Foundations
What Works Centre for Children & Families

SYSTEMATIC REVIEW OF EDGE OF CARE AND FAMILY PRESERVATION INTERVENTIONS

Systematic review protocol

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Summary

Entry into care is associated with poorer long-term outcomes for many children, substantial and rising costs for local authorities, and profound impacts on family life. Interventions aiming to prevent care entry for children at risk of entering care are an increasing policy priority in England, as they offer an opportunity to promote greater stability, wellbeing, and more positive long-term outcomes for vulnerable children and young people and their parents/families. Importantly, the aim of these interventions to keep families together aligns with outcome 1 of the Children's Social Care National Framework (Department for Education, 2026). The evidence base on effective edge of care interventions, whilst expanding, remains limited in scope and quality.

This mixed-methods systematic review will examine which interventions are effective in preventing care entry for children and young people at imminent risk of entering care and their parents/families, for whom they are most effective, and which practice elements are associated with success. It will also explore the barriers and enablers to successful implementation of these interventions, alongside the views of children and young people, parents and carers, and practitioners on the acceptability and usefulness of different approaches. By synthesising evidence across impact, implementation, and user perspectives, the review aims to inform the development of a Practice Guide that can support more effective and equitable edge of care provision.

Following established systematic review methods, the review will use an overarching search strategy across major bibliographic databases, grey literature sources, reference lists, and key websites to identify relevant studies published from 2000 onwards. Eligibility criteria will be guided by the PICOS framework for questions on intervention effectiveness and the SPIDER framework for questions on implementation and user perspectives. Quantitative findings will be synthesised narratively, and, where sufficient comparable data are available, pooled effects will be estimated via meta-analysis. Qualitative data will be synthesised thematically and reported narratively to explore implementation barriers and enablers, alongside user and practitioner perspectives. The review will also code practice elements across interventions to identify the discrete practices and intervention components most consistently associated with effective outcomes. The methodological quality of included studies will be assessed using established critical appraisal tools, with findings used to weight and contextualise the evidence.

The review will apply an equity lens throughout using frameworks such as PROGRESS-Plus and PRISMA-Equity, and draw on input from Foundations' Advisory Group, comprising lived, practice, and academic experience, to support the development, interpretation, and reporting of the review.

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Background, rationale, and question formulation

Background and overview

While there is meaningful variation in how different countries conceptualise child protection and out-of-home care (Corliss et al., 2022), a common concern has emerged globally around children identified as being at high risk of removal from their birth families and entering statutory care, situating them as being at the "edge of care" (Oliveira et al., 2025; Redgate et al., 2024). Child protection systems around the world grapple with the challenge of how to support families whose circumstances place their children at serious risk of removal into statutory care. Significantly, in many high-income countries, the population of children in care has grown over recent decades (Redgate et al., 2024).

The landscape in England reflects this broader pattern, with the looked-after child population growing by 25% since 2011, more than three times the increase seen in the total child (ages 0–17) population (Horton and Franklin, 2026). Children from mixed ethnic groups are over-represented in this population relative to the general child population, while children from Asian ethnic groups are under-represented (Department for Education, 2025). Children entering care are also getting older, with the average age of a child entering care rising from 8 in 2011 to almost 10 in 2025, largely due to the two-and-a-half-fold increase in the number of children aged 16 and over entering care over the same period (Horton and Franklin, 2026). This increase in age in turn drives higher costs of placements due to increased complexity of cases that requires more specialist support (Horton and Franklin, 2026). Abuse or neglect is the primary driver of children entering care in England, followed by family dysfunction and acute family stress (Department for Education, 2025). Care entry tends to serve a protective function for young children, protecting them from parental abuse or neglect, while removals of adolescents more often reflect additional drivers, such as the young person's own involvement in offending or substance misuse (Dalgaard et al., 2024; Lindquist, 2023).

Approximately 0.7% of children in England are looked after by a local authority at any one time (Department for Education, 2025). These children are a sub-group of the 402,400 children (1 in 30) designated as a Child in Need (CiN), meaning they have been assessed as needing local authority services to achieve or maintain a reasonable standard of health or development, or are disabled (ibid.). Nearly 50,000 of these children and young people are subject to a Child Protection Plan (CPP), the primary statutory mechanism used when a child is assessed as suffering, or likely to suffer, significant harm, which sets out the decisions made and responsibilities for keeping a child safe (ibid.; Horton and Franklin, 2026). Notably, children who are subject to CPPs are often exposed to a range of prolonged and often co-occurring adversities. Research consistently shows that parental difficulties including domestic violence, parental substance misuse, and mental health issues (Lippard and Nemeroff, 2020), can affect their capacity to parent safely. These adversities are further aggravated if they occur simultaneously and are compounded by material hurdles, including poverty, poor housing, and limited social support (Ward et al., 2014). All these conditions have been linked to a broad range of negative developmental outcomes for children and young people, such as attachment difficulties, emotional and behavioural problems, and poor educational attainment (Baxter et al., 2023). Over-representation of children from the most deprived communities and from some ethnic minority backgrounds is a pattern driven in part by

poverty, discrimination, and differential thresholds for intervention, and it reflects wider structural inequalities that children's services alone cannot resolve (Allain et al., 2023; Bywaters et al., 2020, 2022).

Outcomes for looked-after children

When children's services are unable to sufficiently reduce the risk of significant harm and prevent the removal of children from parental care, entry into statutory care can itself become a source of further harm for these children (Oliveira et al., 2025). Research indicates that mental and physical health outcomes of children taken into care are poorer relative to peers in the general population, and these disparities are compounded for those who enter care later in childhood, particularly adolescents (Talbot et al., 2020; Rees et al., 2017), who make up the largest group in care (Rose et al., 2026). Longitudinal research indicates that social, educational, and health disadvantages experienced by children in out-of-home care persist long into adulthood (Cameron et al., 2018; Murray et al., 2020; Xie et al., 2021). Other studies point to heterogeneous effects across contexts, suggesting that, in some cases, the absence of positive development among children in out-of-home care may stem from the adversity they experienced prior to placement, while in other contexts it may be a consequence of the placement itself (Bald et al., 2022; Baron and Gross, 2022; Dalgaard et al., 2024).

Irrespective of the relative contribution of pre-placement adversity, separation from caregivers is itself traumatic for both children and parents (Bruce et al., 2019; Storhaug and Kojan, 2017), and placement should only be considered when other interventions and support have been exhausted. Furthermore, multiple placement changes in care can further destabilise children and young people whose lives have already been disrupted, compounding the very harms that initially brought them to the attention of services (Rubin et al., 2007). This underscores the need for authorities to provide support that diverts children from entering care, and to understand which interventions are effective in achieving this.

Economic costs

Detrimental impacts of entry into care are also associated with consequences that extend beyond individual households, with considerable economic costs and societal impact. Spend on looked-after children has doubled from £4.2 to £8.4 billion between 2010/11 and 2024/25, with children's social care representing an increasing proportion of local authority budgets (Horton and Franklin, 2026). The average cost per child in local authority care in England has risen sharply in recent years, likely due to the increased complexity of cases, and is now over £100,000 per year (Horton and Franklin, 2026). This has significant implications for local authorities' wider capacity to fund necessary services elsewhere (Conti et al., 2017). The increased costs of care are further compounded by reduced investment in early intervention services, falling 40% from 2010/11 to 2024/25 (Horton and Franklin, 2026). Earlier analysis found that, since 2010/11, early intervention spend per child has fallen by around 40% nationally and over 50% in the most deprived areas, exacerbating inequities by widening the gap between those at greatest risk and the services available to support them (Larkham and Ren, 2025). While expenditure on children's centres and young people's services each fell by more than 70%, spending on family support services grew by 43% within the same timeframe, indicating a shift away from universal and community-based provision to increased emphasis on service provision for families in need (Larkham and Ren, 2025). This shift, paired with the human and financial costs of care entry,

makes a case for effective edge of care interventions as a means of improving outcomes for children, young people, and their parents/families, and to ensure the efficient use of resources within the wider system (Rose et al., 2026; McPherson et al., 2018).

Edge of care and family preservation interventions

Considering the substantial detrimental impacts associated with entry into care, interventions aiming to prevent children at risk from entering care have become an increasing policy priority in England (Oliveira et al., 2025; Baxter et al., 2023; McPherson et al., 2018). The aim of these interventions to keep families together aligns with outcome 1 of the Children's Social Care National Framework (Department for Education, 2026). According to Rose et al. (2026), this prioritisation is not only a preventative investment, but also an opportunity to promote greater stability, wellbeing, and more positive long-term outcomes for vulnerable children, young people, and their parents/families. While entry into care is sometimes necessary, the aim of edge of care interventions is to ensure that the decisions about care are made in the best interests of the child (Talbot et al., 2020).

Defining the 'edge of care'

Even though the term 'edge of care' has become increasingly used in national policy and practice, it has not been adopted under a single, shared definition. Rees et al. (2017) found that different practitioners within the Children's Social Care ecosystem hold differing views on what constitutes edge of care, with inconsistent applications across and within local authorities. Their analysis further suggests that the term is frequently used implicitly to refer to complex and challenging family cases, where entry into care is considered a highly likely outcome. This definitional ambiguity makes it difficult to set clear boundaries for service intervention and determine the appropriate level of service intensity. Moreover, it also complicates efforts to quantify the scale of need within this population, particularly because no formal national or UK data are collected on the number of children and young people considered to be at the edge of care (Baxter et al., 2023; McPherson et al., 2018).

