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Factors Influencing Mental Health Outcomes of Looked After and Accommodated Children

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BSc (Hons) Psychology, MSc in Applied Psychology for Children and Young People

Submitted in partial fulfilment of the requirements for the degree of

Doctorate in Clinical Psychology

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May 2023

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Acknowledgements

First and foremost, thank you to the participants who took the time to participate in the interviews and share their experiences. Your work is an invaluable contribution to the children you support and without your time and commitment, this thesis would not be possible.

Second, a huge thank you to my wonderful supervisors, Gary Kainth and Professor Helen Minnis. Gary, you opened my eyes to a subject I never lost interest in and helped me understand my research from different perspectives. Helen, just when I got lost in my project you were always able to guide me in the right direction and restoke my enthusiasm. Thank you.

I am so grateful to Lynn Irvine. Your knowledge, encouragement, and patience in the development of the search strategy has been invaluable and guided me through the depths of the search strategy!

Thank you to my research advisor, Dr Breda Cullen. Your insight was intrinsic in supporting me to develop a better understanding of qualitative analysis when it initially appeared very daunting.

To my family, my parents and sister. I would not be in this position without you. Your values in hard work and perseverance helped me pursue Psychology. I thank you for your kindness throughout this challenging, yet rewarding journey. To my fiancé, thank you for your patience, endless tea, and encouragement! To my best friend, thank you for your unending support and the loan of a spare laptop, just in case! I also want to thank you all for your proof reading over the years!

Chapter 1

A Systematic Review Examining Outcomes of Children Following Permanency Placements

Prepared in accordance with the author requirements for Social Sciences and Medicine;

https://www.elsevier.com/journals/social-science-and-medicine/0277-9536/guide-for-authors

Abstract

Children in care have experienced adversities, including maltreatment prior to contact with the system, negatively impacting on their mental health outcomes. The type of placement and length of time in care are thought to be important and the child welfare system aim is to achieve a permanent decision for children that best supports their needs by establishing a stable familial network. Permanency decisions can include reunification, foster care, kinship care, adoption, and residential placements. This review aims to establish to what extent *permanent placement type, maltreatment experienced, length of time in care* and *age at which permanency is achieved* impacts child mental health outcomes. Following PRISMA guidelines, five databases (ASSIA, CINAHL, PsycINFO, Scopus and SocINDEX) and two registers (CENTRAL and TRoPHI) were systematically searched yielding six articles for inclusion in the study. Data were extracted and articles critically appraised utilising the Crowe Critical Appraisal Tool (CCAT). Papers reported mixed findings for *permanent placement type* and child mental health outcomes with little or no significant overall differences reported. *Type of maltreatment experienced* moderated the type of mental health symptomology reported. Difficulties in attachment and social relationships were reported for children placed older than two years, although confounding factors such as type of maltreatment likely reduce the strength of the association. Typically, children in permanent placements had better outcomes compared with peers in short-term or unstable placements. A lack of suitable validated and age-appropriate outcome measures and the existence of confounding factors impair our understanding of the interaction between pre-care adversities, the child welfare system itself and permanent placement outcomes.

Key words: legal permanency, children, maltreatment, child welfare, adoption, kinship

Introduction

Adverse Childhood Experiences (ACEs) have been linked to poor long-term physical and mental health outcomes in both childhood and adulthood (Felitti et al., 1998). Furthermore, children experiencing maltreatment may be removed from the care of their parents, resulting in interactions with the care system. In England this is governed under the Children Act (1989) outlining key practices paramount to ensuring the child's welfare. Several countries have established a child welfare system to prevent and/or reduce further incidences of childhood maltreatment. Episodes of suspected maltreatment may be met with enhanced support for families while the child remains at home or may result in a child being removed from the care of their parents. This removal may ultimately result in reunification with the birth family (either immediate or extended family) or may result in a permanent placement elsewhere. Whilst this reduces the immediate concern for the child's welfare, care-experienced children have poorer outcomes across a range of domains including educational, cognitive and emotional functioning compared with their peers (Teyhan et al., 2018). Disentangling early life experiences and the impact of entering the care system is a research area which has gained momentum in recent years with numerous studies reporting factors including type of placement, age placed in care, type of maltreatment experienced, and placement stability can further influence outcomes of care-experienced children (Maclean et al., 2019; McGuire et al., 2018).

In Scotland between 1st August 2020 and 31st July 2021, 13,255 children were classed as "Looked After and Accommodated Children" (LAAC) by the local authority (Scottish Government, 2022). This represents 1.5% of the population under 18 who were placed in accommodation separate from their biological parents. Following an initial child welfare investigation, a permanency decision will be made resulting in multiple placement types including reunification with birth families or permanent removal to kinship care, foster

care, residential care or placed for adoption. Maclean et al. (2019) found that the type of maltreatment experienced likely contributed to the type of placement identified. For example, a decision to remove children from their biological parents would be more likely when there is a concern they may have been exposed to higher levels of childhood maltreatment (both in duration and severity) compared with children who remain in parental care. Conn et al. (2015) found stable out-of-home placements can be more beneficial to children's mental wellbeing outcomes compared with children remaining at home with biological parents (excluding children aged between three and five years). The authors noted that by measuring and adjusting for risk, the in-home and out-of-home group could be compared. Whilst risk of remaining at home was adjusted, children in the in-home group may be increasingly likely to experience some degree of adverse experiences compared with their out-of-home counterparts, negatively impacting mental health. Unfortunately, the out-of-home group consisted of both kinship carers and non-related foster carers so comparisons between those groups could not be drawn. There are several distinguishing factors reported between the groups, including an increased sense of stability (subjective permanence) for children placed in kinship care compared with non-related foster care (Biehal et al., 2015; Gaddis, 2010) which could have limited conclusions drawn in relation to the benefit of out-of-home care.

Adoption has been considered a permanent placement outcome prior to the implementation of legislation incorporating legal permanency for other available placements. For example, in Scotland, permanency orders were introduced under the Adoption and Children (Scotland) Act (2007) to widen the provision for children and young people who required permanent, stable placements who may not otherwise be placed for adoption. Adopted children have poorer outcomes when compared with their peer groups raised with biological parents and no contact with the child welfare system (Barroso et al., 2017). It is likely the range of pre-adoptive adversities adoptees can have in relation to their prior

experience of maltreatment, institutionalised care, cultural and ethnic adaptations, as well as length of time spent in care prior to adoption will influence their outcome. For example, Balenzano and colleagues (2018) found international adoptees from Romania have an increased likelihood of experiencing significant neglect within institutionalised care prior to adoption, increasing reports of behavioural challenges in adolescence compared with Chinese adoptees who reported better outcomes in relation to adjustment. This is possibly due to early experiences of attachment with the caregiver which were limited for children placed in institutionalised care. Factors including reduced time spent in care and improved environmental enrichment with adoptive family further support adjustment with adoptive family. The challenge with various adoptive studies appears to be variation in methodological practice including self-report and parent report measures and the heterogeneous nature of the study sample. Further, many adoptive families are not aware of the pre-adoption adversities often faced by the children they adopt (Lee et al., 2018). This can result in limited or missing information for data analysis, or parents may be asked to make a reasonable assumption on the child's history based on the limited information they have. Thus, conclusions drawn are often tentative across the literature base.

Due to well established links between type of maltreatment on poorer mental wellbeing outcomes and the increased risk of children remaining in-home whilst experiencing ongoing maltreatment (Carr et al., 2020; Felitti et al., 1998) several factors are considered during the decision-making process. The frequency, severity and type of maltreatment experienced often forms the basis to decision making regarding placement type (Biehal et al., 2015). McGuire et al. (2018) found severe neglect and high frequency sexual abuse were positively associated with externalised behaviours. Furthermore, Biehal et al. (2015) found externalised behaviours including delinquency were linked to an increased risk of placement breakdowns and failed reunification, conversely McGuire et al. (2018) report this did not

impact on placement stability. Methodological factors, such as measured factors (frequency and severity of maltreatment and maltreatment type) could contribute to the variability in findings across studies, as an individual incident or multiple incidents of different maltreatment types could confound the data analysis. Maclean et al. (2019) report all children who experienced maltreatment had elevated levels of mental illness with sexual abuse further elevating the reported rate of mental illness compared with other types of maltreatment. Furthermore, multiple incidents of maltreatment are often unreported, and it is likely children have experienced more than one maltreatment type prior to commencement of a child protection investigation; preventing direct comparisons from being drawn due to several confounding variables (Negriff et al., 2017). Whilst similar findings have been reported in the community, factors including sex, socioeconomic status and type of informant vary the strength of the association and type of symptomology (Cecil et al., 2017).

Finally, there is evidence suggesting the age at which a child enters the care system and the length of time in care can both impact on permanency decision making (Akin, 2011) as well as mental health outcomes (Sullivan & van Zyl, 2008). Conn et al. (2015) found children entering out-of-home care between ages three and five had poorer outcomes compared with children who remained at home. All other age ranges examined (18 months – 18 years) fared better, although the results were not statistically significant across all age ranges. It could be that this is a critical age of development, in which the attachment to the primary caregiver should only be disrupted if the risk of the child remaining at home exceeds the risk of disrupting the parent-child attachment. Prior to the analysis, Conn and colleagues (2015) removed the in-home group who were not engaging with services as their risk factors were statistically significantly higher compared to the in-home and out-of-home groups. It is likely these groups are difficult to compare due to the multiple confounding factors likely to influence the outcomes of these children.

Another factor could be levels of contact for children of this age which may mediate the link and reduce the risk of deteriorating mental health outcomes for this age range (McWey & Cui, 2021). Furthermore, the length of time in placement has been linked to increased perceived placement stability which has been associated with improved educational attainment in line with non-care experienced peers after two years (Luke & O'Higgins, 2018); although children entering the care system at a later stage did not have the same improvements as younger peers. In contrast, Sullivan and van Zyl (2008) found as the length of time in care increased the emotional needs of children between five and 12 also increased. Although, the study did not control for placement stability and the children examined had a number of placement moves the longer they remained in care. Furthermore, Perry et al, (2012) found kinship placements resulted in perceived placement stability compared with non-relation foster care, therefore, type of placement can influence the length of placement and perceived stability.

