studies demonstrate benefits across outcomes for many of these groups. As noted in the previous section, the ability to detect change may have been affected by which groups high levels of need amongst kinship carers, which may make it easier to detect change, as well as by factors that make it harder to detect change including the high-levels of commitment of carers to the children in their care and placement stability, comparison to services as usual for different populations, and broader structural constraints such as poverty and the level of social assistance.

In line with the international literature, certain populations were overrepresented in the studies compared to the wider population of those countries. For example, populations from the global majority (such as Black/African American, Hispanic/Latino) were prevalent in the populations of interventions. In addition, the authors of the one study from Australia noted that Aboriginal or Torres Strait Islander children were overrepresented amongst child ethnicity and caregiver ethnicity compared to the general population. These imbalances speak to the structural inequities, racism, and historical legacies of populations that have experienced forced removals, slavery, and discrimination.

Further, some studies targeted only specific groups of kinship carers. Six studies recruited solely from grandparent carers, and of these four studies were for grandmothers (and at times great-grandmothers), and one study focused specifically on grandparents caring for at least one kinship child with a developmental disability or delay.

Kinship navigator programmes were generally open to informal and formal caregivers (although some studies only reported findings for formal caregivers if using official statistics for comparison). The growth of evidence around what is effective for informal kinship carers should be particularly noted as they are often considered ‘invisible’ in society and research, due to the lack of interaction with statutory services.

Finally, the presence of intersecting identities and social groups (such as African American grandmothers) in the included studies highlights the important role of intersectionality amongst this population. The, likely underreported, prevalence of these intersecting identities in kinship carers brings to the fore the ways in which systems of inequality, based on gender, age, race, ethnicity, disability, class, and other forms of social grouping, interact to determine access to and the ability to benefit from available support services.

How? Common elements for effective interventions

The group of interventions included in this review varied too much to determine how they worked through the common elements of effective interventions. Further research such as a network meta-analysis would be required to determine which elements reliably bring about positive outcomes, and how they interact. However, the research team created hundreds of lines of coding consisting of 18 general techniques, and 85 different operationalisations identified in the included quantitative studies. This common-element coding serves as a strong basis for future work and provides insight into the particular approaches implemented in kinship support, for interested practitioners and researchers.

Implementation of kinship interventions in the UK: barriers, enablers, acceptability, and usefulness

From six qualitative studies in the UK, we developed 10 finding statements:

1. An intervention's distinction from statutory services is perceived to facilitate engagement, favourable experiences, and positive outcomes.
2. Providing carers with access to a network of peers enhances an intervention's acceptability and usefulness.
3. Carers find that consistent and intensive interactions with practitioners facilitate positive relationships which promote engagement.
4. Practitioners' interpersonal skills are key to building positive, supporting, trusting relationships with kinship carers.
5. Programme developers found codesign and incorporation of evidence-based frameworks to be effective when developing new interventions.
6. Kinship carers view specialised support as highly acceptable and useful due to their unmet needs and the gaps in statutory services.
7. Carers find interventions that incorporate referrals and liaise with other services useful.
8. Kinship carers are more likely to engage with and enjoy interventions that actively address the accessibility of the services.
9. Being recipient-centred is an important element for a programme's acceptability.
10. Caregivers and practitioners perceive a broad range of positive outcomes as a result of targeted kinship interventions.

These finding statements are interrelated and support the impact evaluation findings in terms of the importance of interventions of kinship carers due to unmet needs, the importance of recipient-centred interventions such as needs assessments with kinship navigator programmes, and the implementation of interventions. Relationships are central across the finding statements, including the relationships involved when developing the programmes, between carers and practitioners, in peer support, and when facilitating engagement and accessing other services. It should be noted that the qualitative studies express the perceptions of practitioners and kinship carers – and, as written in other reviews, it may be that the most efficacious programmes, such as parenting programmes, are not the ones perceived as most efficacious or important to implement.

The perspectives of children in kinship care were notably missing from the included studies. However, this is often because interventions engaged carers alone[23] as well as due to the ethical and practical challenges of engaging young people in research, and this omission is not thought to reduce the relevance and applicability of the findings.

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[23] In alignment with broader practice, interventions often sought to improve a caregiver's ability to care for the child and respond to their needs (through accessing other services and assistance or changing knowledge, skills, and/or attitudes) rather than seeing the child as the problem.

Any other interesting findings

The review did not examine the implementation of the quantitative impact evaluation studies beyond the identification of common elements. However, many of the studies were reported with specifically identified 'core elements', programme manuals, specific implementation evaluation findings, and/or 'Type 2 Hybrid trials' that examine not only the impact of an intervention, but also how implementing it in a certain way may be more effective.

This information on the effectiveness of different implementation strategies was not systematically extracted, nor is there sufficient data for a thorough analysis. However, several studies examined effects of different implementation models or intensities. In Wheeler et al. (2016), they compared two models of delivery and found that a two-worker Kinship Navigator model was more effective in the implementation areas in Ohio than the one-worker model. The study of the Arizona Kinship Support Services Kinship Navigator programme (Schmidt & Treinen, 2021, p. 13) showed that children in the intervention group achieved positive outcomes with any level of service type, intensity, and duration received by their caregiver. These findings suggest primarily that more research into implementation approaches is needed, but they suggest also that: 1) implementation and understanding the delivery model is important, and 2) positive outcomes can occur for kinship carers even with varied implementation. These findings circle back to the high level of needs of kinship carers and the importance of high-quality, accessible services for them.

LIMITATIONS

Strength and limitations of the review methods

This review answered questions specifically around the impact of programmes, policies, and interventions for kinship carers and their implementation in the UK, but it did not answer questions about the needs of kinship carers, compare kinship care to other forms of care (e.g. Winokur et al., 2018), or around correlational literature between interventions and outcomes (Lin, 2014; Wu et al., 2020). It also only looked at qualitative literature on the implementation of programmes in the UK, although there are vast literatures from other countries which may include relevant implementation insights (and indeed in some of the quantitative reports in this review).

This review was a full systematic review with transparent review methods. The search methods were relatively sensitive, with 8,085 records identified (4,654 after de-duplication) and many citations and included studies coming from the grey literature, email contacts, and targeted searches of references. We used the research team's networks of researchers around kinship care to identify relevant studies. The literature identified may be more likely to be those indexed with terms for kinship carers, rather than where there is a subgroup analysis for kinship carers or children in kinship care which would be relevant for RQ2. For example, we did not specifically search for studies around educational interventions or outcomes for children in kinship care or target grey literature sources around educational outcomes, and there may be more studies from the vast parenting literature for kinship carers than was detected in this study.

While the search strategy means most relevant literature was likely identified and extracted, the review was done at speed, which may have resulted in missing studies or less thorough quality assurance processes than a review over a longer period. Calls for studies continued to be fruitful until the cut-off date, suggesting that there may be more unidentified unpublished or grey literature pieces available, particularly around kinship navigator and the UK qualitative literature. Although all screening and extraction was done by two independent reviewers, the risk of bias and extraction of common elements was done by one reviewer. We were limited in our analysis by availability and heterogeneity of evidence, as discussed in the next section, and we were unable to undertake meta-analysis or provide narrative synthesis for some outcomes.

Strengths and limitations of available evidence

Methodological limitations and clarity in reporting

There were methodological limitations for studies across the pieces and gaps in the clarity of the reporting of statistics, effect sizes, and methods, as evidenced through the risk of bias and quality appraisal processes (the ROB-2, ROBINS-I, and CASP checklist findings). One common methodological limitation includes that many of the quantitative studies only report on 'closed cases' – those no longer considered in care/open to child welfare – which may create endogenous subgroups where having a particular support service both affects which cases are closed as well as the outcomes for those cases (e.g. guardianship, re-entry into care, reports of abuse or neglect), but this issue was not raised by authors. Some studies relied on administrative data which excluded informal carers, and there were concerns around data quality for various measures.

Another limitation of the study was that the included studies did not capture outcomes for kinship carers and children in kinship care in relation to services and supports provided to traditional foster families. While these studies were in scope for the review, we did not identify any that reported outcomes for children in kinship care of their caregivers. For example, this group is likely to benefit from financial support and universal mental health services, but this was not identified in the included studies. It is also important to note the different financial support available to kinship carers – particularly informal kinship carers – and the differing perception of financial support when caring for a relative.