For the purpose of this review, we will adopt a pragmatic operational definition of edge of care, drawing broadly on Rees et al. (2017) efforts to conceptualise and operationalise the term, acknowledging it covers at least children and young people whose imminent entry to care is anticipated without further support. As described in further detail below, it includes families already engaged with child protection or welfare services who are explicitly framed as being at the edge of care, evidenced by indicators such as CPP status, pre-proceedings or comparable legal escalation, or explicit reference to imminent removal risk; as well as families referred to interventions specifically designed to prevent care entry.

Rationale and question formulation

What is known about effective interventions and practice elements

A range of approaches have been developed and evaluated with families at the edge of care, spanning from intensive family-focused support to multi-agency service models, and structured family decision-making processes such as Family Group Conferences (FGC) (Corliss et al., 2022; Ward et al., 2014). Evidence for intensive in-home family interventions in reducing entry to care is

promising but mixed, with variation in outcomes suggesting implementation may play a key role in determining effectiveness (Bezeczky et al., 2020; Lippens et al., 2025). Shared decision-making approaches such as FGC are often valued by families and practitioners (Schrader-McMillan and Barlow, 2017), and their use is now widespread across UK local authorities and a growing policy priority (Wood et al., 2024). Evidence from a large randomised control trial of FGC in England produced promising evidence, with children whose families were referred to an FGC less likely to be in care 12 months later than children receiving usual services (Taylor et al., 2023). However, evidence from other UK and international studies remains somewhat limited and inconsistent, with context and implementation emerging as likely determinants of effectiveness (Dijkstra et al., 2016; Wood et al., 2024).

Among the more clearly specified evidence-backed programmes, Multi-Systemic Therapy (MST) and Functional Family Therapy (FFT) have shown evidence of effectiveness in reducing entry to care, especially for adolescents, though results have not translated as well in practice (Rose et al., 2026). Furthermore, narrow eligibility criteria mean these programmes can exclude families with the most complex co-occurring adversities, limiting their potential impact for families most likely to be at the edge of care. A recent synthesis of the mechanisms underlying effective edge of care services identified home-based and individually tailored responses, consistent social-worker and family relationships, and quick responsiveness to emerging needs as particularly important features (Redgate et al., 2024). Taken together, these findings suggest that, while certain intervention components and practice elements show promise, the gap between evidence and consistent delivery in routine local practice remains a significant hurdle.

Translating evidence into sustained, real-world delivery proves a significant challenge. This is reflected in the wide range of approaches adopted by local authorities in England to reduce entry to care, from whole-system relational models to targeted programme-based interventions. These approaches are not defined consistently in national policy, and the models available vary considerably between areas. A survey of local authority leads indicated that whole-system approaches were considered most effective in reducing the number of children entering care, followed by edge of care services, early help, and FGC (Corliss et al., 2022). Yet, the evidence underpinning these preferences was limited, relying on partial economic analyses or anecdotal accounts from practitioners and families rather than robust independent evaluation (Corliss et al., 2022). Furthermore, there is a recognised gap in the evidence base for service-level models capable of addressing the full range of issues faced by families on the edge of care. Existing programmes tend to target specific problems rather than offering a comprehensive response to complex, co-occurring needs (McPherson et al., 2018; Schrader-McMillan and Barlow, 2017). This is a particularly pressing issue given that routes into care are multifactorial, and reducing care entry safely requires integrated responses spanning children's social care, health, and education (Allain et al., 2023).

Beyond differences in intervention models and local service configurations, the literature points to several factors that may shape effectiveness in practice. For instance, parental engagement is a recurring theme, with families' capacity to engage with and benefit from support appearing to depend not only on the intervention itself, but also on how support is delivered and whether it is experienced as respectful and collaborative (Schrader-McMillan and Barlow, 2017; Warde et al., 2014). Relatedly, fear, stigma, and mistrust of statutory services have been acknowledged as barriers to engagement (Bacon et al., 2023; Schrader-McMillan and Barlow, 2017), further



highlighting the significance of a strong family–worker relationship in enabling parental engagement. When support offered by services does not align with what parents need, it can be experienced as intrusive, stressful, or even traumatic, potentially worsening the very risks it aims to address (Bacon et al., 2023). This highlights the importance of understanding user perspectives to ensure services are acceptable to the families they seek to support. There is also some evidence that intervention effects may differ by the developmental age of the child, with certain approaches being better suited to particular age groups than others (Oliveira et al., 2025; Talbot et al., 2020). These findings point to the need to examine not only which interventions are effective overall, but which work best for different subgroups of children and families at the edge of care.

Overall, despite emerging evidence, the field remains characterised by significant methodological challenges. Studies in the area frequently involve small samples, high drop-out rates, and short follow-up periods, while heterogeneity in outcome measures makes comparison across studies difficult (Oliveira et al., 2025; Corliss et al., 2022). Existing reviews synthesise evidence on individual forms of maltreatment (Kennedy et al., 2016), single parental risk factors (Bacon et al., 2023), narrow child age ranges (Oliveira et al., 2025) or specific types of programmes (Bergsund et al., 2023), with few focused exclusively on edge of care populations. Local authorities, when surveyed, frequently reported practitioner and family self-report as their main evidence source for decisions about which approaches to use, with some drawing on independent evaluations (Corliss et al., 2022). Some edge of care interventions may lead to detrimental impacts (e.g. ineffective interventions that fail to keep children safe and deny parents the support they need to show they can change; intervention approaches relying on coercion that may entrench harmful behaviours among parents), underscoring the importance of rigorous evaluation (Ward et al., 2014).

Ultimately, commissioners and practitioners in England have limited clarity and guidance on which interventions to invest in, and how best to deliver them across different family contexts at the edge of care. This systematic review seeks to address these current limitations by synthesising high-quality research and producing clearer, more actionable evidence to support the development of a Practice Guide for families with children at the edge of care. Specifically, the review will provide insight into the effectiveness of interventions and services for supporting families whose children are at risk of entering care, and what works for families with different presenting needs and risk profiles at referral. It will additionally examine the practice elements and intervention components associated with effective interventions (how and why interventions work), explore the barriers and enablers to successful implementation, and capture the views of children, young people, parents, and practitioners on the acceptability and usefulness of different interventions.

Equity considerations are woven throughout every stage of this review through a set of complementary frameworks and organisational commitments. The review follows the PRISMA-Equity reporting framework, and we have used and will continue to use the CEI Equity Framework (CEI, n.d.) to help embed an equity, diversity, and inclusion perspective in the review.[1] Data extraction and coding will integrate PROGRESS-Plus to ensure data is extracted to explore

[1] The Framework was informed by Child Trends (Andrews et al., 2019) and writing on equity in implementation. It consists of 23 questions to prompt discussion and consideration of equity issues, to support reflection and planning of appropriate action.

diversity and equity. Synthesis is planned to consider subgroups and equity, and reporting will note where included studies' data limit the analysis of equity-related differences. In reporting on effective interventions and practice elements, we will draw out any available information regarding experience of delivery with different equity groups, potential risks or unintended consequences for specific groups, or recommended adaptations. In the analysis around implementation, we will use an equity-in-implementation science lens to examine the factors at different levels that influence take-up, reach, and impact (Baumann and Cabassa, 2020).

Research questions

This systematic review will aim to answer the following primary research questions, exploring what works (RQ1), for whom (RQ2), how and why (RQ3), as well as exploring processes around implementation (RQ4) and beneficiary perspectives (RQ5). RQ1–3 focus on impact, while RQ4–5 will explore implementation alongside user and practitioner perspectives and experiences.

RQ1 – What works: Which interventions for children and young people at imminent risk of entering care, and their parents/families, are effective in preventing care entry, and what are their effects on other parent-, family-, and child-level outcomes?

> RQ1.1. What is the effectiveness of these interventions in preventing care entry?
>
> RQ1.2. What effects on parent-, family-, and child-level outcomes are reported alongside placement outcomes, and what do these suggest about how the interventions achieve (or fail to achieve) their effects on placement?

RQ2 – For whom: Which interventions (and models) are effective for different populations of children and young people at imminent risk of entering care and their parents/families?

> RQ2.1. What are the known demographics and characteristics of the children, young people, and parents/families served by these interventions, and what evidence is there on how effectiveness varies across these groups?
>
> RQ2.2. Which types of interventions/models demonstrate effectiveness for children and young people at different developmental age ranges?
>
> RQ2.3. Which types of interventions/models demonstrate effectiveness for children and young people, as well as parents/families, with different presenting needs and risk profiles at referral (e.g. child behavioural and developmental difficulties, parental mental health and substance use, familial domestic violence, history of statutory system involvement)?
>
> RQ2.4. What unintended or adverse effects of these interventions are reported, for whom, and in what circumstances?

RQ3 – How and why: What practice elements and intervention components are associated with effective edge of care interventions?

> RQ3.1. What are the practice elements and intervention components found in interventions aimed at preventing care entry for children at imminent risk of entering care and their parents/families?

RQ3.2. What is the frequency and distribution of practice elements and intervention components among identified interventions?

RQ3.3. What practice elements and intervention components are associated with effective interventions in preventing care entry for children at imminent risk of entering care and their parents/families?

RQ4 – Implementation: What are the enablers and barriers to effective implementation of edge of care interventions in preventing care entry for children at imminent risk of entering care and their parents/families?

RQ5 – User perspectives: What are the views of intervention users (perspectives of children, young people, and parents/families) and practitioners about the acceptability and usefulness of edge of care interventions?