Internationally, numerous countries have introduced legislation regarding permanency placements over the past 40 years (Adoption and Safe Families Act 1997 (US); Juvenile Justice (Care and Protection of Children) Act, 2000 (India); Child Rights Act 2003 (Nigeria)). Whilst increased placement stability and consistency in caregiver have been reported to improve emotional wellbeing (Biehal et al., 2009) a number of factors including type of maltreatment experienced, type of placement and the age at which the child entered the child welfare system have been linked to variations in mental wellbeing outcomes. To date, a review examining the impact of the above factors following permanent placement decisions and mental wellbeing outcomes has not been conducted. Furthermore, this systematic review will aim to disentangle a number of contributing factors to child wellbeing outcomes to address ways in which the legislation and policies aimed at protecting this population can adapt to positively influence child wellbeing indicators.

Review Questions

This review aims to evaluate the outcomes of children following permanency placements considering *age placed in permanent placement; type of placement* (reunification with biological parents; foster care; kinship care; adoption and residential)*; type of maltreatment experienced* (physical, sexual, emotional/psychological neglect) and *length of time in care*. Adolescents (aged over 12 years) were excluded as developmental factors including an increase in risk taking behaviours (Blakemore, 2018) and increased autonomy towards peer relationships (Hajal & Rosenberg, 1991) could further confound the understanding of the above factors on mental health outcomes.

Methods

Search Strategy

Utilising the PRISMA reporting guidelines for systematic reviews (Page et al., 2021) the following databases were searched from inception to 30th September 2022: ASSIA (ProQuest), Cumulated Index to Nursing and Allied Health Literature (CINAHL), PsycINFO and SocINDEX (EBSCOhost), and Scopus (Ovid) in addition to the following registers: CENTRAL and TRoPHI (Cochrane) to identify journal articles relevant to the review question. A study protocol was registered on PROSPERO (CRD42022358286).

Search Terms

Utilising the PECO framework (participants, exposure, comparator, and outcome(s)) (Woodruff & Sutton, 2014) search terms were constructed. During initial scoping searches and in discussion with the librarian it was agreed to combine the comparator and exposure sections to expand the scope of the searches. Search terms were amended according to their database (see Appendix A for full search terms relevant to each database).

Eligibility Criteria

Inclusion

- Infants and Children (0-12) who have at any stage been removed from parental care and placed into permanent placements including: reunified with family, foster care, kinship care, adoption, or residential care as a direct result of maltreatment
- Publications must include an outcome measure or subjective outcome focusing on the wellbeing of the child
- Publications must be in English language or have an English language abstract available
- Types of maltreatment can include abuse (physical, sexual, emotional/psychological) and neglect.

Exclusion

- Case studies and case series
- Children with severe/profound learning disabilities requiring specialist placements
- No comparator group

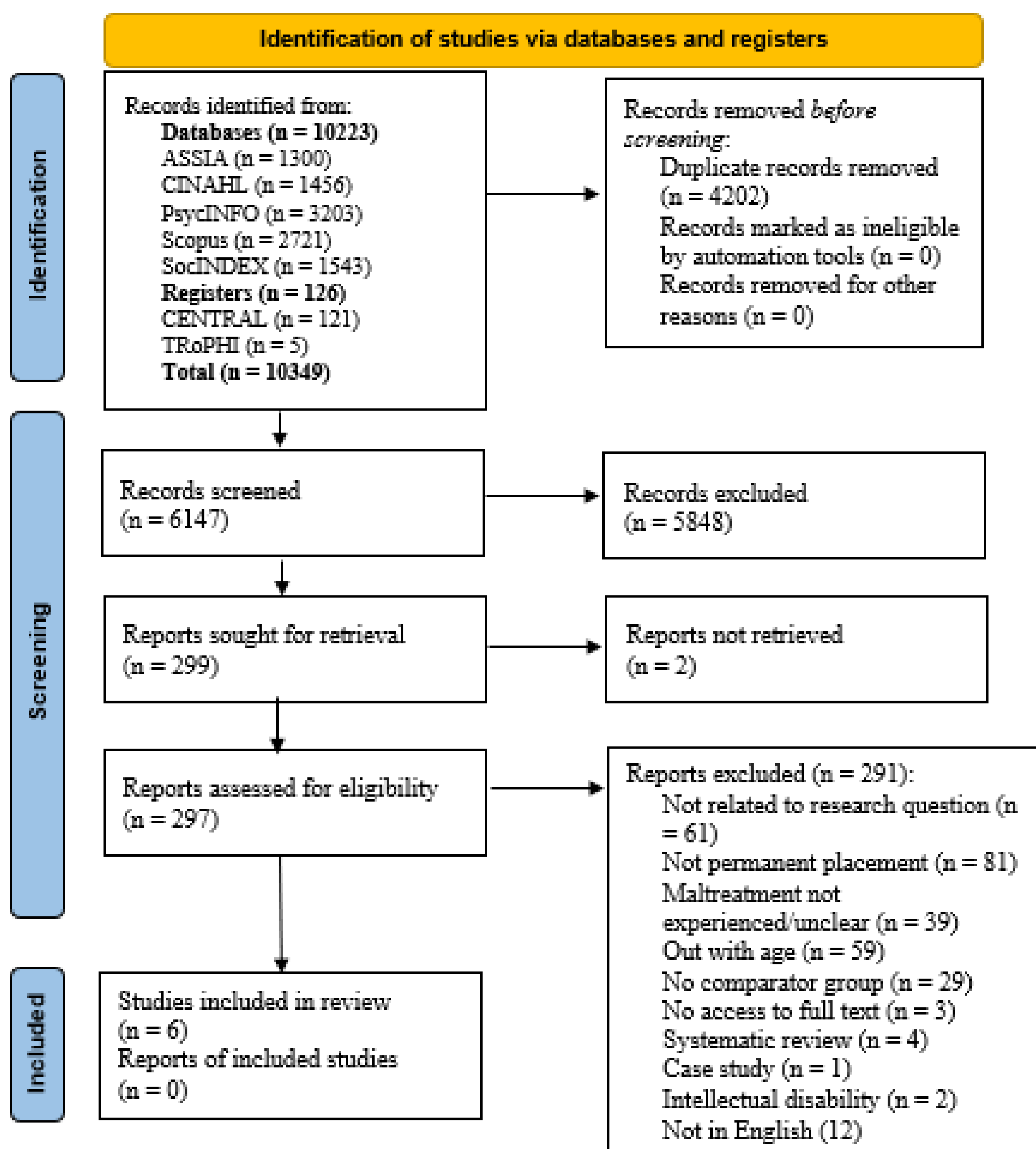
Procedure

10349 papers were identified during the electronic search across five databases, and two registers (Figure 1). Citations of the papers were imported into EndNote X9 for de-duplication and screening. Following de-duplication, 4202 articles were removed. 6147 articles were screened by the primary researcher based on title and abstract. This yielded 297 articles for full text screening (two articles could not be retrieved and were excluded at this stage). A secondary reviewer randomly selected 25% of the articles for full-text independent screening. Random selection was conducted by importing citations to Microsoft Excel and randomly generating and assigning numbers to citations. Using the sort/filter option in Excel

the citations were ordered chronologically and the top 25% of the articles were selected for screening using the eligibility criteria by the secondary reviewer. There were disagreements regarding six studies, these were excluded following discussion as they did not meet eligibility criteria. A total of six studies were deemed to meet the eligibility criteria and were therefore included in the review.

Figure 1:

PRISMA 2020 flow diagram (Page et al., 2021)



Data Extraction

Demographic data were extracted from the articles resulting in 12,897 participants across the six included studies (Table 1). The purpose of this systematic review was to identify if *age placed in permanent placement; type of placement; type of maltreatment experienced* and *length of time in care* influenced child mental health. Data extracted from the studies included any statistical analysis describing mental health outcomes as a direct result of the above factors. Data regarding residential settings were not included. All articles included in the systematic review were of original research.

Quality Appraisal

All six articles included in the systematic review were subject to quality appraisal utilising the Crowe Critical Appraisal tool (CCAT). This tool has demonstrated excellent reliability for use in critically appraising articles (Crowe et al., 2012). Due to the low number of papers included for the analysis the secondary reviewer randomly selected four of the six papers for critical appraisal (using the same random selection method as described above for full-text screening). There were discrepancies in scoring between all papers reviewed by a secondary researcher, totalling 17 disagreements across 32 domains, with a consensus reached for 50% of the domains. For the remaining 50% it was agreed that the difference for a domain should not exceed a score of 1 and the overall difference across all domains should not exceed 10%. Following discussion between the first and secondary appraiser, nine were resolved and consensus agreed. The remaining eight disagreements only differed by one point (Table 3), so the primary appraisers score was used. The percentage differences were calculated using Table 1 in the CCAT user guide (Crowe, 2013).

Results

Of the six studies identified as suitable for analysis and included in the study, five were cross-sectional studies; Villodas et al. (2016) utilised a longitudinal study design. Two

studies (Brand & Brinich, 1999; Vandivere & McKlindon, 2010) included an age range between five and 17 years. Analyses conducted for older participants were excluded from the study as per inclusion criteria detailed above. A separate analysis was conducted for participants aged between five and 11 years.

The included studies utilised a range of mental health outcome measures including the Behavioural Assessment System for Children (BASC) – Spanish version (Barcons-Castel et al., 2011), Behavioural Problem Index (BPI) (Brand & Brinich, 1999); Assessment Checklist for Children (ACC) (Tarren-Sweeney, 2008; Tarren-Sweeney & Hazell, 2006); the Youth Self-Report (YSR) (Villodas et al., 2016) and the Child Behaviour Checklist (CBCL) (Tarren-Sweeney, 2008; Tarren-Sweeney & Hazell, 2006). Vandivere and McKlindon (2010) developed a carer-informed health indictor of ratings of diagnosis (out of 16) and health status was rated as “excellent”, “good”, “fair” or “poor” (Table 2).

None of the papers reported on *length of time in care* prior to permanent placement. Only one paper (Tarren-Sweeney, 2008) reported on the other three areas of interest for the systematic review (*mental health outcome; type of maltreatment* and *age placed in permanent care*). All papers reported on *placement type* and mental health outcome. Vandivere and McKlindon, (2010) did not separate their analysis by age and *placement type*. Three studies reported on *age placed in permanent placement* and mental health outcomes (Barcons-Castel et al., 2011; Brand & Brinich, 1999; Vandivere & McKlindon, 2010) (Table 2).