There were major limitations in the descriptions of methodologies and clarity of reporting for some qualitative studies and grey literature reports, which influenced our confidence in the findings. The lack of clarity in reporting challenged screening, while certain studies had to excluded if we were unable to get clarity about whether it met the inclusion criteria (e.g. population) or were excluded during the extraction phase as more details became apparent.

Coherence and relevance of data

In general, there was considerable coherence in the data. Some studies were more likely to detect an impact due to specific context and comparison group types, but this was coherent across intervention and study type. For questions 1–3, no studies were from the UK, so the relevance to the UK context is not known. For questions 4 & 5, the relevance may be limited by the small sample sizes in the qualitative studies and their contexts. We initially developed some compelling finding statements around the qualitative literature in analysis to discover that they were too thinly supported by the data to include in this report.

Adequacy of the data and gaps in available data

More data is needed to thoroughly answer the review questions. As identified in previous reviews (Wu et al., 2020), the variability in intervention types and outcomes measured makes synthesis challenging. Three meta-analyses were run, but these were based on only two studies each, as the quantitative data was too little and varied (heterogeneous). The richness and quantity of data was limited in some of the finding statements for questions 4 and 5. In particular, we have gaps in being able to understand for whom studies are more effective (e.g. analyses by subgroup) and the 'active ingredients' and why particular approaches are effective.

RECOMMENDATIONS AND NEXT STEPS

Policy and practice recommendations and next steps

Based on studies reporting positive findings for ‘kinship navigator’ programmes, this approach holds promise and should be continued to be funded and delivered in areas where it is present, and rolled out and evaluated in areas where assistance to navigate needs is not present (e.g. informal carers). Many papers clearly highlighted core components for navigator or case management services, which is helpful for considering implementation, and programmes should introduce core components if they do not already do so to enhance implementation. It is important to understand how ‘navigation’-type programmes currently operate in the UK and how this evidence maps onto them. Local authorities in England have documented wide variation in the support offered for kinship carers (Smyth et al., 2023).

The building of an evidence base about kinship navigation programmes has been possible due to the commitment by the US government to build the evidence base, and we recommend investment by national and local government to build rigorous evidence on what works to improve outcomes for kinship carers in the UK and what adapts from elsewhere to various contexts in the UK. In the US, the federal government created a pot of funding for evidence-based kinship navigation programmes; although the evidence standards have been challenging for evaluations to meet, the evidence and practice have grown and adapted (Rushovich, McKlindon & Vandivere, 2021; Schmidt & Treinen, 2021). This also ensures programmes are based on not just good intentions but on models and approaches that can improve outcomes.

There was clear evidence that financial subsidies for guardianship increased permanency outcomes for children in kinship care (for example, adoption, guardianship, or reunification to birth parent(s) with findings holding when looking only at outcomes of adoption or guardianship). The context for these findings in the UK is slightly different with different legal and practical permanency frameworks (e.g. adoptions up to age 18 are much more common in the US), financial support in the absence of the subsidy (e.g. local authority payment to the kinship carer and/or welfare support level in the UK), and cultural interpretation of positive permanency outcomes. More evidence is needed to examine stability and child wellbeing outcomes along with legal permanency.

The evidence base is also growing in terms of the effectiveness of kinship-specific parenting interventions (Wu et al., 2020), and more time and responses from authors may allow future meta-analyses for their effectiveness of parenting programmes. It is important to have greater rigorous evaluations to be able to understand the efficacy of these programmes and other approaches for kinship carers and the children in their care, especially within the UK.

There is clear commitment by governments to kinship care including Championing Kinship Care: The National Kinship Care Strategy (2023), and a commitment of kinship carers to the children and young people in their care. Kinship care is generally a long-term relationship, and services should be attuned to this. As highlighted in the qualitative literature, it is important for programme developers and practitioners to work with kinship carers to establish accessible services and to develop a level of trust where kinship families will be willing to ask for, and receive, assistance. When such assistance is provided, it is important that services are caregiver-centred, including that they are timely and convenient, and that they map onto their needs and those of the children in their care. The included studies in this review also suggest that programme developers and practitioners should be cognizant of their role and the differing perceptions of statutory services and third sector organisations when providing support to kinship families.

Research recommendations

Although the findings for placement in kinship care and placement stability are promising, kinship navigator programmes need further research on caregiver and child wellbeing outcomes to paint a fuller picture of this programme's effects. Further randomised controlled trials and quasi-experimental design evaluations are also needed for other kinship care interventions such as parenting programmes, peer support groups, financial support, and mentoring for children in kinship care. There are gaps in terms of understanding how best to help children in care improve educational outcomes and health, and long-term follow-up is needed to better detect outcomes that happened with less frequency such as substantiated allegations of abuse and neglect. Literature supporting the efficacy of programmes, policies, and interventions for kinship carers – and the confidence of the review team in individual studies as well as meta-analyses – has been limited due to the challenges in meeting rigorous study design and execution standards for evidence-based programmes. This review did not seek to answer questions about the needs of kinship carers, so future research should continue to examine this topic with both quantitative and qualitative methods and align services with need.

Future research with a data equity lens would also be beneficial for the kinship care evidence base. As this review demonstrated, kinship caregivers hold diverse and intersecting identities and programming for this population should align with and support their continuum of experiences and needs. It is likely that kinship care interventions have differential efficacy for caregivers based on factors such as ethnicity, socioeconomic status, and age. Additionally, research is needed to examine differences in outcomes based on informal or formal kinship care arrangements.

The qualitative research findings from this review offer revealing insights into caregiver perceptions about what makes kinship care interventions beneficial. Additional qualitative research could explore children's perspectives of the services they or their kinship carers receive and further explore the caregiver–practitioner relationship from both perspectives to surface recommendations regarding service accessibility and acceptability. Greater and more diverse research is needed to understand the variation of experiences for this diverse group.

Lessons learned

The most glaring lesson learned is that researchers must do better in enhancing the clarity of their reporting and in addressing the coherence, relevance, and adequacy of their data including closing gaps in available data on kinship care interventions. This requires a closer relationship between researchers and administrative data providers, including data sharing agreements and data system transparency. Instrument developers have a role to play in designing assessments that reliably and validly measure change in wellbeing for kinship families. The field would benefit from greater consensus on logic model development and on defining core components to ensure that kinship care research is accounting for practice context and measuring all short- and long-term outcomes.

Lessons learned from the findings are less definitive but equally as important. Most notably, kinship caregivers need resources, supports, and services if children in their care are to experience permanency and placement stability. The field has come a long way since kinship carers were deprioritised due to beliefs such as ‘the apple doesn’t fall far from the tree’, but there is still a way to go before kinship caregivers are treated with the care and respect that they deserve for taking on such a critical role in the lives of their kin. This will require a coordinated effort from governments, policymakers, children social care professionals, service providers, intervention developers, measurement experts, and children’s social care researchers. Advances in kinship caregiver assessment, outreach, and support should serve as a strong foundation for the continued policy and practice emphasis on promoting and supporting kinship care homes and interventions.