Eligibility criteria forRQ1–3 will be informed by the PICOS framework, and the eligibility criteria for questions RQ4–5 will be informed by the SPIDER framework.

PICOS Framework (RQ1–3)

Population

The review will focus on families with at least one child/young person from pre-birth to 18 years of age (at the beginning of the intervention) who is at imminent risk of entering care. This comprises families where removal of the child(ren)/young person(s) from the family home is being actively considered by children's social care services, and/or families who are referred by children's social care to interventions designed to prevent care entry. In England and some other jurisdictions, care proceedings cannot begin until after birth, but child protection planning and pre-proceedings or equivalent steps may begin during pregnancy. Therefore, studies beginning in pregnancy are eligible where children's social care have identified the unborn child as at risk of entering care after birth.

'Care' in this instance refers to foster care, formal kinship care, children's homes, and other out-of-home placements where the child is considered looked after. It excludes informal care arrangements or arrangements where continued statutory involvement was not specified (e.g. adoption) (Bezeczky et al., 2020). The review focuses on entry into care from birth parents' care, and excludes entry or re-entry into care from kinship care arrangements, adoptive placements, or Special Guardianship Orders, which is in line with other reviews on this topic (e.g. Oliveira et al., 2025). In practice, in the England context, this is likely to include children who are subject to a Child Protection Plan (CPP), in pre-proceedings, or otherwise identified by statutory services as being at serious risk of entering care. Eligibility is assessed at the point the intervention begins. Children who are in a care placement at that point, including an emergency placement (i.e. placements that are required by local authorities urgently without forewarning (Department for Education, 2021)), are not eligible, as care entry has already occurred and they are no longer considered at risk of entering care.

This review will also include relevant international literature; as statutory frameworks, thresholds, and terminology used to identify children at this level of risk will differ across jurisdictions,



equivalent indicators for statutory-level child protection concern and proximate risk of care entry will be considered on a study-by-study basis.

The review will focus on studies that meet either of the following criteria:

1. Studies that include children who are already involved with child protection/welfare services and who are explicitly described as being "at the edge of care", "at risk of placement", "at risk of removal", "on the brink of care", or equivalent language signalling statutory-level child protection concern and proximate risk of care placement. Indicators supporting inclusion under this criterion may include CPP, CiN, or equivalent child protection status, pre-proceedings or equivalent legal escalation, or explicit reference to imminent risk of removal or placement. Studies that include children who have been reunified and for whom it is about preventing re-entry into care are also eligible.

OR

2. Studies that include families referred by children's social care services to interventions explicitly designed to prevent care entry. Such interventions may include, for instance, family preservation programmes, edge of care teams, intensive home-based interventions, and family group conferencing/decision making models during pre-proceedings.

Both criteria require studies that include children and/or families already involved with statutory child protection or children's social care services. We will exclude studies of broader 'early help', 'vulnerable families', or universal/targeted prevention populations where statutory involvement is not confirmed, and care entry is not presented as a realistic counterfactual. For studies with mixed populations that include children, young people, and parents/families both at the edge of care and lower risk families receiving other forms of statutory support, we will apply the following decision rules at full-text screening:

- Where a study reports that the majority of its sample (>50%) meets either criterion above, it will be included and the mixed population nature noted as a potential source of bias in the risk of bias assessment
- Where a study includes a mixed population but reports outcomes separately for the edge of care subgroup, it will be included and only the subgroup data extracted.

Literature suggests that differences in social policy make cross-country comparisons difficult (Jay and McGrath-Lone, 2019). To ensure that the review results are relevant to the England context, we will limit study inclusion to research conducted with populations in England and in countries with child welfare systems broadly comparable to England, defined for the purposes of this review as: Australia, Belgium, Canada, Denmark, Finland, France, Germany, Ireland, the Netherlands, New Zealand, Norway, Northern Ireland, Scotland, Sweden, USA, and Wales(Connolly and Katz, 2019). As the population of interest is described differently across jurisdictions, the review will account for jurisdiction-specific terminology for statutory-level concern and proximate risk of care entry in our search strategy and screening process.

Interventions

This review will focus on intensive, family-focused interventions with the primary purpose of preventing entry into care. Eligible studies must therefore measure and report the effect on entry into care.

Given the level of heterogeneity in provision of edge of care services offered by local authorities in England (Corliss et al., 2022), we will include a broad range of family-focused interventions where the primary aim is to prevent entry to care. We expect that most interventions will include multiple components, usually including at least an element of therapeutic intervention. Other components may include practical support (e.g. case management, organising financial support, debt management, housing assistance) and 24-hour or crisis-response availability. Interventions may be flexible and tailored to the specific needs of the families (Dalgaard, 2024; Lee et al., 2014).

Given that supporting family functioning and preservation is the primary focus of edge of care interventions, included interventions must involve at least one parent (Oliveira et al., 2025). We will therefore exclude interventions that only target children and young people, unless they specify an explicit parent component. We will include interventions that only target parents where the specified aim is to prevent care entry for a child in their care.

Contextual safeguarding interventions will be eligible for inclusion where they have an explicit parent/family component. Interventions that work solely with peer groups, schools or communities, without working directly with parents, will be excluded. Contextual safeguarding approaches respond to harm outside the home by targeting the contexts and social conditions in which it occurs, rather than focusing on families, and measure success in terms of changes to those contexts as well as to individuals (Contextual Safeguarding, 2024). As these interventions operate at a system rather than family level, including them would introduce substantial heterogeneity and limit meaningful synthesis. We will not exclude interventions on the basis of their theoretical underpinnings, and anticipate that these may include ecological systems theory, family systems theory, social learning theory, crisis theory, and attachment-, psychotherapeutic-, or mentalisation-based approaches.

Eligible interventions include, but are not limited to: family preservation programmes, edge of care teams, multi-systemic therapy (MST) and its variants (e.g. MST-Child Abuse and Neglect), functional family therapy (FFT and FFT CW), other structured intensive family therapies, multi-disciplinary team models, and other structured, time-limited models used specifically to divert children from care at the pre-proceedings or edge of care stage, such as Family Group Conferences, Family Group Decision-Making (FGDM) meetings, and other family-led decision-making approaches, where their primary purpose is to prevent care entry by supporting family decision-making and planning support. We will treat FGDM models as a distinct intervention category within our synthesis, given their growing policy prominence (i.e. requirement under the Children's Wellbeing and Schools Act 2026 for all local authorities in England to offer FGDM at pre-proceedings stage).

Interventions aimed at supporting reunification for children who are currently in out-of-home care are out of scope. Interventions that provide short stays (e.g. respite, crisis beds, or residential short stays) as part of their intervention model are eligible, provided they are bundled with other intervention components and otherwise meet the intervention criteria.

Studies which do not measure and evaluate effects on measures related to care entry will be excluded (see further details under Outcomes).

Comparator

This review will include both studies with inactive control groups (no intervention, waiting list, minimal intervention, or service as usual) and studies with active comparators (another comparable intervention). Synthesis will consider the relevance of the comparator, and in 3-arm trials (intervention A, Intervention B, service as usual), we will compare interventions to the inactive comparator. Studies where service as usual involves residential care, foster care, or formal kinship care will be excluded (Lippens et al., 2025). The interventions included in this review focus on families at risk of care entry and therefore control groups of children already in care are unsuitable comparison groups.

Outcomes

This review will include studies that report care entry as an outcome measure. This is the primary outcome against which intervention effectiveness will be assessed. We acknowledge that this may exclude some well-delivered interventions for which care entry data are difficult to collect. However, as preventing care entry is the primary aim of the interventions in this review, we consider measuring it to be essential. This outcome may be measured as either a dichotomous variable (entry into care) or a continuous variable (time to entry). Outcomes may be measured using administrative data, record reviews, or questionnaires completed by child protection agencies or intervention participants (Dalgaard, 2024).

This review will include a wide range of exploratory outcomes, covering child, parent, and family domains. As noted above, the heterogeneous effects of care entry found in some studies underscore the importance of considering effects across a range of outcomes. Final classification will depend on the outcomes reported in the included studies. The outcomes considered in scope are:

- **Primary outcome.**
  - Entry to care, e.g. initial entry to care, accommodation, re-entry following reunification, and time-to-entry where reported.
- **Explanatory outcomes.** These outcomes represent the proximal mechanisms which may help explain how interventions contribute to prevention of care entry.
  - Family level outcomes:
    - Family functioning, e.g. parent-child relationship quality and attachment
  - Parent-level outcomes:
    - Parental mental health and wellbeing, e.g. psychopathology, mood-related disorders such as depression and anxiety, and general psychological distress
    - Parenting stress, e.g. stress related to the parenting role
    - Parenting self-efficacy/sense of competence, e.g. parent's confidence in their ability to manage their child's behaviours and needs
    - Parenting skills/capacity, e.g. positive parenting
    - Parental substance use, e.g. alcohol and other drug use frequency, severity, and dependence.

- Child-level outcomes:
  - Child internalising behaviours, e.g. anxiety, depression, withdrawal, somatic complaints
  - Child externalising behaviours, e.g. aggression, conduct problems, hyperactivity symptoms
  - Child safety/maltreatment/recurrence of maltreatment, including subtypes (e.g. physical abuse, neglect, emotional abuse), where reported, as well as closely related indicators such as harsh parenting where clearly conceptualised as maltreatment risk.