Table 1:

Outline of study design and demographic information of participants

Article	Country	Design	Sample Size	Age Range	Race/Ethnicity of Sample	Gender
Barcons-Castel et al. (2011)	Spain	Cross-sectional	96	6-11 years	Asia: 51.9% (China: 25; Nepal: 2) Eastern Europe: 26.9% (Bulgaria: 2; Russia: 4; Ukraine: 8) Central and South America: 15.4% (Columbia: 1; Guatemala: 2; Haiti: 1; Peru: 4) Africa: 5.8% (Ethiopia: 3) Non-adopted control group: not reported	Internationally adopted: 52 (54.2%) Girls: 36 (62.2%) Boys: 16 (30.8%) Non-adopted control group: 44 (45.8%) Girls: 28 (63.6%) Boys: 16 (36.4%)
Brand and Brinich (1999)	United States	Cross-Sectional	9488	5-11 years and	Placement with biological parent	Placement with biological parent: Male: 51%; Female: 49%

			(5-11 years: 4934)	12-17 years (not included in current study)	White: 79%; Black: 16%; Other: 5% Adoptive placement White: 81%; Black: 11%; Other: 8% Foster Care: White: 49%; Black: 32%; Other: 19%	Adoptive placement: Male: 52%; Female: 48% Foster Care: Male: 60%; Female: 40%
Tarren-Sweeney and Hazell (2006)	Australia	Cross-sectional	547	4-11 years	Not reliably measured, therefore not reported	Boys: 276 Girls: 271
Tarren-Sweeney (2008)	Australia	Cross-sectional	347	4-11 years	Not reliably measured, therefore not reported	Boys: 176 Girls: 171

Vandivere and McKlindon (2010)	United States	Cross-sectional	2089	5-11 and 12-17 years (not included in current study)	Hispanic: 15% White, non-Hispanic: 37% Black, non-Hispanic: 23% Asian, non-Hispanic: 15% Other, non-Hispanic: 9%	Male: 49% Female: 51%
Villodas et al. (2016)	United States	Longitudinal	330	4-12 years	White: 39% Black: 39% Latino/Hispanic: 19% Asian/Other: 3%	Male: 156 (47%) Female: 174 (53%)

Table 2:

Outline of mental health outcomes and measure used, type of maltreatment experienced and age placed in permanent placement

Article	Mental Health Outcome Measure	Placement Type and Mental Health Outcome	Maltreatment experienced and Mental Health Outcome	Age Placed in Permanent Placement and Mental Health Outcome
Barcons-Castel et al. (2011)	Behavioural Assessment System for Children (BASC) – Spanish Adaptation for parents/caregivers and self-report	Overall M and SD on BASC (t-test for independent samples): Non-adopted: 47.32 (11.03) Adopted: 47.73 (12.98) Somatisation (M/SD) (*p* ≤.05): Non-adopted (higher scores): **46.61 (9.98)** Adopted: **42.42 (7.80)** Adaptability (M/SD) (*p* ≤.05):		Sig difference in attentional problems in >37 months compared with non-adopted and adopted younger than 36 months (ANOVA): ***F*(3, 91) = 4.766, *p* = .004**

		Non-adopted (higher scores): **49.36 (8.56)** Adopted: **45.29 (14.23)** No other significant scores were obtained for remaining sub-scales on BASC	
Brand and Brinich, (1999)	Dichotomous questions (not stated); Behaviour Problem Index (BPI) based on Child Behaviour Checklist (CBCL)	Multiple regression on BPI (SE) (all results, $p < .05$), compared with non-adopted children: Adopted before 6 months: **3.010/0.046 (0.912)** Adopted after 6 months: 0.856/0.008 (1.440) Foster Children: **0.622/0.062 (2.169)** F (10 df): 23.917 p-value: .000 R^2: .016 Multiple regression on BPI (SE) (Excluding influential adoptee/foster cases, $p < .05$), compared with non-adopted children:	Placed before 6 months (Mean on BPI): 9.7 Placed after 6 months (M): 7.4 Multiple regression on BPI (SE) (all results, $p < .05$) Adopted before 6 months: **3.010/0.046 (0.912)** Adopted after 6 months: 0.856/0.008 (1.440)

		Adopted before 6 months: 1.257/0.019 (0.945) Adopted after 6 months: -0.068/-0.001 (1.460) Foster Children: **6.318/0.037 (2.384)** *F* (10 *df*): 22.453 *p*-value: .000 R^2: .044 Percentage over 90th percentile on BPI (*N*): Non-adopted: 10% (5401) Adopted before 6 months: 14% (73) Adopted after 6 months: 4% (27) Foster children: 25% (16)	Multiple regression on BPI (SE) (Excluding influential adoptee/foster cases, $p < .05$) Adopted before 6 months: 1.257/0.019 (0.945) Adopted after 6 months: -0.068/-0.001 (1.460)
Tarren-Sweeney	Child Behaviour Checklist (CBCL)	Mean CBCL score - Total problems: Normative: 50.1; Foster: 61.4; Kinship: 56.2 **Foster vs kinship (Cohen's d): 0.39, *P* ≤ 0.01**	

and Hazell (2006)		CBCL clinical range percentage for total problems (*n*): Foster: 51% (*n* = 298) Kinship: 32% (*n* = 49) Statistically significant difference between kinship (lower scores) and foster care (higher scores) on all CBCL scales except somatic, anxious-depressed, and internalising scales.
	Assessment Checklist for Children (ACC)	Mean ACC total clinical score: Boys: 29.8 (SD = 22.4) Girls: 29.9 (SD = 26.3) ACC clinical range percentage for total problems: Boys: 46.6% Girls: 42.7% No reference data obtained

Tarren-Sweeney (2008)	Child Behaviour Checklist (CBCL)	CBCL (temporary vs long-term placement): Effect size (*d*): 0.74 *p* value: *0.02* CBCL (short order/restoration vs long-term placement): Effect size (*d*): 0.65 *p* value: *0.001*	Type of abuse and subscales (t-test) – **significant subscale scores reported**: Contact sexual abuse: social problems (p = 0.03) Physical abuse: anxious-depressed (p = 0.004); social problems (p = 0.005); attention problems (p = 0.01); delinquent behaviour (p = 0.03); aggressive behaviour (p = 0.002) Emotional abuse:

		anxious-depressed (p = 0.02); social problems (p = 0.001); attention problems (p = 0.03); aggressive behaviour (p = 0.002)
Assessment Checklist for Children (ACC)	ACC (temporary vs long-term placement): Effect size (*d*): 0.79 p value: *0.01* ACC (short order/restoration vs long-term placement): Effect size (*d*): 0.63 p value: *0.001*	Contact sexual abuse: sexual behaviour scale (p = 0.02) Attachment difficulties scales: pseudomature (p = 0.02); non-reciprocal (p = 0.05); indiscriminate (p = 0.02) Physical abuse:

			non-reciprocal (p = 0.05); indiscriminate (p = 0.02) Emotional abuse: non-reciprocal (p = 0.05); indiscriminate (p = 0.005); self-injury (p = 0.009)	
Vandivere and McKlindon (2010)	Social behaviour indicator (not specified) and mental health diagnosis	Percentage diagnosed with attachment disorder (logistic regression): **Adopted from foster care: 21% ($p < .05$ compared with private and international adoption)** Private domestic: 6%; International: 8% Diagnosis of ADD/ADHD: **Adopted from foster care: 38% ($p < .05$ compared with private and international adoption)**		2 months – 2 years: all categories non-significant 2-3 years: Attachment disorder: $p < .05$ 4-8 years: Problems with social behaviours: $p < .10$

		Private domestic: 19%; International: 17% (Age not separated for analysis).
Villodas et al. (2016)	Youth Self-Report (YSR)	Child report (at age 12): Externalising Problems overall model: X^2 (4) = 9.88, *p* = .04, Nagelkerke $R^2 = 0.10$ Increased odds of Externalising Problems (5.5 and 6 times greater) for children in the unstable trajectories compared with stable out-of-home, OR = 5.51, *p* = .04, 95% CI [1.06, 28.51], and stable reunified, OR = 6.28, *p* = .03 Internalizing Problems overall model: X^2 (4) = 10.68, Nagelkerke $R^2 = 0.11$

	Increased odds of Internalising Problems (6.5 and 7.5 times greater) for children in the unstable trajectories compared with stable out-of-home, OR = 6.73, *p* = .02, 95% CI [1.33, 33.98], and stable reunified, OR = 7.47, *p* = .02, 95% CI [1.48, 37.79] trajectories.
Child Behaviour Checklist (CBCL) – caregiver report	Caregiver report: increased risk at age 12 of externalising behaviours in adopted (OR = 3.67, *p* = .01, 95% CI [1.42, 9.44]); stable reunified (OR = 3.18, *p* = .02, 95% CI [1.18, 8.57], and Unstable, OR = 4.71, *p* = .004, 95% CI [1.63, 13.64], trajectories compared with out-of-home placements.

List of abbreviations: M (Mean), SD (Standard Deviation), SE (Standard Error)

Quality of Included Papers

The six included studies were reviewed utilising the Crowe Critical Appraisal Tool (CCAT). Overall, the studies included for analysis ranged between moderate (>20) and high (≤30) quality (scores ranged between 23 and 32) (Table 3). The ethical matters domain resulted in the lowest obtained scores compared with the other domains, and all six papers scored poorly. Three of the six studies obtained a score of zero (Brand & Brinich, 1999; Tarren-Sweeney & Hazell, 2006; Vandivere & McKlindon, 2010), as the papers failed to discuss patient confidentiality, data storage or informed consent. Two studies obtained a score of two (Tarren-Sweeney, 2008; Villodas et al., 2016) as they referenced information related to privacy, patient confidentiality, and funding; and was the highest score obtained in the ethical domain. All the included studies had a variation of two between domains, with the results section demonstrating the highest level of variability between papers. Tarren-Sweeney & Hazell (2006) had the lowest quality score overall. It was also noted this paper had a low word count which may have contributed to a lowered score as this is a contrast to the Tarren-Sweeney (2008) study which obtained the highest score of all six papers.