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APPENDICES

- Appendix A: Reference list of included studies
- Appendix B: Example search and results
- Appendix C: Bias domains for ROB-2 tool
- Appendix D: Bias domains ROBINS-I tool
- Appendix E: Detailed GRADE assessments for included meta-analyses
- Appendix F: Detailed risk of bias assessments for included studies – ROB-2
- Appendix G: Detailed risk of bias assessments for included studies – ROBINS-I
- Appendix H: Full CASP assessment for qualitative studies
- Appendix I: Full CERQual assessment for qualitative findings
- Appendix J: Meta-analyses funnel plots
- Appendix K: Sensitivity analysis for effects of guardianship subsidy on guardianship and adoption
- Appendix L: Full list of process elements identified in the included studies
- Appendix M: Accessibility text

Appendix A. Reference list of included studies

Channon, S., Coulman, E., Moody, G., Brookes-Howell, L., Cannings-John, R., Lau, M., Rees, A., Segrott, J., Scourfield, J., Robling, M. (2020) Qualitative process evaluation of the Fostering Changes program for foster carers as part of the Confidence in Care randomized controlled trial. *Child Abuse & Neglect*. 109, 104768. https://doi.org/10.1016/j.chiabu.2020.104768

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Appendix B. Example search strings and number of results for SCOPUS database

Search number	String	Returns
1	“Kin care*” or “Kinship care*” or “Kin foster*” or “Kinship foster*” or “Kin placement” or “Kinship placement” or “friend* and famil* care*” or “famil* and friend* care*” or “Connected care*” or “Famil* foster*” or “Famil* placement*” or “Relative* foster*” or “Relative* care*” or “Custodial grandparent*” or “kin parent*” or “kinship parent*” or “Grand* care*” or “Custodial grand*” or “foster parent*”	5,186
3	“Affect*” or “Effect*” or “Comparison group*” or “Experiment*” or “Impact*” or “QED” or “Quasi experimental” or “Quasiexperimental” or “RCT” or “Random* control* trial” or “Treatment group*” or “Intervention group*” or “Control group*” or “control* evaluation” or “intervention condition*” or “control condition*” or “random* clinical trial*” or “random* trial*”	35,372,859
4	“Qualitative” or “Survey*” or “Questionnaire*” or “Interview*” or “Focus group*” or “Process evaluation” or “ethnog*” or “ethnomethodolog*” or “ethnolog*” or “phenomenolog*” or “grounded theory” or “narrative analysis” or “lived experience*” or “life experience*” or “thematic analys*” or “discourse analys*” or “perspective*” or “case stud*”	8,037,610
5	“United Kingdom” or “UK” or “Great Britain” or “British Isles” or “England” or “Scotland” or “Wales” or “Northern Ireland”	1,303,499
6	1 AND 3	2,181
7	1 AND 4 AND 5	123
8	6 OR 7	2,253

Appendix C. Bias domains for ROB-2 tool

Domain	Related Terms	Explanation
Pre-intervention Bias arising from the randomisation process	Sample bias	Bias that arises when the assignment that was not properly randomised or the randomised assignment was not sufficiently concealed, and so the person enrolling participants was aware of allocation sequence and influenced which patients were assigned to each group based on their prognostic factors.
Post-intervention Bias due to deviations from intended interventions	Performance bias; Time-varying confounding	Performance bias; Time-varying confounding
Bias due to missing data	Attrition bias; Selection bias as it is sometimes used in relation to observational studies	Attrition bias; Selection bias as it is sometimes used in relation to observational studies

Domain	Related Terms	Explanation
Bias in measurement of outcomes	Detection bias; Recall bias; Information bias; Misclassification bias; Observer bias; Measurement bias	Detection bias; Recall bias; Information bias; Misclassification bias; Observer bias; Measurement bias
Bias in selection of the reported result	Outcome reporting bias; Analysis reporting Bias	Outcome reporting bias; Analysis reporting Bias

Appendix D. Bias domains for ROBINS-I tool

Domain	Related terms	Explanation
Pre-intervention Bias due to confounding	Selection bias as it is sometimes used in relation to clinical trials (and currently in widespread use within Cochrane); Allocation bias; Case-mix bias; Channelling bias.	Baseline confounding occurs when one or more prognostic variables (factors that predict the outcome of interest) also predicts the intervention received at baseline. ROBINS-I can also address time-varying confounding, which occurs when individuals switch between the interventions being compared and when post-baseline prognostic factors affect the intervention received after baseline.
	Selection bias as it is usually used in relation to observational studies and sometimes used in relation to clinical trials; Inception bias; Lead- time bias; Immortal time bias. Note that this bias specifically excludes lack of external validity, which is viewed as a failure to generalize or transport an unbiased (internally valid) effect estimate to populations other than the one from which the study population arose.	When exclusion of some eligible participants, or the initial follow up time of some participants, or some outcome events, is related to both intervention and outcome, there will be an association between interventions and outcome even if the effects of the interventions are identical. This form of selection bias is distinct from confounding. A specific example is bias due to the inclusion of prevalent users, rather than new users, of an intervention.

Domain	Related terms	Explanation
At intervention Bias in classification of interventions	Misclassification bias; Information bias; Recall bias; Measurement bias; Observer bias.	Bias introduced by either differential or non-differential misclassification of intervention status. Non-differential misclassification is unrelated to the outcome and will usually bias the estimated effect of intervention towards the null. Differential misclassification occurs when misclassification of intervention status is related to the outcome or the risk of the outcome and is likely to lead to bias.
Post-intervention Bias due to deviations from intended interventions	Performance bias; Time-varying confounding	Bias that arises when there are systematic differences between experimental intervention and comparator groups in the care provided, which represent a deviation from the intended intervention(s). Assessment of bias in this domain will depend on the type of effect of interest (either the effect of assignment to intervention or the effect of starting and adhering to intervention).
Bias due to missing data	Attrition bias; Selection bias as it is sometimes used in relation to observational studies	Bias that arises when later follow-up is missing for individuals initially included and followed (e.g. differential loss to follow-up that is affected by prognostic factors); bias due to exclusion of individuals with missing information about intervention status or other variables such as confounders.

Domain	Related terms	Explanation
Bias in measurement of outcomes	Detection bias; Recall bias; Information bias; Misclassification bias; Observer bias; Measurement bias	Bias introduced by either differential or non-differential errors in measurement of outcome data. Such bias can arise when outcome assessors are aware of intervention status, if different methods are used to assess outcomes in different intervention groups, or if measurement errors are related to intervention status or effects.
Bias in selection of the reported result	Outcome reporting bias; Analysis reporting Bias	Selective reporting of results in a way that depends on the findings.

Appendix E. Detailed GRADE assessments for included meta-analyses

Outcomes	Evidence can be downgraded					Evidence can be upgraded			Grade
	Risk of bias	**Imprecision**	**Inconsistency**	**Indirectness**	**Publication bias**	**Large magnitude of effect**	**Dose response gradient**	**Effect of plausible residual confounding**	
Likelihood of being placed in kinship care	1 moderate, 1 serious; downgrade 2 levels	Estimate comes from a small number of studies (n = 2) with varied confidence intervals; downgrade 1 level	No evidence of inconsistency; no change to rating	No evidence of indirectness; no change to rating	No evidence of publication bias observed; no change to rating	No large magnitude of effect observed; no change to rating	No dose response gradient observed; no change to rating	No plausible residual confounding suspected; no change to rating	Low
Placement disruption (RCTS)	2 some concerns; downgrade by 1 level	Estimate comes from a small number of studies (n = 2) with varied confidence intervals; downgrade 1 level	No evidence of inconsistency; no change to rating	No evidence of indirectness; no change to rating	No evidence of publication bias observed; no change to rating	No large magnitude of effect observed; no change to rating	No dose response gradient observed; no change to rating	Not applicable for RCT; no change to rating	Moderate

Outcomes	**Evidence can be downgraded**					**Evidence can be upgraded**			**Grade**
	Risk of bias	**Imprecision**	**Inconsistency**	**Indirectness**	**Publication bias**	**Large magnitude of effect**	**Dose response gradient**	**Effect of plausible residual confounding**	
Placement disruption (QEDS)	1 moderate, 1 serious; downgrade 2 levels	Estimate comes from a small number of studies (n = 2) with varied confidence intervals; downgrade 1 level	No evidence of inconsistency; no change to rating	No evidence of indirectness; no change to rating	No evidence of publication bias observed; no change to rating	No large magnitude of effect observed; no change to rating	No dose response gradient observed; no change to rating	No plausible residual confounding suspected; no change to rating	Low
Permanence, subsidised guardianship	2 high, 1 low; downgrade one level	Estimate comes from a small number of included cohorts (n = 4) with similar confidence intervals; downgrade 1 level	No evidence of inconsistency; no change to rating	No evidence of indirectness; no change to rating	No evidence of publication bias observed; no change to rating	No large magnitude of effect observed; no change to rating	No dose response gradient observed; no change to rating	Not applicable for RCT; no change to rating	Moderate