We will include outcome measures that use systematic direct observational techniques, administrative data, and validated instruments that rely on self-report or proxy report (e.g. parent/carer report). Outcome measures that use unvalidated instruments that rely on self-report or proxy report will be excluded. We will consider all reported time points and categorise these into appropriate bands based on the distribution of the data (e.g. up to 12 months, and more than 12 months post-intervention/baseline).

It is important to note that several of these outcomes are not independent of one another. For instance, better family functioning can help prevent out-of-home placement, but the reverse is also true: a child's placement out of the home immediately alters family dynamics. If family functioning is measured after placement has occurred, the family structure being measured has already changed as a result of the placement, so the measurement would no longer provide a clean indication of the intervention's effect on family functioning, as distinct from the effect of placement itself. The timing of outcome measurement relative to placement will be extracted and considered in interpreting these outcomes where possible.

We will include any reporting on potential unintended or adverse effects of these interventions.

If insufficient evidence is identified from studies measuring and reporting on care entry, we will expand inclusion to all studies that report family functioning as an outcome.

Study design

Studies using randomised controlled trials and quasi-experimental studies which include a valid counterfactual, such as a parallel group or highly controlled time-series, will be included in the review. Studies without a valid counterfactual (e.g. pre-post studies without a comparator) will not be eligible for RQ1–3.

Table 1. Summary of PICOS inclusion criteria

Domain	Inclusion criteria	Exclusion criteria
Population	• Families where removal of a child (pre-birth to 18) from their birth parents' care is being actively considered by children's social care, demonstrated by meeting either of the following criteria: 1. Children already involved with children's social care who are explicitly described as "at the edge of care", "at risk of placement", "at risk of removal", or equivalent. Supporting indicators include CPP, CiN, pre-proceedings or equivalent legal escalation (or their equivalents in other jurisdictions), or explicit reference to imminent risk of removal or placement. 2. Families referred by children's social care to interventions explicitly designed to prevent care entry. • Children who have been reunified with their parents and are living in parental care, where the aim is to prevent re-entry into care • Families residing in England or countries with comparable child welfare systems • Studies with mixed samples where >50% of participants meet either of the above population criteria • Studies with mixed samples where outcomes are reported separately for the edge of care subgroup	• Young people aged 18 and over • Broader 'early help', 'vulnerable families', or universal/targeted prevention populations where statutory involvement is not confirmed and care entry is not presented as a realistic counterfactual • Children and young people who are not in their birth parents' care (e.g. kinship care, adoptive placements, SGO or equivalent permanence orders) or who are 'looked after' at the start of the intervention (e.g. foster care, emergency placement) • Families outside of England or countries with comparable child welfare system to England • Studies with mixed populations where ≤ 50% of participants meet criteria for our population of interest • Studies that do not report outcomes separately for our population of interest.
Intervention	• Family-focused interventions where the primary purpose is to prevent entry to care • Interventions engaging at least one parent • Interventions that provide short stays (e.g., respite, crisis beds) as part of their intervention model when bundled with other intervention components	• Interventions where the primary purpose is other than preventing entry into care • Interventions targeting only children and young people, without an explicit parent component • Interventions whose purpose is to achieve reunification for children currently in a care placement (support following reunification to

Domain	Inclusion criteria	Exclusion criteria
	• Contextual safeguarding interventions with an explicit parent component.	prevent re-entry is eligible; see Population) • Short stays (e.g. respite, crisis beds) as a standalone crisis response rather than bundled with other intervention components • Interventions working solely with peer groups, schools, or communities, without an explicit parent component.
Comparator	• Inactive control groups (no intervention, waiting list, minimal intervention, service as usual) • Active control group(s) (another single or multiple interventions).	• Studies that use an undefined or inappropriate comparison group (e.g. where the standard treatment involves residential care or foster care) • Studies with no comparison group.
Outcomes	• Studies that measure and report the effect on care entry • Entry to care is defined as entry from parental care into any out-of-home placement (e.g. foster care, formal kinship care, children's homes, and other residential placements), as defined by each study. It is measured as the proportion of children entering care by follow-up, or as time to entry where reported. Entry to care includes first entry and re-entry following reunification.	• Studies that do not measure and report effect on care entry • Entry into informal care arrangements or arrangements where continued statutory involvement is not specified.
Study design	• Controlled experimental and quasi-experimental designs which include a valid counterfactual.	• Studies with methodology other than controlled experimental and quasi-experimental design.

SPIDER Framework (RQ4–5)

Sample

The sample here comprises three groups: 1) children pre-birth to age 18 at imminent risk of entering care; 2) their parents and/or wider family members, where involved in interventions; and 3) practitioners working with these families, including social workers, family support workers, other child welfare professionals and professionals involved in the wider delivery of interventions. Our operationalisation of "imminent risk of entering care", including the two eligibility criteria and mixed-population decision rules, is set out in the Population section of the PICOS framework above. Given the policy and practice context of the Practice Guide, we will only include studies with

UK-based populations for RQ4–5. Studies that do not report on the experiences or perspectives of the specified sample groups, or that are conducted outside the United Kingdom, will not be eligible for inclusion.

Phenomenon of interest

This review will identify enablers and barriers to successful implementation of interventions aimed at preventing care entry for children and young people at imminent risk of entering care and the perceived acceptability and usefulness of different interventions for intervention users (children and young people, and their parents/families) and practitioners. Implementation factors will be examined using the Consolidated Framework for Implementation Research Framework (Damschroder et al., 2022) as the guiding framework. Studies will be limited to those conducted in the UK. This restriction reflects the extent to which implementation barriers and enablers, and the experiences of service users and practitioners, are shaped by national policy, legislation, and the structure of the UK care system.

Study design

This review will include studies that use appropriate methods to examine the experiences and perspectives of individuals involved in delivering or receiving the intervention (i.e. intervention users and practitioners), such as implementation and process evaluations. Methods may include surveys, interviews, and focus groups, as well as mixed-methods approaches.

Evaluation

This review will include any studies that contain information on enablers and barriers to the successful implementation of interventions, as well as the perceived acceptability and usefulness of different interventions aimed at preventing entry to care for children and young people on the edge of care and their parents/families.

Research type

This review will consider any study type that explores the perceptions and experiences of the phenomenon of interest for inclusion (e.g. phenomenology, grounded theory, or case study methodology). Studies may be in the grey literature or peer-reviewed journals.

Advisory group

Foundations' advisory group will be consulted to provide a critical, equity-focused lens, grounded in lived, professional, and practice-based experience. The advisory group comprises multi-disciplinary stakeholders from children's social services. The advisory group will contribute to the interpretation and sense-making of emerging and preliminary findings, helping to surface equity implications, contextual factors, and practice-relevant insights that may not be evident from the literature alone.

Identifying relevant work

While all five research questions look at the same population, interventions, and outcomes of interest, RQ1–3 focus on impact and will be best answered by literature employing rigorous causal designs, specifically randomised controlled trials and quasi-experimental designs with a valid counterfactual, as set out in the study design criteria in the PICOS framework above, with methodological quality further assessed through critical appraisal (see Risk of bias assessment). RQ4–5 explore perspectives and experiences and may be best answered through exploration of qualitative or mixed-methods literature. As such, our search methodology will involve two separate sets of inclusion and exclusion criteria – one set for RQ1–3 and another for RQ4–5. Additional searches of key sites that publish high-quality grey literature will also be conducted to answer both sets of research questions, as described below.

A comprehensive and systematic search strategy has been developed to ensure thorough coverage of the relevant literature. This search was developed iteratively, incorporating terminology from relevant reviews and refined to balance sensitivity with precision.

Search strategy and search terms

We will screen 13 pre-identified systematic reviews for relevant studies:

- Oliveira et al. (2025). Psychosocial interventions for edge of care families in the early years: A Systematic Review and meta-analysis. *Trauma, Violence, & Abuse*, *0*(0).
- Lippens et al. (2025). Evaluating the effectiveness of intensive family preservation services: A multi-level meta-analysis. *Child Abuse & Neglect,* 160, 107198.
- Bezeczky et al. (2020). Intensive family preservation services to prevent out-of-home placement of children: A systematic review and meta-analysis. *Child Abuse & Neglect*, 102, 104394.
- Dijkstra et al. (2016). The effectiveness of family group conferencing in youth care: A meta-analysis. *Child abuse & neglect*, *62*, 100–110.
- Redgate et al. (2024). Mechanisms That promote and support family preservation for children at the edge of care: A Realist synthesis. *SAGE Open, 14*(2).
- Al et al. (2012). A meta-analysis of intensive family preservation programs: placement prevention and improvement of family functioning. *Children and Youth Services Review*, 34(8), 1472–1479.
- McGinn et al. (2020). Family Group Decision-Making for children at risk of abuse or neglect: A systematic review. *Campbell Systematic Reviews*, 16(3), 1–64.
- Lee et al. (2014). Program and practice elements for placement prevention: A review of interventions and their effectiveness in promoting home-based care. *American Journal of Orthopsychiatry*, 84(3), 244–256.
- Van Assen et al. (2020). Home-visiting interventions for families with complex and multiple problems: A systematic review and meta-analysis of out-of-home placement and child outcomes. *Children and Youth Services Review*, 114, 104994.