Table 3:

Quality appraisal of included studies using Crowe Critical Appraisal Tool (CCAT)

Study	Preliminaries	Introduction	Design	Sampling	Data Collection	Ethical Matters	Results	Discussion	R1 Total (n/%)	R2 Total (n/%)	Agreed Final Score
Barcons-Castel et al. (2011)	4	5*	3	4*	4	1	4	4*	29/73%	26/65%	29/73%
Brand and Brinich (1999)	4	5*	3	3	3	0	4*	5*	28/70%	24/60%	28/70%
Tarren-Sweeney and Hazell (2006)	3	3	4	3	4	0	2	4	23/58%	NA	23/58%
Tarren-Sweeney (2008)	5	4	4	4	4*	2	4	5	32/80%	31/78%	32/80%
Vandivere and McKlindon (2010)	3	5	3	4	3	0	5	3	26/65%	NA	26/65%
Villodas et al. (2016)	4	4	3	3	3	2	4*	4	27/68%	26/65%	27/68%

* Disagreements differing by 1 point

Placement Type

All included studies reported on mental health outcomes and *placement type*, however, studies varied reporting methods so could not be directly compared. Four papers reported on adoption outcomes (Barcons-Castel et al., 2011; Brand & Brinich, 1999; Vandivere & McKlindon, 2010; Villodas et al., 2016). Of the four papers measuring adoption outcomes, Vandivere and McKlindon (2010) had the lowest quality rating and report a significant difference between *placement type* (adopted from foster care; private domestic and international adoption) and child health outcomes. Those adopted from foster care had statistically higher levels of attachment difficulties and were statistically more likely to have a diagnosis of ADD/ADHD; although the age was not separated for analysis. In contrast, Villodas et al. (2016) compared six groups (adopted; kinship care; stable foster care; stable reunified; disrupted reunified; unstable foster care). Those in adopted, stable reunified and unstable groups had increased odds of 6.5-7.5 of exhibiting externalising problems at aged 12 on the parent-report measure compared with other out-of-home placements. Similar to findings by Brand and Brinich (1999). Barcons-Castel et al. (2011) did not find a significant overall difference between *placement type* and adopted and non-adopted groups and mental health outcomes. Brand and Brinich (1999) compared four groups (adopted *before* six months; adopted *after* six months; foster care and non-adopted). When adjusting the data to exclude "influential" adoptee/foster cases ("influential" cases were outliers likely influencing the regression results) there was no difference between adopted and non-adopted groups (supporting findings from Barcons-Castel et al. (2011)). When comparing the percentage of children over the 90th percentile in each group there is a small difference between adopted and non-adopted children when the influential cases remain.

Three papers reported on non-adoptive permanent placements (Tarren-Sweeney, 2008; Tarren-Sweeney & Hazell, 2006; Villodas et al., 2016). The lowest quality paper,

Tarren-Sweeney and Hazell (2006) found a statistically significant difference ($P \leq 0.01$) in mental health between the foster and kinship care groups (with kinship groups scoring lower). Further, kinship groups had a reduced risk of developing attachment ($P = 0.05$) and externalising ($P = 0.06$) problems compared with foster care; although the kinship care group had a lower population for analysis. Second, Villodas et al. (2016) reported children at age 12 in unstable trajectories were between 5.5 and 6 times more likely to exhibit externalising problems and 6.5-7.5 times more likely to exhibit internalising problems compared with stable out-of-home and stable reunified children. Finally, the highest quality paper, Tarren-Sweeney (2008), compared three placement types (short order/restoration; temporary and long-term). Children in temporary and short-order foster placements had higher attachment problem scores and poorer mental health outcomes compared with children in long-term placements.

Type of Maltreatment Experienced

Only one study reported on *type of maltreatment* and mental health outcomes (Tarren-Sweeney, 2008), despite all the studies obtained in this systematic review reporting that the non-control sample had experienced maltreatment. On the CBCL measure physical abuse ($p = 0.001$) and classic emotional abuse ($p = 0.01$) were associated with poor mental health. All types of maltreatment were correlated with statistically significant higher scores. Children who had experienced contact sexual abuse, physical abuse and emotional abuse had reported difficulties with social problems compared with children who had experienced physical abuse who also scored highly on anxious-depressed; attention problems and aggressive behaviour subscales compared with attachment subscales. Children who experienced sexual abuse scored high on all three attachment subscales (Table 2).

Age Placed in Permanent Placement

Finally, three studies reported on *age placed in permanent placement* and mental health outcomes (Barcons-Castel et al., 2011; Brand & Brinich, 1999; Vandivere & McKlindon, 2010), and each study reported variability in outcomes. First, Vandivere and McKlindon (2010), which had the lowest quality score of the three studies in this subsection, found those placed between ages two and three years were increasingly likely to report a diagnosis of attachment disorder ($p < .5$) compared with the two months – two years and four – eight years groups. Those placed between ages four and eight were more likely to report problems with social behaviours ($p < .10$) compared with the other two age groups. Secondly, Brand and Brinich (1999) found the adopted group placed *after* six months had a better mental health compared with the non-adopted group. In addition, the group placed *before* six months had a lower score compared with those placed *after* six months, however, the results were not statistically significant once adjusted to remove outliers. The highest quality paper included in this subsection, Barcons-Castel et al. (2011), found children placed between 13 and 37 months were more likely to have reported problems with attention compared with children placed before 12 months ($F(3, 91) = 4.766$, $p = .004$).

Length of Time in Care

This study had hoped to review if *length of time in care* impacted on mental health outcomes, however, this was not studied in the six papers included in the study.

Discussion

This systematic review aimed to find out if *placement type, type of maltreatment experienced, length of time in care* and *age placed in permanent care* impacted on mental health outcomes. Six studies were identified as suitable for inclusion. The studies reported mixed findings for placement type and child mental health outcomes varying between an association between increased risk of developing externalising and internalising problems at

age 12 (Villodas et al., 2016) to little or no significant overall differences reported between groups (Barcons-Castel et al., 2011; Brand & Brinich, 1999). Typically, children in permanent placements appeared to have better outcomes compared with peers in short-term or unstable placements supporting previous findings regarding improved placement stability in foster care and better mental health outcomes (McGuire et al., 2018). Study quality was moderate to high, however, few studies reported on all outcomes examined in the review placing limited weight on the findings.

The current results suggest that *placement type* influences symptom presentation differently, with less evidence indicating it has a significant impact on overall mental health outcomes. The results suggest overall that those in permanent placements are more likely to report lower scores on outcome measures compared with those who remain in short-term placements. Those in kinship placements appeared to have a reduced risk of developing attachment and externalising problems compared with non-related foster groups. Kinship groups may be best placed to support a continued link to biological parents, including a familial support network reducing disruption following removal from parental care and improve placement stability (Andersen & Fallesen, 2015). This may also indicate why children who were adopted from foster care had poorer outcomes compared with children adopted in private adoption as the demographics of this group indicated private adoptions are more likely to be carried out between family members compared with adoption from foster care (Vandivere & McKlindon, 2010). Furthermore, international adoptees may have undocumented prior adversities including experience of institutionalisation or may be less likely to have early experiences of maltreatment as cultural norms may result in unmarried mothers relinquishing care of their children to the state, rather than removal due to child welfare concerns (van IJzendoorn et al., 2020). Second, post-adoption outcomes differ from domestic and foster care adoptions in which international adoptees are expected to adapt to

different cultural expectations where their ethnicity could place them in a minority, risking cultural discrimination which can contribute to negative mental health outcomes. Positively, adoptive family characteristics with this group indicate they are often well placed to mitigate these concerns through positive open discussion and a construction of a multi-ethnic identity (van IJzendoorn et al., 2020).

An issue raised when comparing all studies was the inclusion of a mix of self-report measures and carer measures, in addition to the overall use of measures normed with a typically developing population. Further, children in care have higher instances of neurodiversity, interpersonal and relatedness difficulties which, consequently, may result in higher scores on externalising problems (e.g. inattentiveness and conduct problem) scales as identified by carer respondents but, carers may be less sensitive to internal problems (e.g. self-esteem) which are more likely to be recognised on a self-report measure. It could be that this is a result of observer subjectivity since externalising difficulties can be more easily observed (Fischer et al., 2016). It could be hypothesised many of the measures may be poorly sensitive to the needs of children in care, including an increased risk of trauma-related symptomology, such as, Post-Traumatic-Stress-Disorder (PTSD) resulting in ceiling level scores incomparable with the normed population the measures have been standardised for (Tarren-Sweeney, 2007). Furthermore, the inclusion criteria of this review included children who had experienced maltreatment prior to removal to care. There is often a lack of transparency between agencies and adoptive parents and carers and pre-care adversities are not always communicated, therefore, there is likely to be a degree of variation in parental understanding of their child's adversities prior to permanent placement (Lee et al., 2018).

Much of the population were characterised by multiple variations and potential confounding variables resulting in challenges comparing the data. Furthermore, the majority of the data included in this systematic review were secondary data with limited information

available to establish what underlying factors contributed to the variations in mental health between groups. The majority of children had reported difficulties across interpersonal relationships which possibly correspond to unstable relationships with caregivers and placement disruption. A permanent placement may mitigate the long-term impact of these difficulties on child-carer relationship through consistent and supportive care. Yet, due to the nature of the highly complex emotional and behavioural challenges and increasing risk of comorbid mental health difficulties, there is a requirement for caregivers to be better attuned and responsive to the difficulties to promote placement stability (Murray et al., 2011). McGuire et al. (2018) found an increase in frequency and severity of maltreatment are strongly correlated with placement instability, indicating a bidirectional relationship between the two. Finally, influential cases may skew results for the previously in care population. It could be that the age at which maltreatment was experienced and/or its' severity negatively impair children's mental health. Furthermore, the included studies did not separate adolescents or children with intellectual disabilities for analysis. These populations are increasingly likely to have different physical and mental health needs further confounding the understanding of the impact of maltreatment and placement type on mental health outcomes (Liao, 2016).

Children undergo significant developmental changes between the ages of zero and 12 and *age at entry into permanent placement* and mental health outcomes did appear to correlate. Overall, children placed earlier reported lower scores on the outcome measures, indicating an association between better mental health outcomes compared with children placed later. In addition, Vandivere and McKlindon (2010) found symptom differences suggesting children aged between two and three were more likely to have reported attachment difficulties indicating this might be a critical period for the development of key caregiver relationships and possibly an increased challenge of forming key caregiver

attachments which may be disrupted at this age. This supports previous research on short-term stable foster placements which found children in this bracket had increased mental health difficulties compared with those aged under three and over five years (Conn et al., 2015). It could be that factors including ongoing contact with biological families further contribute to challenges in forming a new caregiver attachment as the attachment with the foster/adoptive caregiver is regularly disrupted through contact. In addition, children aged between four and eight years were found to have reported social difficulties compared with their peers. Whilst social difficulties may be present in younger years, the typical developmental trajectory of beginning school and interacting with age-appropriate peers may highlight these difficulties in the presence of typically developing children, or children may not have had opportunities to develop social skills due to exposure to neglect or lack of suitable social stimulation. Furthermore, factors including type of maltreatment experienced were also linked to higher scores on social indices. Villodas and colleagues (2016) found the oldest children at initial removal (and therefore increasingly likely to be placed later) were also more likely to be in a proportion to have been removed due to sexual abuse which may result in the increased reports of older children reporting higher levels of social difficulties on these indices. Although, the measures utilised for data collection with the younger population have not been validated for this group.