Appendix F. Detailed risk of bias assessments for included studies – ROB-2

	Risk of bias due to the randomisation process	Risk of bias due to deviations from intended interventions	Risk of bias due to missing outcome data	Risk of bias in measurement of the outcomes	Risk of bias in selection of the reported result	Overall
Feldman (2013)	Low	Low	Low	Low	Low	Low
Forehand (2023)	Low	Low	Low	Low	Low	Low
Hong (2006)	Some concerns	Low	Low	Low	Low	Some concerns
Littlewood (2020)	Low	Low	Low	Low	Some concerns	Some concerns
Littlewood (2021)	Low	Low	Low	Some concerns	Some concerns	Some concerns
McCallion (2004)	Low	Low	Low	Some concerns	Some concerns	Some concerns
Montoro-Rodriguez (2021)	Low	Some concerns	Low	High	Some concerns	High
N'ZI (2016)	Low	Low	Low	Low	Low	Low
Pandey (2016)	Low	Some concerns	Low	Some concerns	Some concerns	Some concerns
Pasalich (2021)	Low	Some concerns	Low	Some concerns	Low	Some concerns

	Risk of bias due to the randomisation process	**Risk of bias due to deviations from intended interventions**	**Risk of bias due to missing outcome data**	**Risk of bias in measurement of the outcomes**	**Risk of bias in selection of the reported result**	**Overall**
Rhodes (1999)	Some concerns	Some concerns	Low	Some concerns	Some concerns	High
Schoemaker (2020)	Some concerns	Low	Low	Low	Low	Some concerns
Smith (2018)	Low	Low	Low	Low	Low	Low
Smith (2023)	High	Some concerns	Low	Low	Some concerns	High
Testa (2003)	Low	Low	Low	Low	Low	Low
Testa (2008)	Some concerns	Some concerns	Some concerns	Low	Some concerns	High
Zauszniewski (2014)	Low	Low	Low	Low	Low	Low

Appendix G. Detailed risk of bias assessments for included studies – ROBINS-I

	Bias due to confounding	**Bias in the selection of participants into the study**	**Bias in the classification of the intervention**	**Bias due to deviations from intended interventions**	**Bias due to missing data**	**Bias in measurement of outcomes**	**Bias in selection of reported result**	**Overall**
Day et al. (2023)	Serious	Moderate	Low	Low	Moderate	Low	Low	Serious
Preston (2021)	Moderate	Low	Serious	Low	Low	Low	Low	Serious
Schmidt (2021)	Moderate	Low	Serious	Low	Low	Low	Low	Serious
Wheeler (2020)	Low	Low	Low	Low	Low	Low	Low	Low

Appendix H. Full CASP assessment for qualitative studies

Study	**Q1**	**Q2**	**Q3**	**Q4**	**Q5**	**Q6**	**Q7**	**Q8**	**Q9**	**Quality judgement**
Channon et al. (2020)	Y	Y	Y	Y	Y	U	Y	Y	Y	High
Hartley, McAteer, Doi and Jepson (2019)	Y	Y	Y	Y	Y	U	Y	Y	Y	Moderate
Welch (2018)	N	Y	U	U	U	U	Y	U	Y	Moderate
Starks and Whitley (2020)	Y	Y	U	U	Y	U	Y	Y	N	Moderate
Whitley, Fischer, Van Zanten and Kelson (2023)	Y	Y	U	Y	Y	U	Y	U	Y	High
Schroer and Samuels (2019)	Y	Y	U	U	Y	U	U	N	Y	Moderate

Q1: Was there a clear statement of the aims of the research?

Q2: Is a qualitative methodology appropriate?

Q3: Was the research design appropriate to address the aims of the research?

Q4: Was the recruitment strategy appropriate to the aims of the research?

Q5: Was the data collected in a way that addressed the research issue?

Q6: Has the relationship between researcher and participants been adequately considered?

Q7: Have ethical issues been taken into consideration?

Q8: Was the data analysis sufficiently rigorous?

Q9: Is there a clear statement of findings?

Appendix I: Full GRADE CERQual assessment for qualitative findings

Finding statement	Summary	Relevance	Methodological limitations	Coherence	Adequacy	CERQual assessment of confidence in the evidence	Studies contributing to the review finding
1	An intervention's distinct separation from statutory services facilitates engagement and contributes to favourable experiences and outcomes.	Minor concerns: In papers exploring populations beyond the scope of the review questions, relevant data had to be extracted from within the primary data in response to the questions.	Moderate concerns: In the studies contributing to the finding, there was a lack of description of researcher reflection or reflexivity during data collection or analysis, as well as a lack of detail reported on the rationale for methodological choices and/or process.	No or very minor concerns: The finding is supported by the data from the contributing studies.	No or very minor concerns: The finding is broadly supported by a range of studies which offer sufficiently rich detail.	High: This finding was graded as high confidence because of the richness of the data, and there was only moderate concerns regarding methodological limitations, as well as minor concerns regarding relevance.	Studies: Welch (2018); Starks and Whitley (2020); Whitley, Fischer, Van Zanten and Kelson (2023); Schroer and Samuels (2019)

Finding statement	Summary	Relevance	Methodological limitations	Coherence	Adequacy	CERQual assessment of confidence in the evidence	Studies contributing to the review finding
2	Providing carers with access to a network of peers enhances an intervention's acceptability and usefulness.	No or very minor concerns: The studies contributing to this finding represented different countries in the UK.	Moderate concerns: In the studies contributing to the finding, there was a lack of description of researcher reflection or reflexivity during data collection or analysis, as well as a lack of detail reported on the rationale for methodological choices and/or process.	Minor concerns: The finding is broadly supported by the data; however, one study gave a contradictory account of usefulness, which may be explained by peer group composition.	No or very minor concerns: The finding is broadly supported by a range of studies which offer sufficiently rich detail.	High: This finding was graded as high confidence because of the richness of the data, and there was only moderate concerns regarding methodological limitations, as well as minor concerns regarding relevance.	Studies: Welch (2018); Starks and Whitley (2020); Whitley, Fischer, Van Zanten and Kelson (2023)

Finding statement	Summary	Relevance	Methodological limitations	Coherence	Adequacy	CERQual assessment of confidence in the evidence	Studies contributing to the review finding
3	The frequency and format of interactions with practitioners serves as a barrier/enabler to cultivating positive, supportive, and trusting relationships.	Minor concerns: In papers exploring populations beyond the scope of the review questions, relevant data had to be extracted from within the primary data in response to the questions.	Moderate concerns: In the studies contributing to the finding, there was a lack of description of researcher reflection or reflexivity during data collection or analysis, as well as a lack of detail reported on the rationale for methodological choices and/or process.	No or very minor concerns: The finding is supported by the data from the contributing studies.	No or very minor concerns: The finding is broadly supported by a range of studies which offer sufficiently rich detail.	Moderate: This finding was graded as moderate confidence because of the sufficient richness of the data, and the moderate concerns regarding relevance and methodological limitations.	Studies: Welch (2018); Starks and Whitley (2020); Whitley, Fischer, Van Zanten and Kelson (2023); Schroer and Samuels (2019)

Finding statement	Summary	Relevance	Methodological limitations	Coherence	Adequacy	CERQual assessment of confidence in the evidence	Studies contributing to the review finding
4	A practitioner's interpersonal skills are a key factor in building positive, supporting, trusting relationships.	Minor concerns: In papers exploring populations beyond the scope of the review questions, relevant data had to be extracted from within the primary data in response to the questions.	Moderate concerns: In the studies contributing to the finding, there was a lack of description of researcher reflection or reflexivity during data collection or analysis, as well as a lack of detail reported on the rationale for methodological choices and/or process.	No or very minor concerns: The finding is supported by the data from the contributing studies.	Minor concerns: The finding is broadly supported by a range of studies, some of which offer sufficiently rich detail.	Moderate: This finding was graded as moderate confidence because of the sufficient richness of the data, and the moderate concerns regarding methodological limitations, as well as the minor concerns regarding relevance and adequacy.	Studies: Welch (2018); Starks and Whitley (2020); Whitley, Fischer, Van Zanten and Kelson (2023); Schroer and Samuels (2019)