- Littell et al. (2021). Multisystemic Therapy for social, emotional, and behavioural problems in youth age 10 to 17: An updated systematic review and meta-analysis. *Campbell Systematic Reviews*, 17(4), e1158.
- Littell et al. (2023). Functional Family Therapy for families of youth (age 11–18) with behaviour problems: A systematic review. *Campbell Systematic Reviews*, 19, e1324.
- Neo et al. (2021) Integrated treatment programmes for mothers with substance use problems: A systematic review and meta-analysis of interventions to prevent out-of-home child placements. *Journal of Child and Family Studies*.
- Bacon et al. (2023). At the edge of care: A systematic review and thematic synthesis of parent and practitioner views and experiences of support for parents with mental health needs and children's social service involvement. *Health & Social Care in the Community*.

We will apply backward and forward citation chaining to these 13 reviews: screening their reference lists and tracking studies that cite them, using Google Scholar's citation-tracking feature and AI-assisted citation-mapping tools. Records identified this way will go through the same screening and eligibility checks as records found through database searching.

Additionally, the following databases will be searched for published studies:

- Applied Social Sciences Index & Abstracts (ASSIA) (ProQuest)
- Cochrane Central Register of Controlled Trials
- CINAHL (Cumulative Index to Nursing and Allied Health Literature)
- International Bibliography of Social Sciences (IBSS) (ProQuest)
- PsycINFO (Ovid)
- MEDLINE (Ovid)
- Social Policy & Practice (Ovid)
- Social Services Abstracts

In addition to searching the databases outlined above, we will conduct searches for grey literature sources such as policy reports, evaluations, and research reports. For this, we will search the following key websites:

- Australian Institute of Family Studies (aifs.gov.au/)
- California Evidence-Based Clearinghouse for Child Welfare (cebc4cw.org/)
- CASCADE: Children's Social Care Research and Development Centre (cascadewales.org/)
- CELCIS: Centre for Excellence for Children's Care and Protection (celcis.org/)
- Centre for Child, Youth, and Family Welfare, Queen's University Belfast (qub.ac.uk/research-centres/centre-for-child-youth-and-family-welfare/)
- Centre for Innovation and Research in Childhood and Youth (CIRCY), University of Sussex (sussex.ac.uk/esw/circy/)
- Centre for Research on Children and Families (CRCF), University of East Anglia (uea.ac.uk/groups-and-centres/centre-for-research-on-children-and-families)
- Chapin Hall at the University of Chicago (chapinhall.org/)
- Children's Bureau, An Office of the Administration for Children & Families (acf.hhs.gov/cb)
- Children and Families Research Centre, University of Bristol (bristol.ac.uk/sps/research/centres/family/)

- Department for Education Social Care Innovation Round 1 and 2 reports (gov.uk/guidance/childrens-social-care-innovation-programme-insights-and-evaluation; whatworks-csc.org.uk/wp-content/uploads/WWCSC_IP_dashboard_draft_7_hyperlinks_Acc.pdf)
- Early Intervention Foundation (archived website; eif.org.uk)
- Foundations (foundations.org.uk/)
- National Children's Bureau, Social care research (ncb.org.uk/what-we-do/research-evidence/our-research-projects/social-care-research)
- National Institute for Health and Care Excellence (NICE) and SCIE Guidance (nice.org.uk/guidance/published?ngt=Social%20care%20guidelines&ndt=Guidance)
- Nuffield Foundation (nuffieldfoundation.org/)
- Office of Planning, Research, and Evaluation, US Administration for Children and Families (acf.hhs.gov/opre)
- Rees Centre, University of Oxford (education.ox.ac.uk/rees-centre/)
- Research in Practice (researchinpractice.org.uk)
- Washington State Institute for Public Policy (wsipp.wa.gov/)
- What Works for Children's Social Care (archived website; whatworks-csc.org.uk/).

For each listed website, searches will be conducted using the site's internal search function where available, supplemented by manual browsing of relevant topic areas and publication lists. Searches will be documented by one reviewer.

The authors of the above listed pre-identified systematic reviews will be contacted to identify any supplemental, additional, or in-press literature. We will also contact Foundations' advisory group (through our Foundations contact) and our subject matter experts by email to ascertain if they are aware of any supplemental and/or additional literature or key authors we should contact. If additional key authors are identified during screening, contact will be capped at 15 individuals, with priority given to those with the most recent and most cited work. The team will also contact authors via email to resolve eligibility questions for studies that reach full-text review without sufficient information for a clear inclusion decision.

For information on the practice elements of interventions identified through our search we will also draw on information from programme websites, guidebooks, repositories of evidence-based programmes, and programme manuals where needed, due to the included paper(s) not providing sufficient detail.

Search terms

Our database search terms will be based on population, intervention, and study design. For RQ4–5, also search terms for location (UK only) are included. The preliminary search terms have been refined to optimise coverage of the literature while minimising returns of irrelevant results. The search terms will be tested to include a pre-defined set of relevant papers known by the team. We also used the large language model Sonnet 4.6 (Anthropic, 2026) in August 2026 to help with suggestions for ways to structure searches, using a detailed explanation of the search question as a prompt, in line with Cochrane guidance (Higgins et al., 2024). These searches were conducted for

the purposes of search strategy development only. Formal database searches will begin after protocol registration.

In testing the search, we decided to undertake two searches to separate literature for questions 1–3 and questions 4–5, while acknowledging that some literature may appear in both searches. This approach will enable us to apply distinct sets of screening criteria, and report separate PRISMA diagrams for transparency.

Search terms developed in Psychinfo (Ovid) for RQ1–3 are listed here (line number, search string, results count) for each row:

#	Search string
1	(family or families or parent* or caregiver* or guardian* or child or children or youth or youths or youngster* or (young adj (person* or people)) or baby or babies or newborn* or infant or infants or toddler* or "early adult*" or teen or teens or teenage* or preteen* or "pre teen*" or "pre-teen*" or adolescen* or preadolesc* or pre-adolesc* or juvenil* or boy* or girl* or kid or kids).ti,ab.
2	(("looked after" or "looked-after") adj5 (child* or "young person*" or "young people" or youth or youths)).ti,ab.
3	("edge of care" or "edge-of-care" or "on the brink of care" or "at risk of placement" or "risk of removal" or "placement prevention" or "tak* into care" or ((enter* or entr*) adj3 (care or placement*)) or "care entry" or (child* adj ("in need" or "in care")) or (("out-of-home" or "out of home" or "outside the home") adj1 (care* or placement* or placed)) or "family court*" or "care proceeding*" or "pre-proceeding*" or "pre proceeding*" or "care order*" or "public law outline" or "PLO process" or (court adj3 (proceeding* or hearing* or petition*))).ti,ab.
4	((substantiat* adj (finding* or report*)) or "substantial safety concern" or "supervision order*" or "dependency petition*" or "shelter care hearing*" or "pre-petition status" or (concern adj (report* or notification*)) or "child endangerment" or "safety plan*" or "family group conferenc*" or "at risk of harm").ti,ab.
5	(child* adj3 (abus* or maltreat* or neglect*) adj5 (substantiat* or investigat* or referral* or "at risk" or removal or placement* or "out-of-home" or statutory or intervention*)).ti,ab.
6	((custody adj3 (los* or remov*)) or (remov* adj3 (child* or parent* or famil* or home*))).ti,ab.
7	("children's social care" or "child protect*" or "child* welfare" or "protective service*").ti,ab.
8	"youth protect*".ti,ab.
9	((substitute or "local authority" or public or group) adj (care or placement*)).ti,ab.
10	((nonparent or non-parent) adj3 care).ti,ab.
11	((residential or foster or kinship) adj1 (care or home* or placement)).ti,ab.
12	((children's or childrens or group) adj home).ti,ab.
13	"support* living".ti,ab.
14	"Special guardian*".ti,ab.
15	exp Protective Services/ or exp Child Welfare/ or exp Child Abuse/ or exp Child Neglect/
16	(((family adj2 intervention) or (family adj1 support*)) adj5 (intensive or team or service* or project* or program* or therap*)).ti,ab.

#	Search string
17	((prevent* adj3 (placement* or placing)) or (care adj5 (placement adj prevent*))).ti,ab.
18	(((family or home) adj (visiting or visitation)) or "home visit*" or "home-visit*").ti,ab.
19	(Family adj5 (home-based or in-home)).ti,ab.
20	(("edge of care" or "edge-of-care") adj3 (service* or intervention* or team*)).ti,ab.
21	((("crisis" or "family crisis" or "intensive family" or "home-based" or "home based" or "in-home" or "in home" or "family-focused" or "family focused" or "family-centred" or "family centred" or "family-centered" or "family centered" or family-based or family based) adj3 (intervention* or service* or therap*)) or "in-home family treatment" or "wraparound care").ti,ab.
22	(("Multi-disciplinary" or "multi-agency") adj (service* or team*)).ti,ab.
23	(preserv* adj1 famil*).ti,ab.
24	("multisystemic therapy" or "multi-systemic therapy" or "functional family therapy" or "multidimensional family therapy" or "multi-dimensional family therapy" or homebuilders or "famil* first" or "signs of safety").ti,ab.
25	("family group decision making" or "family group decision-making" or "family-led decision making" or "family-led decision-making" or "family-centred decision-making" or "family decision making" or "family decision-making" or "family-centered decision-making" or "family centred conferenc*" or "family centered conferenc*" or "family group conferenc*" or "family conferenc*" or "family and group conferenc*" or "family unity meeting*" or "family team meeting*" or "team decision making" or "team decision-making").ti,ab.
26	((parent* or famil* or mother* or father* or caregiver*) adj3 (program* or intervention* or training or education or group or service* or therap*)).ti,ab.
27	exp Family Preservation/ or exp Family Therapy/ or exp Home Visiting Programs/ or exp Family Intervention/
28*	(trial* or rct or randomi* or "random* allocat*" or "random* assign*" or "treatment group*" or "intervention group*" or "control group*" or "control condition*" or "comparison condition*" or "comparison group*" or (random* adj assign*) or (random* adj allocat*) or qed or quasi-experiment* or quasiex* or "quasi ex*" or "interrupted time series" or "propensity score" or "instrumental variable*" or "difference in difference*" or "difference-in-difference*" or "matched control" or "matched comparison" or "repeated measures" or "regression discontinuity" or "effect size*" or "controlled time series" or "non-randomi?ed" or "non randomi?ed" or nonrandomi?ed or "pre-post" or "pre post" or "pretest posttest" or "pretest-posttest" or "pre-intervention" or "pre intervention" or preintervention or "post-intervention" or "post intervention" or postintervention or (before adj1 after) or (control* adj1 intervention*) or (control* adj1 treat*) or (wait* adj2 list*) or waitlist* or "evaluat* study" or "impact evaluat*" or experiment* or "outcome stud*" or "outcome evaluat*" or "treatment effect*" or (matched adj2 (cohort* or group* or sample* or comparison* or control* or pair*)) or "retrospective cohort*" or "prospective cohort*" or "comparison cohort*").ti,ab.
29*	exp Treatment Effectiveness Evaluation/ or exp Program Evaluation/ or exp Quasi Experimental Methods/ or exp Clinical Trials/
30	2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15
31	16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27