Overall, the included papers varied considerably across methodological design (cross-sectional, retrospective, and longitudinal) and many report utilising secondary data. This was one of the contributory factors to reductions in the quality of the appraised papers, as replicability would be challenging since many papers could not report on data collection methods. There was a considerable degree of variation in the chosen quantative methods and data handling for extraneous variables and management of missing data was not addressed. Although direct comparisons cannot be drawn there is evidence to suggest *type of placement*

including variability in adoptive placements, and pre-adversities can negatively influence child mental health outcomes. Further, *types of maltreatment* influence symptomology, however, without a longitudinal investigation it is difficult to establish if a permanent placement improves mental health outcomes or children continue to exhibit increased problems with social skills, adaptability, attachment and externalised behavioural symptoms. Methods to remove influential cases were not always applied across the studies which could account for the significant differences between groups. Furthermore, methodological decisions to dichotomize data for analysis, as reported by Villodas et al. (2016) positively skewed data. By assigning a rating of 1 to a response of "excellent" and 0 to responses between "good, fair and poor", it is likely this contributed to the difference in mental health outcomes obtained between groups.

Limitations

Over 6,000 articles were obtained for title and abstract screening and while every attempt was made to ensure that all articles suitable for inclusion were included there is a risk due to the volume of articles screened some studies suitable for analysis may have been unintentionally overlooked or excluded. This was mitigated by the inclusion of a second researcher during full-text screening. Second, the search strategy was designed to capture a high number of potentially suitable papers although, despite the researcher's best efforts, this may not have captured all suitable studies due to the variability between countries and legislation in what constitutes or defines "permanency placements". Third, there are multiple factors which could be examined including experience in the care system and number of previous placements, which have been reported to influence outcomes including attachment difficulties in future placements which have not been included in the present study. Further, the included studies did not report on all the factors this study was attempting to consider. Finally, the exclusion criterion regarding "comparator group" was useful in determining

outcomes for specific populations, with considerations to the cultural backgrounds of individuals and comparisons between the same outcome measures, however, this criterion may have excluded potential studies who did not have a comparator group but did measure the other outcomes this study was interested in. Despite the limitations of this study, a strength was the inclusion of all quantitative data and outcome measures. This provided an exploratory overview of the symptomology of children in permanent placements to support the efforts to best understand how policy and the care system interact with this vulnerable population, to inform future research and outline potential recommendations for policy makers.

Implications for Research and Policy

It seems surprising permanent placements have been a legal option for children for decades, however, research on children's mental health outcomes appears limited. Recent systematic reviews by Engler and colleagues (2022) and Xu and Bright (2018) explore short term placements, placement stability (not legal permanency) and pre-adversities in these settings which could impact on a number of factors including mental, behavioural and educational outcomes. However, it would appear this is not replicated in the area of legal permanency which is why reviews of this kind are important in establishing outcomes for children in permanent placements.

Policy makers would be advised to consider a number of pre-adversities including *type of maltreatment* and *age in which a child is placed* as this has been shown to negatively impact on mental health symptomology. Further, transparent information regarding a child's maltreatment history would be beneficial in better understanding likely arising difficulties and to prevent further harm through the implementation of appropriate supports. For example, children who have experienced contact sexual abuse might benefit from social skills support and parental support to manage externalised symptoms that are increasingly likely to

occur in this population (Tarren-Sweeney, 2008). By improving transparency for parents, they might also benefit from training and support in managing children who are likely to have higher needs resulting from their pre-care adversities, as well as attachment disruption that occurs as a result of removal from biological parents and the experience of multiple care givers within the child welfare system. By withholding this information from families, it violates the rights of the child who have the right to access information about themselves.

Legal permanency typically identifies the end of state ordered care, and thus, routine outcome measures usually cease to be carried out. Future research would benefit from a longitudinal approach to exploring outcomes following the completion of child protection proceedings to identify the ongoing needs of this population, post-permanency factors that mediate the relationship between pre-adversities and integration into families/residential care and how this influences mental health outcomes (Liao, 2016). In addition, this population would benefit from validated outcome measures suitable for a population, such as the ACC, as they are more likely to experience neurodiversity and have higher levels of trauma related symptomology which may positively skew outcome measures normed with a typically developing population.

Conclusions

This systematic review highlighted the dearth of research examining permanency outcomes for children under 12. Achieving permanency is considered to be an important outcome in ensuring the child welfare system is best meeting the needs of these vulnerable children in society. However, without further exploration of both the pre-adversities and post-placement outcomes it is uncertain to what extent their mental health is impacted by their experiences and what factors are likely to moderate and mediate the relationship. What this study has shown is there is an elevated risk of mental health symptomology for children in permanency placements, although this is reportedly better compared with children in non-

stable or short-term placements. Future research would benefit from comparative groups with children, who have experienced maltreatment but who remain at home under child protection processes. However, it is acknowledged that the severity of the maltreatment may not be comparable as presumably those who are removed may be more likely to have experienced maltreatment so severe that remaining at home was deemed impossible. The lack of suitable, validated and age-appropriate outcome measures significantly impair our understanding of the interaction between pre-adversities, the child welfare system and permanent placement outcomes and future research would benefit from utilising validated measures for this population. Finally, to better inform future systematic reviews, research would benefit from clearer methodological procedures with explicit reference to pre-care adversities and the child's legal status.

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Chapter 2

A Qualitative Analysis Exploring the Impact of the English Legal System on Infant Mental Health

Prepared in accordance with the author requirements for Social Sciences and Medicine;

https://www.elsevier.com/journals/social-science-and-medicine/0277-9536/guide-for-authors

Plain Language Summary

Title

A Qualitative Analysis Exploring the Impact of the English Legal System on Infant Mental Health.

Background

The impact of child abuse and neglect on health is well researched (Felitti et al., 1998). Researchers are becoming interested in how the welfare system affects children in care, who often have poorer outcomes than the general population (H. Baldwin et al., 2019). One factor might be the legal system which oversees important aspects of the children's lives.

This study is situated within the Best Services Trial (BeST[?]) - a Randomised Controlled Trial (RCT), looking at whether the New Orleans Intervention Model (NIM) is more effective than Services-As-Usual (SAU) for infants (under five years old) in foster care.

Aims and Research Question

What are the opinions of child welfare professionals working in England regarding factors in that legal system that (a) facilitate and (b) create barriers to positive mental health outcomes for infants in care?

Methods

This study analysed nine individual interviews and focus group interviews already conducted by BeST[?]. A total of 14 participants who have

roles in the child welfare system in England took part in the study. Using reflexive thematic analysis, the transcribed interviews were analysed to generate themes related to the research question.

Main Findings

Five themes were generated. Participants reported that the legal system appeared to take parents' views into account over the views of the child, which can mean a child's voice is lost in the system. Participants raised the importance of a timescale although found this was difficult to keep to alongside the considerations of the best interests of the child and wanting to help a child to no longer experience maltreatment. Other reported factors included minimal resources and costs to the public that affects the decision to bring children into care or to return them to the care of their parents.

Conclusions

The law tries to balance the rights of the child and the parent, as well as protect the child from further risk. Professionals found that this system does not fully support the needs of the children it is trying to help and found that the "best interests of the child" and the "welfare of the child" were two different things. In order to better support children, it would be beneficial for law and policy to reflect and act according to the rights of the child first. To do this, more research asking children about their experiences would help to guide policy and law makers.

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Abstract

Numerous studies have outlined the impact of maltreatment on child health and wellbeing outcomes. Often children who have experienced maltreatment encounter safeguarding services, including social work and the legal system who take appropriate action to prevent further harm. Child protection proceedings govern all aspects of children's lives while proceedings are ongoing. This study aims to understand the impact of the English legal system on infant (under five years) mental health. A reflexive Thematic Analysis (TA) was conducted with interviews and focus groups carried out with 14 professionals involved in child safeguarding services in London, England. Four themes *(decision-making; competing professional roles; financial considerations and service issues;* and *timescales*) and a fifth overarching theme (*best interests of the child*) were generated. The rights of the parent and the child are key considerations when enacting legislation and often these conflict with what would be in the "best interests of the child". The best interests of the child are universally acknowledged, however, the interpretation of this varies considerably. The paramount role of the legal system is safeguarding the child and preventing further significant harm and balancing this with the risk of further exposure to maltreatment and the trauma of removal from biological families, whilst also ensuring fundamental human rights are upheld complicate decision-making. Current legislation and future policy would benefit from identifying and defining how best to support the needs of these children with a focus on children's rights.

Keywords: Childhood maltreatment; Child welfare system; Infant mental health; Qualitative analysis; England

Introduction

Childhood maltreatment has been linked to numerous long-term negative outcomes, including a higher risk of offending behaviour (Fitton et al., 2020), as well as physical and mental illness (Danese & Tan, 2014; Tran et al., 2017). The literature addressing Adverse Childhood Experiences (ACEs) has grown considerably since the original study observed the link between dysfunctional households and later life physical and mental illness (Felitti et al., 1998) and recent research continues to support the link between multiple ACEs and negative health outcomes (Hughes et al., 2017). Childhood maltreatment has been linked to diagnosable mental disorders in adults, including depression (Nanni et al., 2012), suicidality (Angelakis et al., 2019) and anxiety (Li et al., 2016).

Despite the bleak outcomes of numerous studies, not all outcomes for children with a background of maltreatment are negative. Meng et al. (2018) suggested some children have increased resilience due to several factors including personality, social relationships and education. However, reviews of this kind are limited due to the quality of available studies, and the contextual differences in the definition of resilience which causes difficulties when synthesising results. In addition, variabilities across methodologies and a poor understanding of the mechanisms involved influencing resilience can be problematic.

In the United States it is estimated over three quarters of children entering the child welfare system have experienced at least one form of maltreatment (Miller et al., 2011). Several factors including the type of maltreatment experienced (Fitton et al., 2020) and the accessibility of evidence-based interventions might influence the long-term mental and physical health outcomes of childhood maltreatment. Although the purpose of the care system is to protect children from the acute impact of maltreatment, the complex and idiosyncratic nature of interactions with the care system and, the potential for re-exposure to abuse either within the care system or following reunification with the biological family,

could further increase the child's vulnerability to the development of mental and/or physical health conditions (H. Baldwin et al., 2019; West et al., 2020). Unfortunately, there are significant challenges posed when attempting to disentangle the role of the care system from a history of childhood maltreatment, due to the retrospective nature of most studies or limited availability of relevant information in child and family records (J. R. Baldwin et al., 2019).