Finding statement	Summary	Relevance	Methodological limitations	Coherence	Adequacy	CERQual assessment of confidence in the evidence	Studies contributing to the review finding
5	When developing new interventions, codesign and incorporation of evidence-based frameworks are effective strategies for both successful implementation and high acceptability.	Minor concerns: The study contributing to this finding were partially relevance as not all countries in the UK were represented.	Moderate concerns: In the studies contributing to the finding, there was a lack of description of researcher reflection or reflexivity during data collection or analysis, as well as a lack of detail reported on the rationale for methodological choices and/or process.	No or very minor concerns: The finding is supported by the data from the contributing studies.	Moderate concerns: The finding is supported by one study which offers sufficient detail.	Low: This finding was graded as low confidence because of the lack of richness of the data, and the moderate concerns regarding methodological limitations, and adequacy, as well as the minor concerns regarding relevance.	Studies: Hartley, McAteer, Doi and Jepson (2018)

Finding statement	Summary	Relevance	Methodological limitations	Coherence	Adequacy	CERQual assessment of confidence in the evidence	Studies contributing to the review finding
6	Specialised support is viewed as highly acceptable and useful due to the high levels of unmet needs experienced by kinship families.	Minor concerns: In papers exploring populations beyond the scope of the review questions, relevant data had to be extracted from within the primary data in response to the questions.	Moderate concerns: In the studies contributing to the finding, there was a lack of description of researcher reflection or reflexivity during data collection or analysis, as well as a lack of detail reported on the rationale for methodological choices and/or process.	No or very minor concerns: The finding is supported by the data from the contributing studies.	No or very minor concerns: The finding is broadly supported by a range of studies which offer sufficiently rich detail.	High: This finding was graded as high confidence because of the richness of the data, and there was only moderate concerns regarding methodological limitations, as well as minor concerns regarding relevance.	Studies: Welch (2018); Starks and Whitley (2020); Whitley, Fischer, Van Zanten and Kelson (2023); Schroer and Samuels (2019)

Finding statement	Summary	Relevance	Methodological limitations	Coherence	Adequacy	CERQual assessment of confidence in the evidence	Studies contributing to the review finding
7	Interventions that incorporate referrals and support access other services are considered very useful.	No or very minor concerns: The studies contributing to this finding represented different countries in the UK.	Moderate concerns: In the studies contributing to the finding, there was a lack of description of researcher reflection or reflexivity during data collection or analysis, as well as a lack of detail reported on the rationale for methodological choices and/or process.	No or very minor concerns: The finding is supported by the data from the contributing studies.	No or very minor concerns: The finding is broadly supported by a range of studies which offer sufficiently rich detail.	Moderate: This finding was graded as moderate confidence because of the sufficient richness of the data, and there was moderate concerns regarding methodological limitations.	Studies: Welch (2018); Starks and Whitley (2020); Whitley, Fischer, Van Zanten and Kelson (2023)

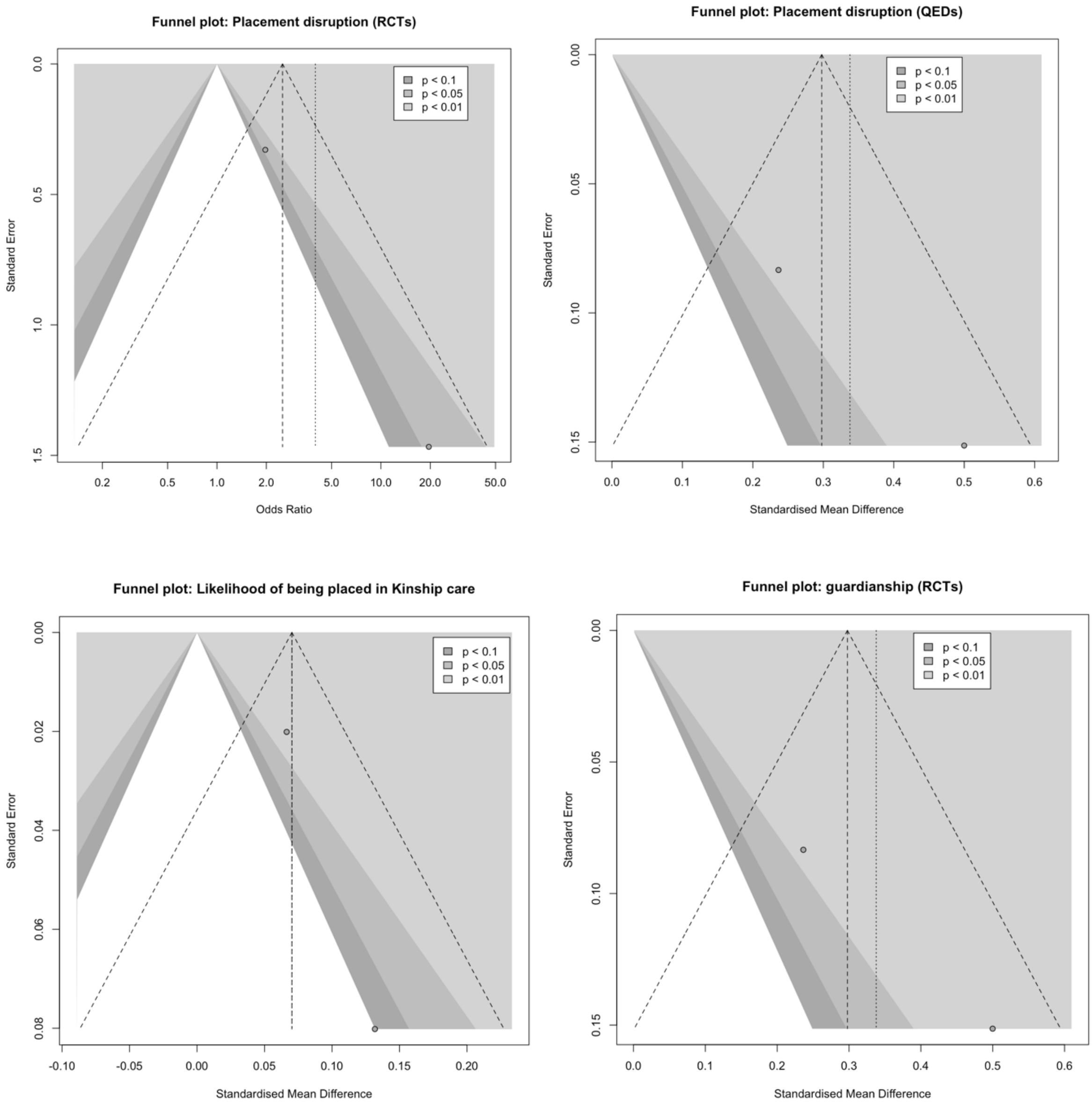
Finding statement	Summary	Relevance	Methodological limitations	Coherence	Adequacy	CERQual assessment of confidence in the evidence	Studies contributing to the review finding
8	Interventions that address the accessibility of services facilitate engagement and are considered highly acceptable and useful.	No or very minor concerns: The studies contributing to this finding represented different countries in the UK.	Moderate concerns: In the studies contributing to the finding, there was a lack of description of researcher reflection or reflexivity during data collection or analysis, as well as a lack of detail reported on the rationale for methodological choices and/or process.	No or very minor concerns: The finding is supported by the data from the contributing studies.	Moderate concerns: The finding is broadly supported by a few studies, some of which offer sufficiently rich detail.	Moderate: This finding was graded as moderate confidence because of the sufficient richness of the data, and the moderate concerns methodological limitations and adequacy.	Studies: Starks and Whitley (2020); Whitley, Fischer, Van Zanten and Kelson (2023)