#	Search string
32	28 or 29
33	1 and 30 and 31 and 32

*For RQ4–5, lines 28 and 29 are replaced with the following:

#	Search string
34	(Qualitative or Survey* or Questionnaire* or ((Implementation or process) adj1 (research or stud* or evaluat*)) or Interview* or "focus group*" or "process evaluation" or "mixed method*" or barrier* or enabler* or facilitat*).ti,ab.
35	exp Qualitative Methods/ or exp Mixed Methods Research/ or exp Program Evaluation/
36	34 or 35
37	(UK or United Kingdom or England or Wales or Scotland or Northern Ireland or Great Britain or British Isles).mp.
38	1 and 30 and 31 and 36 and 37

We will combine search terms using Boolean operators and include wildcards and truncation symbols to maximize efficiency. Database-specific search strategies will be created, as different databases accept different syntax.[2]

Following PRISMA guidelines, we will document each search, including terms used, their combinations, search dates, sources consulted, and the number of studies identified and retrieved.

Study selection criteria

Inclusion and exclusion criteria will be guided by the PICOS and SPIDER frameworks outlined above. In addition, we will apply exclusion criteria based on:

- **Timeframe:** We will include studies published from 2000, as the statutory and service frameworks governing entry to care have since evolved substantially, and the edge of care intervention models most relevant to the policy and practice context of the Practice Guide were largely developed, formalised, or scaled from this period onward.
- **Language:** We will only include studies in English.

The final search strategy will be tailored to each database and tested for sensitivity to ensure all relevant studies are identified.

[2]Where a database's indexing supports it, the search will be supplemented with relevant subject-heading terms alongside the title and abstract terms above.

Study records

Data management

All citations identified in the searches will be imported into Covidence, where duplicate records will be removed prior to screening. We aim to screen all studies and will use Covidence's machine learning algorithm to enhance efficiency of the screening process.

If the initial number of hits is too large across the two searches (e.g. over 3,700[3]), we will work with Foundations to either refine the search or negotiate a stopping point leveraging on Covidence's machine learning algorithm that analyses screening patterns from earlier decisions within the review, and, using these insights, predicts the relevance of yet-to-be-assessed studies (we will provide data on diminishing returns in order to make an informed choice together). For this, at least 25 studies need to be double screened by humans for title and abstract to refine 'most relevant' publications as screening continues. Over time, the system's predictions become increasingly accurate as more studies are screened. Thus, Covidence can prioritise studies by ranking the most relevant and likely-to-be-included items first. This enables quicker identification of pertinent studies, streamlining the process of advancing them to the full-text review stage compared to traditional methods. Additionally, Covidence offers the flexibility to screen a subset of studies, which is particularly valuable if the volume of retrieved records exceeds the resources available for this review.

Extraction of study details, quantitative, and qualitative findings will be managed using Microsoft Excel (web version), incorporating both free text entry and pre-specified codes to aid comprehensive but targeted reporting.

Screening and full text review

The screening approach will be proportionate to the volume of literature identified through the finalised search strategies and will be agreed with Foundations to ensure completion of the review within the available time and resources. Where the volume of literature permits[4] (<1850 across all components of the search), systematic review screening methods will be applied, with titles and abstracts independently screened by two reviewers and any discrepancies resolved by a third reviewer. Where the volume of records necessitates a more rapid approach (>1,850 records), we propose to adopt established rapid review screening methods (Garritty et al., 2024). In such cases, a subsample of titles and abstracts (at least 20%) would be independently screened by two reviewers, and if sufficient inter-rater agreement is reached between two reviewers (>0.8 Kappa coefficient score), the remainder of screening would be completed by a single reviewer, with uncertainties resolved with a second reviewer.

[3] This number is based on the estimated maximum volume manageable for single screening within the project's available staffing and timeline.

[4] This number is based on the estimated maximum volume manageable for full systematic double-screening within the project's available staffing and timeline.



All texts deemed potentially eligible at the title and abstract stage will undergo a full-text screening to determine final inclusion. Full-text screening will be conducted using systematic or rapid review methods, depending on the volume of included studies and, again, based on the volume of results and the time/resources available. Where there are uncertainties or discrepancies, a third reviewer will be consulted to make a final decision. Additionally, we will carefully check for duplicate reporting of the same trial to ensure data integrity and avoid double-counting results.

All studies excluded at the full-text review stage will be recorded with the primary reason for exclusion. We will apply a hierarchy of exclusion criteria at full-text screening, starting with outcomes measured and reported as the first criterion to be assessed. These will be reported in a supplementary appendix to the final review report. A PRISMA flow diagram will document the number of records identified, screened, assessed for eligibility, and included or excluded at each stage of the search and selection process.

Extraction

Quantitative data

A data extraction template spreadsheet will be developed with input from methods and subject area experts in the team to extract data from studies included under RQ1–3. In addition to study design and outcome data, extraction will cover information as relevant, for example on demographics and risk profiles of the study population, name or type of intervention, intervention length and dosage, details on the intervention (e.g. using TIDieR checklist definitions for delivery format, delivery modality, workforce, etc.) (Hoffmann et al., 2014). Extraction will record the funding source or sources for each included study, as reported by the study authors. Data items will also include the PROGRESS-Plus Framework (Welch et al., 2024), to identify characteristics that stratify opportunity and outcomes and to ensure an equity focus (including e.g. place of residence, race/ethnicity, gender/sex, religion, socioeconomic status[5]).

Fields for use in meta-analyses will be included in the Excel extraction template, including means, standard deviations, and sample sizes of intervention and control groups; standardised effect sizes with confidence intervals; and quantitative variables to consider for use in subgroup analyses (e.g. developmental stage, history of statutory system involvement). The framework will be piloted by team members on a sub-set of 2–5 included studies, selected to reflect diversity in study design, intervention type, and outcome reporting. The framework will be refined iteratively before formal data extraction of all selected studies is commenced.

In line with AMSTAR 2 (Shea et al., 2017), two reviewers are expected to extract data. However, if the number of included studies exceeds the team's capability of double extraction, single extraction will take place according to established rapid review methods (Garritty et al., 2024), with the piloting of the extraction template serving as a calibration opportunity. Extraction will be supervised by senior members of the team to ensure reliable and valid extraction for the remaining studies. The extraction will be checked for a sample of 5% of trials by an experienced member of the research team.

[5] https://methods.cochrane.org/equity/projects/evidence-equity/progress-plus

Where key outcome data are missing or insufficiently reported, study authors will be contacted by email, with a maximum of three attempts per study during the data extraction period.

Qualitative data

Qualitative data extraction and coding of studies included under RQ4–5 will be conducted using the data analysis software NVivo 15, selected for artificial intelligence features that support the coding process. Human coders will apply their own codes first; NVivo's AI functions will then be used for suggestions on clusters and child codes, keeping human judgement central throughout. Relevant studies containing qualitative data, such as participant quotes, thematic descriptions, and report findings sections, will be imported into the software.

A coding framework will be developed based on the research questions and relevant theoretical models to analyse these studies, combining deductive coding (using predefined codes) with inductive coding (identifying emerging themes). This framework will be refined iteratively during the initial coding process to capture unanticipated patterns.

Coders will independently apply codes, and NVivo's coding comparison query will be used to assess coding consistency and resolve discrepancies through regular discussions. Codes will be organised hierarchically to distinguish between overarching themes, subthemes, and specific data points. For all imported qualitative studies, data will be extracted and coded in NVivo 15 by two reviewers. Where the volume of qualitative studies exceeds available capacity, a calibration exercise will be conducted on a subset of studies (20%), and remaining studies will be coded by one reviewer with a second reviewer consulted to resolve uncertainties.