Recent figures indicate that in England between 1st April 2021 and 31st March 2022, 82,170 children were classed as "Looked After Children (LAC)" by the local authority (UK Government, 2022), representing 0.7% of the population under 18. Internationally, timescales in which a child should be residing in short-term placements vary. In England, children should be placed in a permanent placement after 26 weeks (Children and Families Act, 2014) whereas in the United States the Adoption and Safe Families Act (ASFA), 1997 states this should be within 15 months. The primary aim of the legal system is to safeguard the child whilst also adhering to Articles set out in the 1989 United Nations Convention of Human Rights (UNCHR). Children should only be separated from their family if they are at risk of abuse or neglect (Article 9, 1989 United Nations Convention on the Rights of the Child (UNCRC)). Therefore, government agencies, including child welfare systems are bound to ensure they do not violate these rights and assessing whether a child should be reunited with their birth family following removal resulting from maltreatment is paramount. Decisions of this magnitude require careful consideration as there is evidence reunified children can experience further maltreatment within two years of their return home, despite evidence parents have engaged with services and employed recommendations to ensure the safe return of their children (Biehal et al., 2015).

Often children and young people's voices are not heard in the decision-making process despite this being seen as a vital contribution to the overall process (Jones et al., 2011). Preventing the contribution of children and young people in this process when they

have capacity to engage directly violates their rights (Article 12 (parts 1 and 2) of the 1989 UNCRC and Children Act 2004). Children who report being more involved in legal proceedings related to their care have an increased understanding of the process, better informing their decision-making. Not only do children report this to be empowering and meaningful, but social workers have also reported this to be efficacious in improving the quality of decision-making (Falch-Eriksen et al., 2021).

Due to complex interactions between maltreatment and the care system, literature has begun to consider these factors in relation to child wellbeing outcomes (H. Baldwin et al., 2019). Biehal et al. (2015) found a small majority of children returned to the care of their parents were re-exposed to abuse and neglect, resulting in an unstable reunification and re-removal back into care. Failure to manage a child's risky behaviour also accounted for reunification breakdowns. Conn et al. (2015) found children who remain at home without an intervention had higher risk factors compared with those in out-of-home care. Esposito et al. (2013) report children who experience a higher risk of re-exposure to maltreatment are increasingly likely to be placed in out of home care. This could explain the differences in outcomes between groups, or indicate children removed from care were exposed to increased severity of maltreatment, raising questions regarding decision-making and the application of the law when establishing type of placements and the level of risk acceptable. The idiosyncratic nature of a child's experience and their exposure to the care and legal system aimed at safeguarding them is difficult to research, and likely explains the varying outcomes reported in populations of this kind. Further research exploring the influence of legislative procedures on child wellbeing outcomes is needed.

Context of the Study

The New Orleans Intervention Model (NIM) is a multidisciplinary approach between social workers and health care professionals in the assessment and treatment of infants (under

five years) who have been placed in out-of-home care following maltreatment. It has been successfully implemented in the United States (Minnis et al., 2010) but has not been tested as a Randomised Controlled Trial (RCT) in the UK. Therefore, the Best Services Trial (BeST?) has introduced NIM in the form of two UK teams, the London Infant and Family Team (LIFT) and the Glasgow Infant and Family Team (GIFT) to evaluate its effectiveness at improving infant mental health outcomes and cost effectiveness compared with services as usual (SAU). However, between these settings there are numerous contextual factors influencing the mechanism in which the model operates (Kainth et al., 2022). This study sits within the process evaluation of the BeST? Services Trial and explores the mechanisms and impact of the legal system to establish the factors that may influence the implementation of the trial within different legal contexts. Professional views can be a useful way to consider contextual factors which may influence the implementation of complex research designs. For example, within the BeST?,Services Trial social workers report a perception that their views are valued less compared with psychology colleagues in a court-arena (Turner-Halliday et al., 2017).

Aim and Research Question

This paper used a qualitative analysis to explore the interaction between professionals in the system and their influence on decision-making. It aimed to inform the impact the wider context child welfare legislation has on the implementation of such models and thus, the resulting impact on infant mental health. The following research question was examined from the perspective of professionals:

- What are the opinions of child welfare professionals working in England regarding factors in that legal system that (a) facilitate and (b) create barriers to positive mental health outcomes for infants in care?

Methods

Design

This study utilised a qualitative research design analysing transcripts of six individual interviews and three focus groups previously conducted with professionals involved in child welfare in England as part of the wider BeST[?] Services Trial. The research design differed from the initial proposal (Appendix C) with a study aim focusing solely on the English legal system. Therefore, nine of the proposed interviews conducted with professionals in Scotland were removed from the proposed analysis in favour of four additional interviews conducted in England (and the originally proposed five London interviews) to report on the above study aim. Data were analysed using reflexive Thematic Analysis (TA).

Participants and Sample Size

A purposive sample were recruited through contact with senior management for London solicitors and social workers in each borough. They requested two participants per team to participate in the study utilising the participant information sheet (Appendix C). Not all participants invited to participate were interviewed due to logistical issues, however, all those interviewed were included in the analysis. Those involved in NIM services were approached because of their role within the trial and interviewed as part of the process evaluation within the study. The sample was selected by stakeholders, but we have no reason to believe that they withheld information or would have been biased beyond their own implicit bias. Ensuring a range of different professionals were approached from both NIM and SAU this meant a range of professional opinions were captured.

Interviews and focus groups included in this study were conducted between October 2017 and July 2021. A total of 14 participants, who have roles within the child welfare system, were recruited from three London boroughs as part of the BeST[?] Services Trial England (Table 4).

Table 4:

Information on type of group, professionals interviewed and total number in interview

Data Collection Method	Location	Title and overview of role	Number of participants
Individual Interview	London	Judge. (NIM and SAU) Responsible for hearing evidence, establishing facts where disputed and making appropriate decisions on the long-term care of children.	1
Individual Interview	Tower Hamlets	Social Worker (SAU) Support children and families and carry out assessments, develop and implement individual care plans. Give evidence to court and provide recommendations to support long-term decisions for children.	1
Individual Interview	Barking and Dagenham	Local Authority Solicitor (NIM and SAU) Provide advice to the local authority from a legal perspective regarding legal threshold and advice regarding proposed permanency plans. Represent the local authority in child-care proceedings.	1
Individual Interview	Croydon	Local Authority Solicitor (NIM and SAU) (As above)	1

Focus Group	London	Team Managers (NIM) (Clinical Psychologist and Child and Adolescent Psychiatrist) Support the implementation of the Trial in London. Overall operational responsibility for assessments carried out within the team. Can be called as an expert witness in court proceedings.	2
Focus Group	London	Recruitment Coordinator (Social Worker – NIM and SAU) Significant experience of child-care proceedings, through work in the legal system.	2
Focus Group	Croydon	CAFCASS Workers (also known as Guardians) (NIM and SAU) Represent the child's views in court. Give independent advice to courts.	4
Individual Interview	Tower Hamlets	Senior Leader (SAU) Responsible for the strategic direction of childcare services in the borough.	1
Individual Interview	Barking and Dagenham	Senior Solicitor, Local Authority. (NIM and SAU) (As described above)	1

Materials and Measures

Interviews were semi-structured with a topic guide of relevant topics planned prior to interview (Appendix D). Topic guides differed between focus groups and individual groups due to the nature of the professional role. Legal specific interviews conducted with solicitors and judges utilised topic guides specific to the legal process and included questions asking participants to discuss their role within child protection proceedings or specific legal processes including the 26-week timescale to permanency planning. Compared with topic guides utilised in focus groups (NIM and SAU groups) and social worker interviews which focused on the process of intervention delivery. Topic guides were developed following initial focus group discussions centring on intervention delivery in which legal issues emerged as potential barriers to the promotion of positive infant mental health.

Research Procedures

Data collection has been ongoing throughout the BeST? Services Trial, and previously transcribed interviews were analysed for inclusion in the study. Participants took part in semi-structured interviews and focus groups lasting between 60 and 90 minutes. Prior to Covid-19 all interviews and focus groups were conducted in the offices of the participants. Participants were asked about their views relating to their role within the child welfare system, the implementation of the BeST? Services Trial and SAU. Interviews conducted post March 2020 were conducted remotely over Zoom or Microsoft Teams in accordance with UK Government Covid-19 legislation and recorded for transcription.

All 14 participants were interviewed once either in a focus group or individually. The individual interviews with legal practitioners were conducted separately due to logistical implications of interviewing in focus groups. Two interviews consisted of two interviewers (judge and solicitor) and three interviews (solicitor and social worker interviews) consisted of observers (two interviews were directly observed by the researcher). All interviews were

saved to a secure drive accessed by members of the research team. This file was accessed by the team administrator and transcribed. Once transcribed, the researcher transferred the file to NVivo software for coding.

Ethics, Governance and Data Protection

Informed written consent was obtained from all the participants. The consent form outlines the scope and nature of the research and has been approved by the West of Scotland Research Ethics Service (WoSRES), Committee 3 (Appendix C). The author applied to the WoSRES for permissions to access the secure server for data collection and analysis purposes following the submission of the approved proposal and confirmation to proceed to ethics (Appendix E). This was granted in January 2022 and the researcher became a member of the BeST? Services Trial research team (Appendix F).

The recordings of the interviewees taking part in the trial contained identifiable information, therefore, this information is stored on the secure server in accordance with the data protection policies of the BeST? Services Trial. Data was pseudonymised prior to analysis with data pertaining to the professional role and county of the participant remaining.

Data Analysis

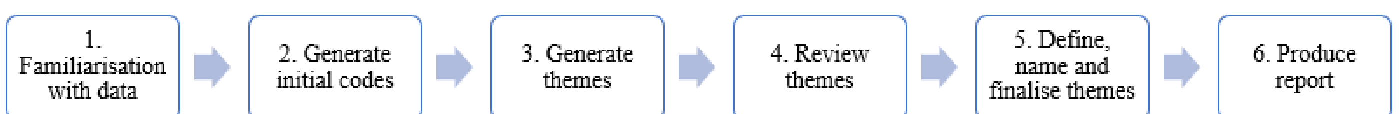
The data were analysed using reflexive Thematic Analysis (TA) (Braun & Clarke, 2006). TA can be used within differing theoretical frameworks and is ideally suited for secondary analysis of qualitative data as it allows a degree of flexibility through the exploration of data to generate codes and themes. Braun and Clarke (2021), state that regular review should be carried out throughout the analytic process to ensure consistent, high-quality data is collected throughout the analysis. As the concept of "data-saturation" does not fit within reflexive TA the researcher focused on "information power" (the utility and relevance of the sample in exploring the research question) to establish if the themes generated provided a good insight into the professional's views. Through regular discussion

between the researcher and supervisor, such as through the use of a reflexive log and regular review of generated themes and codes, this helped establish if the data were representative of a diverse opinion across and between professional disciplines with relevance to the research question.