Finding statement	Summary	Relevance	Methodological limitations	Coherence	Adequacy	CERQual assessment of confidence in the evidence	Studies contributing to the review finding
9	Being recipient-centred is an important element for a programme's acceptability.	Minor concerns: In papers exploring populations beyond the scope of the review questions, relevant data had to be extracted from within the primary data in response to the questions.	Moderate concerns: In the studies contributing to the finding, there was a lack of description of researcher reflection or reflexivity during data collection or analysis, as well as a lack of detail reported on the rationale for methodological choices and/or process.	No or very minor concerns: The finding is supported by the data from the contributing studies.	No or very minor concerns: The finding is broadly supported by a range of studies which offer sufficiently rich detail.	High: This finding was graded as high confidence because of the richness of the data, and there was only moderate concerns regarding methodological limitations, as well as minor concerns regarding relevance.	Studies: Channon et al. (2020); Hartley, McAteer, Doi and Jepson (2018); Welch; Starks and Whitley (2020); Whitley, Fischer, Van Zanten and Kelson (2023)

Finding statement	Summary	Relevance	Methodological limitations	Coherence	Adequacy	CERQual assessment of confidence in the evidence	Studies contributing to the review finding
10	Caregivers and practitioners perceive a broad range of positive outcomes as a result of targeted kinship interventions.	Minor concerns: In papers exploring populations beyond the scope of the review questions, relevant data had to be extracted from within the primary data in response to the questions.	Moderate concerns: In the studies contributing to the finding, there was a lack of description of researcher reflection or reflexivity during data collection or analysis, as well as a lack of detail reported on the rationale for methodological choices and/or process.	No or very minor concerns: The finding is supported by the data from the contributing studies.	No or very minor concerns: The finding is broadly supported by a range of studies which offer sufficiently rich detail.	High: This finding was graded as high confidence because of the richness of the data, and there was only moderate concerns regarding methodological limitations, as well as minor concerns regarding relevance.	Studies: Hartley, McAteer, Doi and Jepson (2018); Welch (2018); Starks and Whitley (2020); Whitley, Fischer, Van Zanten and Kelson (2023); Schroer and Samuels (2019)

Appendix J: Meta-analyses funnel plots

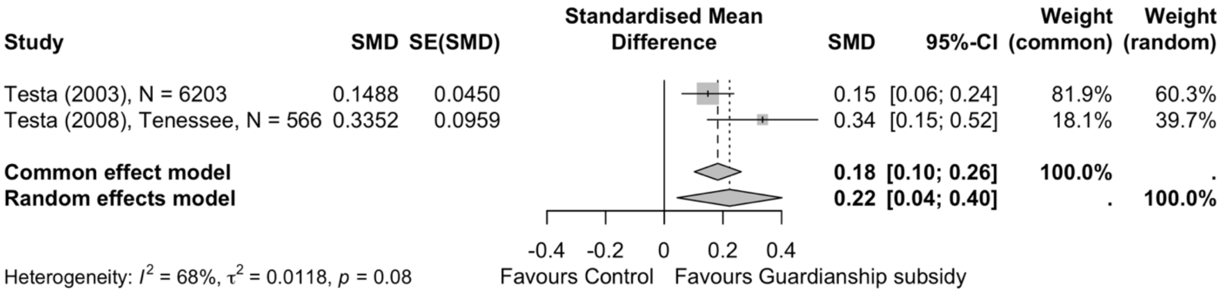
Figure 9: Meta-analyses funnel plots (go to accessibility text)



Appendix K: Sensitivity analysis for effects of guardianship subsidy on guardianship and adoption

Sensitivity analyses were conducted on just adoption and guardianship outcomes within the two Testa, Cohen and Smith (2003) and Testa (2008). Outcomes were combined in a fixed-effects meta-analysis ($I^2 = 67\%$, $p = .08$, indicating non-significant study heterogeneity, both fixed-effects and random effects models were calculated for completeness). Both studies had effects favouring Guardianship subsidy, as shown in Figure 10. The combined effect size was positive and statistically significant in both the fixed-effects model and random-effects models. These analyses suggest that there may be a small effect of guardianship subsidy on permanence, as measured as adoption and guardianship. However, the small number of studies present cause for caution in the interpretation of these effects.

Figure 10: Sensitivity analysis on effects of the guardianship study on permanency (adoption + guardianship) (go to accessibility text)



Appendix L: Full list of process elements identified in the included studies

Type of element	General technique (i.e. what)	Specific operationalisation (i.e. how)	Definition
Process	**Delivery support**	**What methods and technologies are used to support and deliver the intervention?**	**Recruitment / delivery methods and technologies used by the programme**
Process	Delivery support	Website/app	A website/app used to navigate and apply for services
Process	Delivery support	Laptop/tablet	Providing caregivers with a laptop/tablet
Process	Delivery support	General community engagement	Frontline community engagement for recruitment
Process	Delivery support	Programme oversight	A board, committee, advisory group etc. who have oversight of the programme
Process	Delivery support	Dedicated support line	A dedicated telephone number which is used for self-referrals and support
Process	**Delivery method**	**What activities are involved for the delivery of the intervention?**	**Delivery techniques that the practitioner uses**

Type of element	General technique (i.e. what)	Specific operationalisation (i.e. how)	Definition
Process	Delivery method	Use of video interaction guidance	Observe video recordings of the target parent–child interaction; providing strengths-based feedback; exploring what is happening and what the child might be feeling
Process	Delivery method	Use of video vignettes	Observe video recordings of generic parent–child dyads
Process	Delivery method	Reframing techniques	Practitioner helps parent to reframe their perceptions of their child's behaviours
Process	Delivery method	Discussions of challenging situations	Practitioner discusses challenging situations that caregiver brings up
Process	Delivery method	Speaking for the baby/child	Practitioner narrates child's possible intentions to parent
Process	Delivery method	Coaching	Practitioner coaches a caregiver during interactions with their child
Process	Delivery method	Physical materials	Caregiver is given physical materials to support learning (e.g. handbook)

Type of element	General technique (i.e. what)	Specific operationalisation (i.e. how)	Definition
Process	Delivery method	Homework	Caregiver are given homework sheets for active learning and reflection
Process	Delivery method	Modelling	Practitioner demonstrates desired behaviours to the caregiver and the caregiver observes and then imitates this behaviour
Process	Delivery method	Interactive exercises	Interactive exercises (e.g. whiteboards, quizzes, etc.)
Process	Delivery method	Workbooks	Participants are given workbooks
Process	Delivery method	Behaviour charting	Practitioner maps caregive–child interactions
Process	Delivery method	Home visits	Practitioner visits the caregiver’s home
Process	Delivery method	Roleplays	Parent participates in roleplay with practitioner and/or other parents around parenting
Process	**Practitioner’s approach**	**What approach does the deliverer adopt in interaction with the caregiver?**	**Approach that the practitioner adopts in interaction with caregiver**

Type of element	General technique (i.e. what)	Specific operationalisation (i.e. how)	Definition
Process	Practitioner’s approach	Mentalising approach	Includes practitioner taking caregiver’s perspective and understanding caregiver's desires and beliefs
Process	Practitioner’s approach	Advocacy	Practitioner takes on an advocacy role
Process	Practitioner’s approach	Emotional and social support	Practitioner provides emotional and social support
Process	Practitioner’s approach	Promote therapeutic relationship	Includes building rapport with caregiver, addressing rupture in the therapeutic relationship and repair

Appendix M: Accessibility text

Figure 1. PRISMA flow diagram

The image is a PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) flow diagram, depicting the process of identifying, screening, and including studies in a systematic review. It shows two main identification pathways: studies from databases and academic resources (left) and studies identified via other methods (right). Below is a breakdown of the flowchart:

Left Pathway: Identification via Databases and Other Academic Resources

1. Identification:
    - Records identified from databases: **7,073**
    - Snowballed records: **529**
    - Total records before screening: **7,602**
    - Records removed before screening:
        - Duplicate records removed by Covidence: **3,285**
        - Duplicates identified manually: **56**
2. Screening:
    - Records screened: 4,261
    - Records excluded: 4,063
    - Reports sought for retrieval: **198**
    - Reports not retrieved: **7**
    - Reports assessed for eligibility: **191**
    - Reports excluded: **171**
        - Reasons include:
            - Kin carer outcomes not reported separately (78)
            - Wrong population (26)
            - Wrong location (25)
            - No control/comparison group (19)
            - Not an intervention (12)
            - Study results not reported (5)
            - Duplicate (4)
            - Couldn't locate paper (2)
3. Included:
    - Reports included in the review: **36**
        - 20 from databases, 16 from other methods.
        - Reports for Q1-3: **30**

        - Reports for Q4 & 5: **6**

Right Pathway: Identification via Other Methods

1. Identification:
    - Records identified from websites: **341**
    - Reference screening: **142**
    - Total records: **483**
    - Records removed before screening:
        - Duplicate records removed: **90**
2. Screening:
    - Records screened: 272
    - Records excluded: 121
    - Reports sought for retrieval: **93**
    - Reports not retrieved: **7**
    - Reports assessed for eligibility: **91**
    - Reports excluded: **85**
3. Included:
    - Reports included in the review: **36**
        - 20 from databases, 16 from other methods.
        - Reports for Q1-3: **30**
        - Reports for Q4 & 5: **6**

The PRISMA flowchart systematically tracks the progression from identification to final inclusion, showing how studies were filtered and excluded at each stage.