Practice elements

Practice elements and intervention components will be explicitly defined to support reliable and transparent coding (Chorpita et al., 2005) across the RQ1–3 effectiveness studies included in the review. Drawing on the team's expertise in common elements approaches and practice-element methodology, we will build on existing frameworks to develop a bespoke coding framework tailored to this review. Our approach will align with the following steps:

- **Identification of candidate frameworks**: We will identify and review existing coding schemes used in relevant systematic reviews of edge of care and family preservation interventions. This will include the 26-item coding framework developed by Leijten et al. (2019); the programme and practice elements identified by Lee et al. (2014) in their review of interventions aiming to prevent out-of-home placement; the intervention components framework developed by Allen et al. (2025); and the programme theories and mechanisms identified by Redgate et al. (2024) in their realist synthesis of family preservation interventions at the edge of care. We will also draw on coding frameworks used in prior systematic reviews commissioned by Foundations[6].

[6] This will include: What interventions improve outcomes for kinship carers and the children in their care (Ott et al.,2024); Effective interventions and practices for parents experiencing complex and multiple needs (Baan et al., 2025); Equity-focused systematic review of interventions for foster carers and adoptive parents

- **Framework refinement and adaptation**: Building on this starting framework, we will refine and extend the coding scheme to distil discrete practice elements relevant to interventions aimed at supporting families identified as being at the edge of care. This process will be informed by key reviews in the field (listed in Background, rationale, and question formulation) and the team's prior experience applying common elements approaches.
- **Definition of coding domains**: The coding framework will capture both intervention characteristics and content (e.g. strategies to strengthen parent-child relationship, parenting skills building) and delivery and implementation methods (e.g. modelling, coaching, home visits).
- **Review and validation**: The draft coding framework will be reviewed with Foundations and Foundations' advisory group to ensure clarity, relevance, and appropriateness.
- **Application and iterative refinement**: Interventions will be coded for the presence of each practice element. Where new practice elements are identified that are not included in the a priori framework, these will be added iteratively to the codebook, with definitions refined to maintain consistency.

This structured process will support a rigorous and transparent synthesis of common practice elements and intervention components across diverse interventions. For efficiency, we will code each included intervention once, drawing on the study that provides the most recent intervention description, and additional coding interventions described as a modification of, or 'based on', an included intervention. Coding will be carried out by one reviewer with double coding of the initial five programmes by a second reviewer. The extraction and coding will be checked by an experienced member of the research team, with an in-depth check on a select number of programmes (approximately 10%). In coding, we will draw on information provided in the included papers, and where necessary use secondary sources to obtain further details such as online information, other publications, websites, programme manuals or study protocols.

Across data extraction and coding activities, we propose to pilot the use of AI-assisted verification as a secondary check in case double extraction and double coding are not feasible within the team's capacity, following approaches described in emerging literature (Motzfeldt Jensen et al., 2025; Gartlehner et al., 2025). Specifically, following human completion of structured extraction tasks, including quantitative data extraction and practice elements coding, a large language model will then be used to independently complete the same fields, with discrepancies between human and AI output reviewed and resolved by a second human reviewer. This positions AI as a sense-check on human work rather than a primary extractor, maintaining human oversight and control throughout, which is in line with the latest methodological guidelines (RAISE, joint Cochrane/Campbell/JBI position) on responsible AI use in evidence synthesis.[7] We will conduct the piloting and calibration of AI-assisted extraction under the methodological supervision of Prof Aron Shlonsky, who brings in-depth experience integrating AI-enabled methods into evidence

(Featherstone et al., 2026); and A mixed-methods systematic review, combined with primary research what works to support reunification and its associated outcomes (Mallion et al., 2026).

[7] https://www.cochrane.org/about-us/news/setting-standards-responsible-ai-use-evidence-synthesis

synthesis workflows. For qualitative extraction and coding, given the interpretive nature of the work, we will take a more cautious approach and explore whether AI-assisted sense-checking in extraction is appropriate, with any use agreed with Foundations in advance and transparently reported.

Risk of bias assessment

Critical appraisal

The critical appraisal process is designed to systematically assess the quality, rigor, and relevance of studies included in the review, ensuring the reliability of the synthesised findings.

Critical appraisal tools

We will use established tools tailored to the study designs included in the review:

- For randomised controlled trials (RCTs), we will apply the Cochrane Risk of Bias 2 (RoB2)[8] tool, in line with Foundations implementation guidance, to evaluate domains such as randomisation processes, deviations from intended interventions, missing outcome data, measurement of outcomes, and selective reporting.
- For quasi-experimental designs (QEDs), the ROBINS-I[9] tool will be used, in line with Foundations implementation guidance, to assess risk of bias across domains including confounding, selection of participants, and outcome assessment.
- For qualitative studies, we will use the CASP Qualitative Checklist[10] to evaluate methodological rigor, trustworthiness, and transferability of information; this will assist with our scoring for GRADE CERQual finding statements.

For mixed-methods studies eligible for both strands (RQ1–3 and RQ4–5), the risk of bias tool applied to the quantitative component will be determined by study design: RoB2 for randomised components and ROBINS-I for quasi-experimental components. The qualitative component will be appraised separately using the CASP Qualitative Checklist.

Assessment of quality, rigor and relevance

In the case of RCTs and QEDs assessments, we will pilot the use of large language model (LLM) artificial intelligence tools to assist in the ROB2 and ROBINS-I assessments, respectively. Existing evidence, though mixed, indicates that LLMs can function as a complementary tool to support quality appraisal (Eisele-Metzger et al., 2025; Lai, Ge and Sun, 2024; Taneri, 2025).

[8] https://methods.cochrane.org/bias/resources/rob-2-revised-cochrane-risk-bias-tool-randomized-trials

[9] https://methods.cochrane.org/robins-i

[10] https://casp-uk.net/casp-tools-checklists/qualitative-studies-checklist/



Quantitative risk of bias instruments are prioritised for this pilot given the stronger evidence base for AI efficiency gains in this domain compared to qualitative appraisal tools. It will proceed only if pre-specified agreement thresholds are met and will revert to a fully human workflow if they are not. The piloting and calibration of AI-assisted appraisal will be conducted under the methodological supervision of Prof Aron Shlonsky.

We will use an enterprise account of Claude (Anthropic), which ensures inputs are not used to train public models and that uploaded content is not retained beyond the immediate task. We will review publisher terms for each included study to determine what level of AI support is permissible; where AI processing is prohibited, those papers will be handled through a fully human workflow.

LLM use will be strictly assistive within a human-led process, limited to structured appraisal judgements and supporting rationale, without verbatim reproduction of copyrighted text. All outputs will be reviewed by at least one human researcher, with a second consulted in cases of discrepancy, ensuring human judgement takes precedence throughout, consistent with recommendations in the literature (Eisele-Metzger et al., 2025; Fabiano et al., 2024) and with Cochrane standards and RAISE recommendations.

For the pilot, which covers only the quantitative RoB2 and ROBINS-I assessments, two human reviewers and the LLM will independently appraise a 20% sample of included studies. Independent appraisal is used at this validation stage to test whether the LLM's judgements reliably agree with human raters; the pilot is deemed successful upon reaching 80% inter-rater agreement. If this threshold is met, appraisal of the remaining studies will follow a supplementary model: one human reviewer appraises each study with the LLM's output available as a check, and a second human reviewer is consulted only to resolve discrepancies. If 80% agreement is not achieved after three calibration attempts, the pilot will be reported as unsuccessful in supplementary material and appraisal will proceed with a fully human workflow. All AI-use decisions, including prompts, outputs, and validation steps, will be reported in supplementary material, in line with PRISMA guidance and RAISE recommendations. This contingency does not affect the review timeline, as the human workflow is the default approach throughout.

In either case, a calibration exercise will be conducted within the assessment team, whereby two reviewers independently assess a sample of studies followed by discussion to align interpretations. Discrepancies will be resolved through discussion, with a third reviewer consulted, when necessary, before remaining appraisal is completed by a single reviewer.

Synthesising and reporting of appraisal findings

The results of the critical appraisal will be summarised in a risk of bias table, highlighting the strengths and limitations of each study. Studies deemed to have high risk of bias will not be excluded outright but will be flagged for sensitivity analysis to assess their impact on overall findings. Appraisal findings will inform the weighting of evidence during synthesis. Sensitivity analyses will explore the influence of excluding high-risk studies to ensure the robustness of conclusions.

For qualitative studies, where studies have significant methodological limitations according to GRADE-CERQual confidence ratings, these will not be excluded given the risk of losing contextually important evidence in an area where qualitative literature is limited.



Appraisal results will be reported in appendices of the final review, providing clear evidence of the methodological quality of included studies.

Summarising the evidence

Quantitative synthesis

In the first set of analyses, we aim to address RQ1 and examine the summary effect (i.e. estimated pooled effect size) for key outcomes of interventions aimed at preventing care entry.

Where sufficient comparable data is available, and subject to available time and resources, meta-analysis will be conducted to estimate pooled effect sizes for outcomes of interest (e.g. care entry, family functioning). Studies will be considered eligible for pooling in a meta-analysis where they report sufficiently comparable populations, interventions, comparators, and outcome constructs to allow for meaningful clinical interpretation, and where sufficient data are available (or obtainable from study authors) to calculate a common effect size. As a first step, standardised effect sizes (e.g. Hedges' g or odds ratios) will be calculated for continuous and categorical outcomes, converting as needed. This effect size will represent the impact of the evaluated intervention. Effect sizes will be labelled with respect to the outcome domain and will be grouped with dichotomous coding to pre-specified outcome groupings. As a second step, a pooled effect across all eligible effect sizes will be calculated for each key outcome.