An exploratory approach to data analysis was conducted and a critical realist stance was adopted by the researcher, a trainee Clinical Psychologist with experience working in Child and Adolescent Mental Health (CAMH) and complex trauma services in Scotland. This inductive approach placed the researcher at the heart of the data analysis with the researcher's views, values, experiences and knowledge guiding the understanding of the language and perspectives of the participants. The analytic process was exploratory with no requirement to fit the data into an existing framework; rather, to allow for a rich and broad understanding of the data. This approach acknowledges the subjectivity of the researcher. Thus, a reflective log was kept throughout data analysis as recommended by Braun and Clarke (2022) to allow the researcher to reflect on the decisions made throughout analysis and to identify any potential bias. In addition, the reflective log was utilised in two reflective supervision sessions which were conducted between the researcher and supervisor to provide an interpretative enhancement of the data as the supervisor would sensitively challenge the rationale during the analytic process, deepening reflexivity through a richer understanding of latent meaning. (see Appendix G for an example of the reflective log). Data analysis was conducted in six phases, see Figure 2.

Figure 2:

Process of Thematic Analysis



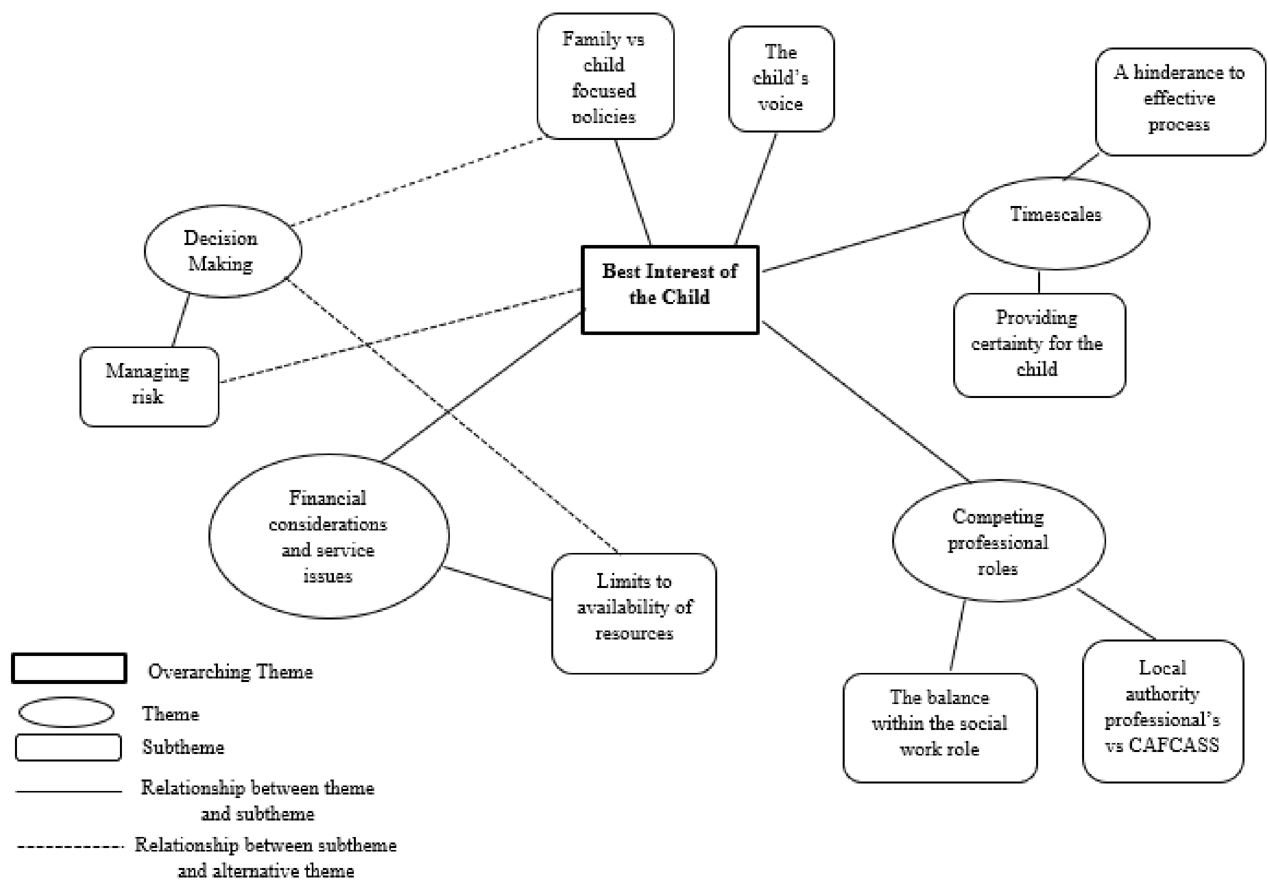
Results

The researcher generated four themes (*decision-making; competing professional roles; financial considerations and service issues;* and *timescales*) which were located under a fifth overarching theme (*best interests of the child)* based on the opinion of child welfare professionals on the impact of the legal system on infant mental health.

The thematic map generated indicates there were two standalone themes: *timescales* and *competing professional roles*. However, there was an overlap between the decision-making theme and two subthemes: *limits to availability of resources* and *family vs child focused policies.* In addition, the subtheme *managing risk* overlapped with the overarching theme *best interest of the child.* The thematic map indicates themes generated were distinct with a pattern of shared meaning among themes. However, like the complex system in which the participants referenced, some subthemes and themes were linked.

Figure 3:

Thematic Map



Theme 1: Decision Making

This theme is defined by references to decision points for the child including the rationale and justification for decision-making the consequences and those likely to be involved in the process or influence the process.

> *"so we are talking about the legal threshold, so it is all governed by the Children Act, so Children Act 1989"…"So under Section 31 have we proved or can we prove that there is emotional harm?"*
>
> Barking and Dagenham: Solicitor

The above statement refers to the role of a legal threshold to support decision-making as a whole and summarises how many of the participants implemented decision-making practices. The legal system here offers a legal underpinning to the decision-making, but there

is also a query about how to prove children are experiencing harm. This statement reflects a "black and white" view of decision-making in the context of the legal system and considers if harm has been evidenced or not. However, there were several factors contributing to complex decision-making processes, including the removal of the child as good or bad.

> "*but ultimately the goal is to get these children back with or to remain with their parents and we will do what we can*"
>
> Tower Hamlets: Team Lead, Social worker
>
> *"I am always consoled with the fact that if we've recommended that the child doesn't go home it is for the best, it is for good reason"*
>
> CAFCASS: Team Lead

It appears there is a conflict in the underlying mechanisms when considering how best to approach decision-making. There was a sense that drivers to good decision-making revolved around keeping families together and ensuring that the child returns home, and all avenues should be explored to ensure that this is done. The second statement reflected a more balanced assessment prior to decision-making which is influenced by what is "best" and the rationale to remove a child should be valid. One of the regularly referenced rationales throughout the decision-making process was risk:

> *"renewed effort lead by the president to push the cases back to local authorities and invite them to consider holding the risk" (...) "I think local authorities have worked really hard in looking at themselves and trying to hold more of the risk"*
>
> London: Judge

Holding risk was considered to be important in preventing court proceedings, influencing the system in advocating for families to remain together, and to encourage voluntary participation in the process. But overall, there is a question about this being in the

child's best interest, or the family's best interest. Further, this appears to contradict the previous statement reflecting on the legal threshold. It is likely that for a case to be taken by the local authority to the court the social worker has established a legal threshold has been met and therefore, the decision to pursue action in the court system is warranted.

Theme 2: Competing Professional Roles

Competing professional roles revolved around how professionals both viewed their role and the roles of others. It also encompassed factors within their role that might result in a shared interest or risk of conflict both within and between professional roles.

> *"highlights the tension that there is between being the social worker working for a local authority and expected to be at the same time the support, the giver of supporting service and the investigator and gatherer of evidence"*
>
> London: Judge

The above statement reflects both the competing nature and potentially conflicting responsibilities within the role of the social worker and the sense that there is a tension between the role of the social worker in both advocating for the child and advocating for the family, as well as, gathering evidence which could ultimately lead to legal proceedings.

> *"their roles, responsibility and risk aversion if you like will put them down a certain path, so, you know, you have seen in the media where social workers will be criticised very quickly if they take a certain course of action, and the course of action they take, quite rightly, is to safeguard the child and I think that can make people quite blinkered sometimes, they are not looking at all of the options"*
>
> CAFCASS: Team Lead

Many of the professionals saw their roles as acting in the "best interests of the child", although it was difficult to determine what they meant by this which could result in the

underlying tension when approaching professional roles which directly competes with the role of another. The above statement reflects the competing factors which contribute to the social workers ability to carry out their professional duty to the child, compared with CAFCASS who appear to consider themselves independent and therefore more suited to the role of supporting the child.

This tension between professionals as three participant groups (CAFCASS, social workers and solicitors) seems somewhat at odds with the pronouncement, made by all three, that they are guided by the underlying principle of the "best interests of the child" and interesting there is an apparent lack of reflection between professionals, that they are all guided by the same principle, yet, the tension persists as outlined in this statement:

> *"which is what we're there for, what's best for the child, not what's best for the parent"*
>
> Croydon: Solicitor

Theme 3: Financial Considerations and Service Issues

Individuals referenced financial considerations and primarily the negative impact this had on professional role, the system and the competing demands this brought when attempting to effectively support children and families in the child welfare system. Multi and within agency working and service level issues were discussed and formed this commonly shared theme.

> *"'I think we should drop the case', I was like 'what!', he was like…'no, I don't think we're going to…, you know you've got to think about it and money and blah blah blah"*
>
> Tower Hamlets: Social Worker

The example above reflects the constraints of the financial considerations which ultimately could prevent an otherwise correct course of action being taken for the child

involved and their family. Many of the participants reflected on the constraints of the budget and the impact of individual cases on service delivery.