(Click here to return to report).

Figure 2. Histogram to show sample sizes across impact evaluation studies

The bar chart in the image shows the number of studies categorized by sample size. The x-axis represents four sample size ranges: "<100", "≥100 and <500", "≥500 and <1000", and "≥1000". The y-axis represents the "Number of studies", ranging from 0 to 10.

- For the "<100" category, there are 5 studies
- The "≥100 and <500" category has the highest number of studies, totalling 9
- The "≥500 and <1000" category has 2 studies
- The "≥1000" category has 6 studies.

The chart illustrates that most studies have sample sizes between 100 and 500, while fewer studies have sample sizes between 500 and 1000.

(Click here to return to report).

Figure 3. Summary of RoB-2 assessments for included RCTs

The image is a horizontal stacked bar chart illustrating the risk of bias across different domains in studies. The x-axis represents the percentage from 0% to 100%, and the y-axis lists six categories: "Overall," "Risk of bias in selection of the reported result," "Risk of bias in measurement of the outcomes," "Risk of bias due to missing outcome data," "Risk of bias due to deviations from intended interventions," and "Risk of bias due to the randomisation process."

Each bar is color-coded to show three levels of bias risk:

- **Green**: Low risk
- **Orange**: Some concerns
- **Blue**: High risk

Breakdown of bias levels by category:

1. **Overall**: Low: ~60%, Some concerns: ~30%, High: ~10%
2. **Risk of bias in selection of the reported result**: Low: ~20%, Some concerns: ~80%, High: 0%
3. **Risk of bias in measurement of the outcomes**: Low: ~70%, Some concerns: ~25%, High: ~5%
4. **Risk of bias due to missing outcome data**: Low: ~85%, Some concerns: ~15%, High: 0%
5. **Risk of bias due to deviations from intended interventions**: Low: ~55%, Some concerns: ~45%, High: 0%
6. **Risk of bias due to the randomisation process**: Low: ~65%, Some concerns: ~25%, High: ~10%

The chart highlights that most studies have a low risk of bias, but some categories show notable concerns.

(Click here to return to report).

Figure 4. Summary of ROBINS-I assessments for included QEDs

The image is a horizontal stacked bar chart displaying the distribution of bias risk levels across various categories in studies. The x-axis represents percentages ranging from 0% to 100%, while the y-axis lists eight bias categories:

1. Overall
2. Bias in selection of reported result
3. Bias in measurement of outcomes
4. Bias due to missing data
5. Bias due to deviations from intended interventions
6. Bias in the classification of the intervention
7. Bias in the selection of participants into the study
8. Bias due to confounding

Each bar is segmented into four color-coded bias levels:

- **Green**: Low
- **Orange**: Moderate
- **Blue**: Serious
- **Red**: Critical

Breakdown of Bias Levels by Category:

- **Overall**: Low: ~60%, Serious: ~40%
- **Bias in selection of reported result**: Low: 100%, Serious: 0%
- **Bias in measurement of outcomes**: Low: 100%, Serious: 0%
- **Bias due to missing data**: Low: ~70%, Moderate: ~30%
- **Bias due to deviations from intended interventions**: Low: ~80%, Moderate: ~20%
- **Bias in the classification of the intervention**: Low: ~90%, Serious: ~10%
- **Bias in the selection of participants into the study**: Low: ~60%, Moderate: ~40%
- **Bias due to confounding**: Low: ~30%, Moderate: ~20%, Serious: ~40%, Critical: ~10%

This chart highlights that most categories have a low risk of bias, but some show notable concerns, particularly in the selection of participants and confounding factors.

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Figure 5. Forest plot for QEDs: likelihood of being placed in kinship care

The image is a forest plot from a meta-analysis, displaying the standardised mean difference (SMD) for two studies: Wheeler (2016) and Schmidt (2021). Each study is listed with its sample size, SMD, standard error (SE) of the SMD, and weights in both the common and random effects models.

- Study Information:
    - *Wheeler (2016)*: Sample size = 11,948, SMD = 0.0664, SE(SMD) = 0.0201.
    - *Schmidt (2021)*: Sample size = 11,294, SMD = 0.1318, SE(SMD) = 0.0802.

- Common and Random Effects Models:
  - Wheeler (2016): Standardised mean difference = 0.07 (95% CI: [0.03, 0.11]).
  - Wheeler (2016): Weight in both the common and random effects model: 94.1%
  - Schmidt (2021): Standardised mean difference = 0.13 (95% CI: [-0.03, 0.29]).
  - Schmidt (2021): Weight in both the common and random effects model: 5.9%
  - Combined model standardised mean difference = 0.07 (95% CI: [0.03, 0.11]) in both the common and random effects model. This forest plot shows a statistically significant effect in favour of the Kinship Navigator programmes.
- Heterogeneity Statistics:
  - $I2 = 0\%$, $r2 = 0$, $p = 0.43$

***Note:** Given there are only two studies, both fixed and random effects models were calculated for completeness, however as the heterogeneity was 0, results are identical (see Deeks et al., 2023).*

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Figure 6. Forest plot for RCTs: placement disruption

The image is a forest plot from a meta-analysis, displaying the odds ratio for two studies: Littlewoord (2020) and Forehand (2023). Each study is listed with weights of individual studies, SMD/OR (with confidence intervals); l2 statistics and p-value.

- Study Information:
  - *Littlewood (2020)*: = Control: number of events - 8 out of 60; intervention: number of events - 0 out of 60
  - *Forehand (2023)*: Control: number of events - 29 out of 200; intervention: number of events - 16 out of 202.
  - Common effect model: There were 37 events out of 260 in the intervention group. There were 16 events out of 262 in the control group.
- Common and Random Effects Models:
  - Littlewood (2020): Odds Ratio = 19.95 (95% CI: [1.10, 347.61]).
  - Littlewood (2020): Weight in common model: 3.1%; weight in random model: 30.6%
  - Forehand (2023): Odds Ratio = 1.97 (95% CI: [1.03, 3.76]).
  - Forehand (2023): Weight in common model: 96.9%; weight in random model: 69.4%
  - Common effect model: There were 37 events out of 260 in the intervention group. There were 16 events out of 262 in the control group.
  - Common effect model = an odds ratio of 2.51 (95% CI: [1.37, 4.61]).

  - Random effect model = an odds ratio of 3.98 CI: [0.50, 31.68]). This forest plot shows a statistically significant effect in favour of the Kinship Navigator programmes.
- Heterogeneity Statistics:
  - *I2* = 57%, *r2* = 1.5057, *p* = 0.13

Note: *Given there are only two studies, both fixed and random effects models were calculated for completeness. The fixed (common) effect model was estimated using the Mantel–Haenszel method, and random-effects using the inverse variance method. A continuity-correction of 0.5 was automatically applied to studies with zero cell frequencies.*

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Figure 7. Forest plot for QEDs: placement disruption

The image is a forest plot from a meta-analysis, displaying the standardised mean difference (SMD) for two studies: Preston (2021) and Wheeler (2020). Each study is listed with its sample size, SMD, standard error (SE) of the SMD, and weights in both the common and random effects models.