For studies that report outcomes at multiple time points, all timepoints will be included in the synthesis. Outcome measurements will be grouped into appropriate follow-up time bands based on the distribution of the data (e.g. up to 12 months, and more than 12 months post-intervention/baseline). Only studies for which an effect size can be obtained will be included in the meta-analysis. We will contact trial authors to request information from study investigators in case of any missing summary data needed for calculating the effect size. Studies for which no effect size(s) can be calculated will be included in the review and their results described narratively.

Q-test and I^2 statistics will be used to assess the degree of heterogeneity among studies. Substantial heterogeneity will trigger further exploration of potential moderators, such as study design (RCTs versus QEDs). Sensitivity analyses will additionally be conducted to assess the robustness of pooled findings by excluding studies at high risk of bias, or those identified as key contributors to heterogeneity. The results of these sensitivity analyses will be compared against the main analysis to evaluate the extent to which these factors influence the overall conclusions.

Where sufficient studies are pooled, funnel plots and Egger's test will be employed to detect potential publication bias, ensuring the robustness of pooled estimates. GRADE (Schünemann et al., 2013) will be used to assess the confidence in cumulative evidence for any meta-analyses. A narrative synthesis will accompany meta-analytic results, summarising intervention characteristics, participant demographics, and study settings to contextualise quantitative findings.

In case statistical pooling is not possible or appropriate due to heterogeneity or insufficient data, then outcomes will be synthesised narratively. Patterns and trends in effect sizes will be explored descriptively and divergences or anomalies in findings will be analysed qualitatively to identify possible explanatory factors, such as differences in study design, population characteristics, or



intervention delivery. The analysis will be stratified by intervention type with FGDM treated as a distinct intervention category where data permits, given their growing policy prominence in the UK context.

In the second set of analyses to answer RQ2, we aim to examine which interventions are effective for different populations of children and young people at imminent risk of entering care and their parents/families. If sufficient papers are identified, we will run subgroup analyses to examine which population characteristics may moderate the effects on the primary outcome: entry into care. We propose subgroup analysis for the following moderators that are likely to be reported with sufficient consistency across the evidence base to support meaningful synthesis:

- History of statutory system involvement (child(ren) previously in care; e.g. first entry versus re-entry)
- Child age at the start of service
- Child behavioural difficulties
- Parental mental health/ psychopathology
- Substance abuse.

Following Cochrane guidance we will consider at least 10 studies per characteristic/covariate modelled as a minimum threshold, while also considering whether studies are evenly distributed across subgroup categories, since uneven distribution may render even this threshold insufficient for reliable interpretation.

In addition to potential sub-group analysis, study participant demographics and study settings will be described to contextualize quantitative findings and examined narratively for whom interventions work considering both selected PROGRESS-Plus characteristics (such as ethnic group, socioeconomic status, care-experience status of parent), and presenting needs and risk profiles (e.g. child behavioural/developmental difficulties, family violence, substance abuse), histories of statutory system involvement (e.g. prior child protection involvement, and child/young person justice involvement). We will also report on any potential adaptations recommended for different groups.

Some widely evaluated interventions, including MST and FFT, operate with specific referral and eligibility criteria, which may restrict their scalability and applicability to some families at the edge of care, particularly where needs are highly complex, co-occurring, or difficult to address safely within standard delivery models (Schrader-McMillan and Barlow, 2017; McPherson et al., 2018). We will document intervention eligibility criteria as part of our descriptive synthesis and will discuss implications for the fit between specific intervention models and local population characteristics in our findings.

It is important to note that this review is unlikely to produce representative insights on the effectiveness of interventions on explanatory parent-, family-, and child-level outcomes. This is because we only include studies that have measured and reported entry to care as an outcome. Instead, evidence on explanatory outcomes will support a more comprehensive evaluation of included interventions and help identify factors that explain heterogeneity in, or the absence of, effects on the primary outcome (Dalgaard et al., 2024). For example, a study demonstrating that an intervention reduces parental stress but does not impact the likelihood of care entry would suggest that among this high risk population, reducing parental stress alone is not sufficient to prevent care



entry. Importantly, this does not imply that interventions reducing parental stress are not important or impactful for other types of outcomes, or that stress reduction is not a possible necessary pre-requisite of reducing care entry, but that these interventions are not sufficient to impact care entry.

The synthesis process will adhere to best practices, and we will report using PRISMA-Equity. Results will be presented using appropriate tables and figures, to facilitate their understanding and interpretation.

Practice elements

We will identify and synthesise practice elements across included interventions and report these in a structured descriptive table. The table will summarise the range of practice elements identified, their frequency across studies, and their distribution within studies reporting statistically significant positive effects on at least one prioritised outcome.

The table supports comparison across intervention types and shows which practice elements appear most consistently in effective interventions. Where the data allow, the team will also use meta-regression to test whether the presence of specific practice elements is associated with larger intervention effects. This requires sufficient comparable studies sharing a practice element and measuring the same outcome (at least 10 observations per practice element) and is subject to available time and resources. Where insufficient studies preclude meta-regression, the association between practice elements and effectiveness will be examined descriptively by comparing the distribution of elements across studies with positive findings against those without, and findings will be reported with appropriate caveats about the limitations of this approach.

Qualitative synthesis

For qualitative data, the synthesis will employ a narrative synthesis approach, focusing on identifying enablers and barriers to the successful implementation of interventions. Additionally, it will explore the perceived acceptability and usefulness of interventions for users (parents, children and young people, and wider family members where relevant) and practitioners, providing contextual insights to complement the quantitative findings.

Data from qualitative studies will be synthesised using a combined framework and thematic analysis approach (Braun and Clarke, 2006), consistent with the coding process described above. Thematic analysis will be used pragmatically to identify recurring themes related to barriers, enablers, and user and practitioner perspectives on interventions, drawing on both the predefined codes from the coding framework and themes emerging inductively during analysis. The coding framework will provide the structure for organising and comparing these themes systematically across studies. Clear and coherent finding statements will be developed to capture key insights from the synthesis. The GRADE-CERQual approach (Lewin et al., 2018) will be applied to systematically assess the confidence in the qualitative evidence, considering factors such as methodological limitations, coherence, adequacy of data, and relevance.

Careful attention will be paid to the participant voice in qualitative synthesis, ensuring we stay close to the language used by participants in the included studies, and embedding reflexive team discussions throughout the review process particularly during the phase of interpreting the

findings prior to reporting. This reflexivity is intended to support transparency, minimise interpretive bias, and ensure the findings are grounded as closely as possible in the evidence and lived experiences reported in the literature.

Reporting

A comprehensive final report will be drafted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Equity extension (PRISMA-Equity) standards, including a PRISMA flow diagram and a supplementary list of excluded studies with reasons, as described in Part 2. The report will begin with an executive summary outlining the purpose, methods, key findings, limitations, and recommendations of the review. Findings will be shaped by sense-making sessions with the advisory group, ensuring that interpretation and recommendations are informed by practitioner and stakeholder knowledge.

The report will include a list of effective interventions detailing: the intervention/practice's model, target population, eligibility requirements, format, duration, and delivery requirements. This list is designed to map directly onto the information needs of the practice guide, enabling commissioners and practitioners to identify interventions that are implementable within their context

In disseminating findings, we will consider equity including who to reach and influence for the findings to address inequity and any risks in dissemination (e.g. distortion of messages) and how to mitigate these. We plan an accessible summary of findings as a first step to addressing power in dissemination of findings, and we will work with Foundations in thinking about equity in the development and implementation of the Practice Guide.

Registration

This review will be registered with the Open Science Framework (OSF).

Personnel

- **Dr Katherine Young:** Director (UK), Centre for Evidence and Implementation – Principal Investigator
- **Anne-Marie Baan:** Principal Advisor, Centre for Evidence and Implementation – Project manager and main point of contact for Foundations
- **Dr Melinda Polimeni:** Director (Australia), Centre for Evidence and Implementation – Subject matter expert advisor
- **India Thompson:** Advisor, Centre for Evidence and Implementation – Lead on Practice elements
- **Paola Castellanos:** Advisor, Centre for Evidence and Implementation – Project researcher
- **Isolt Reardon:** Senior Research Assistant, Centre for Evidence and Implementation – Project Researcher
- **Ssanyu Kayser:** Research Assistant, Centre for Evidence and Implementation – Project Researcher

- **Prof Aron Shlonsky:** Social Work department, Monash University – Methodology expert advisor.

The research team for this project brings a range of academic, professional, and personal backgrounds that shape how this review has been conceptualised and will be conducted and interpreted. The team is multi-cultural, predominantly having been brought up outside the United Kingdom which may influence how national policy and practice contexts are interpreted. The team also includes members from ethnically diverse backgrounds.

Timeline

Dates	Activity	Staff responsible/ Leading
June – October 2026	Preparation of the protocol	Young, Baan, Thompson, Reardon, Shlonsky, Polimeni
October 2026 – April 2027	Literature searches, study selection, data extraction, risk of bias assessments	Baan, Polimeni, Castellanos, Reardon & Kayser
April – May 2027	Coding of Practice Elements and Coding of Qualitative studies	Thompson, Reardon & Kayser
June – July 2027	Quantitative Synthesis	Young, Baan, Castellanos & Reardon
June – July 2027	Qualitative Synthesis	Baan, Castellanos, Reardon, Thompson & Kayser
August – October 2027	Report drafting – first draft submitted to Foundations for peer review	All contributing
September 2027	Preliminary findings presented to the advisory group	All contributing
October 2027 – January 2028	Final report revisions and submission to Foundations	All contributing

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