- Study Information:
  - Preston (2021): Sample size = 1116, SMD = 0.5996, SE(SMD) = 0.1816
  - Wheeler (2020): Sample size - 1610, SMD = 0.2364, SE(SMD) = 0.0834
- Common and Random Effects Models:
  - Preston (2021): Standardised mean difference = 0.60 (95% CI: [0.24, 0.96]).
  - Preston (2021): Weight in the common effects model: 17.4%. Weight in the random effects model: 40.1%
  - Wheeler (2020): Standardised mean difference = 0.24 (95% CI: [0.07, 0.40]).
  - Wheeler (2020): Weight in the common effects model: 82.6%. Weight in the random effects model: 59.9%
  - Combined model standardised mean difference in the common effects model= 0.30 (95% CI: [0.15, 0.45]). Combined model standardised mean difference in the random effects model = 0.38 (95% CI: [0.03, 0.73) This forest plot shows a statistically significant effect in favour of the Kinship Navigator programmes.
- Heterogeneity Statistics:
  - *I2* = *70%*, *r2* = 0.0460, *p* = 0.07

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Figure 8: Forest plot for subsidised guardianship: permanence

The image is a forest plot from a meta-analysis, displaying the standardised mean difference (SMD) for four studies: Testa (2003), Testa (2008), Mandell (2001) Cohort 1, and Mandell (2001) Cohort 2. Each study is listed with its sample size, SMD, standard error (SE) of the SMD, and weights in both the common and random effects models.

- Study Information:
    - Testa (2003): Sample size = 6203, SMD = 0.1669, SE(SMD) = 0.0505
    - Testa (2008): Sample size = 566, SMD = 0.2842, SE(SMD) = 0.0927
    - Mandell (2001), Cohort 1: Sample size = 387, SMD = 0.2517, SE(SMD) = 0.0763
    - Mandell (2001), Cohort 2: Sample size = 449, SMD = 0.6832, SE(SMD) = 0.2072
- Common and Random Effects Models:
    - Testa (2003): Standardised mean difference = 0.17 (95% CI: [0.07, 0.27]).
    - Testa (2003): Weight in the common effects model: 55.7%. Weight in the random effects model: 42.1%
    - Testa (2008): Standardised mean difference = 0.28 (95% CI: [0.10, 0.47]).
    - Testa (2003): Weight in the common effects model: 16.6%. Weight in the random effects model: 22.7%
    - Mandell (2001), Cohort 1: Standardised mean difference = 0.25 (95% CI: [0.10, 0.40]).
    - Mandell (2001), Cohort 1: Weight in the common effects model: 24.4%. Weight in the random effects model: 28.8%
    - Mandell (2001), Cohort 2: Standardised mean difference = 0.68 (95% CI: [0.28, 1.09]).
    - Mandell (2001), Cohort 1: Weight in the common effects model: 3.3%. Weight in the random effects model: 6.3%
    - Combined model standardised mean difference in the common effects model= 0.22 (95% CI: [0.15, 0.30]). Combined model standardised mean difference in the random effects model = 0.25 (95% CI: [0.14, 0.36) This forest plot shows a statistically significant effect in favour of guardianship subsidy.
- Heterogeneity Statistics:
    - *I2* = 55%, *r2* = 0.0045, *p* = 0.08

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Figure 9: Meta-analyses funnel plots

Funnel plot: Placement disruption (RCTs)

The funnel plot visualizes the odds ratios on the x-axis and the standard error on the y-axis. The plot has a symmetrical triangular shape in the center, indicating the region where most data points should lie in the absence of publication bias. Three dots are plotted across the graph, representing individual studies.

Shaded regions correspond to different significance levels, indicated by the key in the upper right corner:

- Dark gray for p<0.1p < 0.1p<0.1
- Lighter gray for p<0.05p < 0.05p<0.05
- Lightest gray for p<0.01p < 0.01p<0.01

Dashed lines extend vertically through the plot at various odds ratios, possibly representing overall estimates or thresholds of statistical significance. The two outer sloped dashed lines form the "funnel," while the shading around them represents the confidence intervals of the estimated effect sizes at various levels of precision. The data points' positions suggest possible asymmetry in the plot, which could indicate publication bias or heterogeneity in study effects.

Funnel plot: Placement disruption (QEDs)

This funnel plot depicts the relationship between standardized mean differences (SMD) on the x-axis and the standard error on the y-axis for studies involving placement disruption in quasi-experimental designs (QEDs). The plot is triangular and symmetrical, with data points represented as small circles.

Shaded regions indicate levels of statistical significance:

- Dark gray for p<0.1p < 0.1p<0.1
- Lighter gray for p<0.05p < 0.05p<0.05
- Lightest gray for p<0.01p < 0.01p<0.01

The plot features dashed lines, with two sloped dashed lines forming the funnel shape, representing the confidence intervals around the summary effect. The vertical dashed lines through the center represent different threshold values for the standardized mean differences, likely including an overall summary effect estimate or other key benchmarks.

Two dots are plotted within the funnel, one closer to the center and the other further out on the right side. This plot helps assess the distribution of study results to detect any asymmetry, which could signal potential publication bias. This funnel plot appears relatively symmetrical, indicating less evidence of publication bias or heterogeneity in quasi-experimental design (QED) studies on placement disruption.

Funnel plot: Likelihood of being placed in kinship care

This funnel plot illustrates the relationship between standardized mean differences (SMD) on the x-axis and the standard error on the y-axis, focusing on the likelihood of being placed in kinship care. The plot forms a symmetrical triangle with two data points plotted within the funnel.

The shaded regions indicate different levels of statistical significance:

- Dark gray for p<0.1p < 0.1p<0.1
- Lighter gray for p<0.05p < 0.05p<0.05
- Lightest gray for p<0.01p < 0.01p<0.01

Dashed lines form the outer boundaries of the funnel, representing confidence intervals around the estimated effects. A vertical dashed line runs near the center at a standardized mean difference of approximately 0.05, which may represent the overall summary effect. One data point is near the center and another is at the bottom right, with no obvious asymmetry in the distribution of studies. This funnel plot shows a fairly symmetrical distribution of standardized mean differences, suggesting little evidence of publication bias or heterogeneity in studies examining the likelihood of being placed in kinship care.

Funnel plot: Guardianship (RCTs)

The funnel plot shows the relationship between standardized mean differences on the x-axis and standard error in randomized controlled trials (RCTs) on guardianship on the y-axis.

Shaded regions indicate levels of statistical significance:

- Dark gray for p<0.1p < 0.1p<0.1
- Lighter gray for p<0.05p < 0.05p<0.05
- Lightest gray for p<0.01p < 0.01p<0.01

The plot features dashed lines, with two sloped dashed lines forming the funnel shape, representing the confidence intervals around the summary effect. The vertical dashed lines through the center represent different threshold values for the standardized mean differences, likely including an overall summary effect estimate or other key benchmarks.

The plot is likely used to assess publication bias or the precision of studies within the meta-analysis of randomized controlled trials (RCTs) on guardianship.

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Figure 10: Sensitivity analysis on effects of the guardianship study on permanency (adoption + guardianship)

The image is a forest plot from a meta-analysis, displaying the standardised mean difference (SMD) for two studies: Testa (2003) and Testa (2008). Each study is listed with its sample size, SMD, standard error (SE) of the SMD, and weights in both the common and random effects models.

- Study Information:
    - Testa (2003): Sample size = 6203, SMD = 0.1488, SE(SMD) = 0.0450
    - Testa (2008): Sample size = 566, SMD = 0.3352, SE(SMD) = 0.0959
- Common and Random Effects Models:
    - Testa (2003): Standardised mean difference = 0.15 (95% CI: [0.06, 0.24]).
    - Testa (2003): Weight in the common effects model: 81.9%. Weight in the random effects model: 60.3%
    - Testa (2008): Standardised mean difference = 0.34 (95% CI: [0.15, 0.52]).
    - Testa (2003): Weight in the common effects model: 18.1%. Weight in the random effects model: 39.7%
    - Combined model standardised mean difference in the common effects model= 0.18 (95% CI: [0.10, 0.26]). Combined model standardised mean difference in the random effects model = 0.22 (95% CI: [0.04, 0.40) This forest plot shows a statistically significant effect in favour of guardianship subsidy.
- Heterogeneity Statistics:
    - *I2 = 68%*, *r2* = 0.0119, *p* = 0.08

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