> *"because of the funding that's available and what we're able to do, you know and at the moment, I just think cases rising, because generally there's a huge amount of deprivation, not only Croydon but just across the board and the support services are diminishing"*
>
> Barking and Dagenham: Senior Solicitor
>
> *"the local authority might be compromising doing that because they are managing a budget"*
>
> CAFCASS: Team Lead

Participants reflected that budget often negatively impacted on their ability to act in the best interests of the child. They reflected on the financial constraints as a barrier to best supporting children and their families and the availability of services. The statement from the CAFCASS Team Lead reflects similar concerns but appears to increase a sense of tension that service and financial issues should not impede decision-making, nor have a negative impact on supporting families. They also suggest that social workers are not putting forward suggestions as they are balancing budget considerations which perhaps impedes their judgement. It is possible this tension is born out of experience as CAFCASS staff are trained social workers and may have direct experience of the negative impact of budget on service delivery.

Theme 4: Timescales

Multiple references were made to timescales and managing schedules, competing policy and legal timescales and the impact this had throughout child welfare processes. There were considerable concerns about timescales and the influence they had on both individuals and to service delivery.

“the timescales are about meeting the needs of the children”

London: LIFT Manager, Clinical Psychologist

“I do sometimes worry that we are making decisions quite quickly as well though”

CAFCASS: Guardian Two

Interestingly, these two contradictory statements summarised the competing views held between disciplines and agencies in reference to the legally imposed timescale of 26 weeks. There was a degree of ambivalence about the usefulness of an arbitrary deadline set by the courts for decisions to be made. There was a perception the timescale allowed a sense of certainty for the child and reduced the potential for time delays to a lengthy process. In particular, social workers referenced the pressures this placed on them to complete paperwork referring to unacceptable staffing levels both within their own service and when requesting expert witness reports which increased the delay. There was a consensus between solicitors acting on behalf of the local authority and social workers that there were competing factors delaying the process:

“I was in contempt of court [...] I just didn't have the time and the time scale, you know, like for another case that I've just got, I've literally been given a week to write a final care plan, and I’m like, what am I, you know, it’s just not enough time.”

Tower Hamlets: Social Worker

“[our timescales are] probably bordering on unacceptable for the judiciary, they've said as much to us, but there's nothing we can do”

London: LIFT Manager, Clinical Psychologist

"we will be criticised if that delay is down to us and it is because we've mismanaged, and again if, you know, delays are in relation to others, but it's a combination of factors generally."

Croydon: Solicitor

All three statements reflect a lack of resources and, possibly, a lack of sympathy of the factors that potentially contribute to delays. Further, the statement above reflecting the concern that decisions were made too quickly may be a consequence of the pressure to meet timescales that appear to be impossible to meet with the resources available. There was a sense of frustration and concern regarding the legally imposed timescale of 26 weeks as the pressures in meeting this negatively impacted on staff. The reference to "unacceptable delays" appeared to relate to the courts and the impact this would have on the system.

Overarching Theme: Best Interests of the Child

Much of the reference to "best interest of the child" related to individual understanding of how their role and the system could be best placed to support the child in the legal setting. Whilst many participants referred to the child's views and needs it was often unclear what they meant by the "best interests of the child". In the first statement above from the clinical psychologist, they referenced the importance of a timescale in meeting the needs of the children. This reflected the arbitrary nature of several statements regarding the best interests of the child, as little clarification about "how" this would meet the needs of the child was referenced. Various statements referring to the "best interests of the child" permeated all the identified themes and therefore, it was felt this reflected an overarching theme as it comprised of further influencing themes which generated discussion.

As mentioned above, all participants referenced a key aim of their role was to act in the best interests of the child. However, factors including parental rights and representing the

child's views in court influenced how professionals viewed how the child's best interests were held in mind.

"I think it's easy for the child to be forgotten about, the adult's needs are so overwhelming in this system, so much need"

London: LIFT Manager, Clinical Psychologist

"'well that expert is quite pro-parent and will give every opportunity and not necessarily…umm… understand the local authority, concerns, etc'"

Croydon: Solicitor

There was a sense across the majority of participants the child's views can be lost in the court process in favour of the rights of the parent. Further, the statement from the Croydon solicitor indicates the concern expert opinions may be biased and not consider individual cases when making informed decisions, possibly siding with parents. This could be because it is often perceived the child is best placed with biological families (as referenced within the *decision-making* theme). There is a reflection the needs of families entering the child welfare system have a high level of need compared with families in the general population, possibly indicating a cyclical process between generations of families who have required additional support from services including child welfare systems. It may be that the child welfare system is therefore attempting to act to best support the needs of the family and not the child.

"trying to very inclusive of the whole family, that perhaps it not doing the job that it was set out to do around protection of the children"

London: Recruitment Coordinator, Social Worker

Levels of contact were a particular concern among social workers in preventing them acting in the best interests of children.

"I've gone into court and I've heard judges order for quite heavy, quite chaotic drug users, 5 times a week, at an hour-and-a-half."

London: Recruitment Coordinator, Social Worker

"sometimes it's the parents need to contact rather than what's best for the child, you know the parents need to have contact regardless of the quality of that contact"

Croydon: Solicitor

One Croydon solicitor appeared to contradict the concerns of the social worker, reflecting that a child's best interests are dependent on their developmental stage:

"we as lawyers might say, 'well, you know this is a new-born baby, why can't we do every day?' You know, 'we should be promoting it, especially if mother is breast feeding?"

Croydon: Solicitor

The child's views were considered a key factor in informing understanding about how professionals acted in the best interests of the child, although there were concerns their views would be lost within the system:

"the voiceless child can't really get heard in that system and that's completely understandable given the restrictions and what they're working against"

London: LIFT Manager, Clinical Psychologist

CAFCASS appeared to reflect they were best placed to ensure the voice of the child was heard in a court setting although also stated their professional opinion could directly contradict the child's wishes.

"Also children who can instruct, you know may want to return home, may want to go back to an unsafe situation, but you will have to explain to them why you are not supporting it, you don't believe it is in their best interest, but

again in our reports we do tell the court quite clearly what the child wants and sometimes why we can't support it."

CAFCASS: Team Lead

This statement reflects the general concern across all professionals the child's voice is a paramount consideration in ensuring the "best interests of the child" are supported in the legal process. This directly reflects the challenges of the multiple definitions they refer to when referencing the child's "best interests". Finally, there is a sense the role of the court arena could indicate to the child in future they were wanted by their parents and the decision to remain with them was taken out of their hands.

"for any child that's removed from their parents, you would like to think that when they come to look at their file that they can see actually my parents fought for me, my parents wanted to keep me, but for whatever reason they couldn't"

Tower Hamlets: Social Worker

There were few notable differences between the participants interviewed in the groups compared with the individual interviews. Those who were interviewed in focus groups made similar reflections compared with their colleagues interviewed separately, although those in focus groups appeared to demonstrate a stronger conviction to the salient points; as their colleagues could be heard agreeing with points and adding justification from their perspective.

Discussion

The aim of the present study was to examine utilising reflexive Thematic Analysis (TA) how the English legal system impacts infant mental health. Four themes (*decision-making; competing professional roles; financial considerations and service issues;* and

timescales) and a fifth overarching theme (*best interests of the child*) were generated from nine interviews and focus groups with 14 participants.

The first theme looked at the factors associated with decision-making. The Children Act 1989 is the legislation referenced by participants as the statutory grounding for decision-making, and multiple references were made to the threshold being met to go to court. There are two key principles in the act: “the paramount nature of the child’s welfare when a matter under the Act is before a court and that children are best looked after by their family unless intervention in family life is essential” (Foster, D., 2020, p. 3). Participants referenced both principles, which could have contributed to the conflicting decisions participants discussed throughout the interviews, such as, the conflict between the decision of returning a child home, or to permanently remove the child from their biological parents. Despite legislative updates encouraging improving safeguarding practices through enhanced communication and established roles and responsibilities between interagency working, there continues to be concerns there is too much weight placed on ensuring families remain together at all costs. Although this could be an assumption the legislation relates to the biological family. This is possibly due in part to Article 8 of the UNCHR “right to respect for private and family life”, and to “hold risk” and keep families together possibly outweighed the welfare of a child in some cases. Alternatively, holding risk may be an attempt to balance the risk of further exposure to maltreatment and the trauma of removing a child from their biological parents. Children placed in out-of-home care are more likely to have higher baseline rates of behavioural difficulties which may contribute to worse outcomes in out-of-home care (Lee & Holmes, 2021) and when controlled for children in out-of-home placements have better outcomes compared with in-home care groups (excluding the three to five year group) (Conn et al., 2015). Further, H. Baldwin and colleagues, (2019) found when confounding variables including cultural background and parental mental health were removed from analysis there

was no difference in mental health outcomes between the out-of-home and in-home groups. This indicates that keeping families together "at all costs" may be negatively impacting the mental health of the children and removing the historical view of the "nuclear family" unit may promote the application of Article 8 (UNCHR) whilst also safeguarding the child from maltreatment, promoting their wellbeing.

The second theme was around competing professional roles, creating both a degree of tension in the professionals' ability to effectively carry out their professional duties, and a crowded field that is confusing for children. Whilst all professionals agreed they were acting in the "best interests of the child", social workers and CAFCASS disagreed on who was best placed to support the child and the family. It is arguable the passing of the Children Act 2004, expanded the role of social work since it outlined provisions for increased accountability by local authority services for the effective delivery of services. This might have created additional challenges for social workers to balance their role in the safeguarding of children with family support-focused policies. CAFCASS viewed this increased social work accountability as a potential hinderance to supporting families since it results in "risk aversion". Risk aversion is further reinforced by the Children and Social Work Act 2017 which outlined recommendations to the conduct of serious case reviews. This might have reinforced the CAFCASS view that social workers will remove children from biological parents when there is *any* risk of harm and not explore avenues for family support since family focused support and preventing removal requires an increased tolerance of risk. The balance needed to uphold everyone's rights in an adversarial system could reflect this tension between professionals, as there is a sense of conflict between advocating for the child's rights when this competes with the rights of the parent. In previous research, children with lived experience have expressed a sense of dissatisfaction with the number of professionals involved, reporting that they were required to repeat their stories to multiple professionals

and were unsure of who to speak with (Mariscal et al., 2015). The tension between CAFCASS and social work likely reflects the motivation amongst professionals to support children. Unfortunately, this motivation inadvertently results in children having to navigate an already complex system causing them to feel "lost" within the system.

A concern amongst all the professionals was the impact of financial considerations and service issues hindering effective implementation of supports, or perceived implementation of appropriate supports. This seems to contradict the Children Act 1989 which specifies the welfare of the child is the paramount consideration, yet financial considerations appear to influence the application of the law in balancing child welfare with the immediate interests of the public purse. Short-term financial considerations were key factors in this theme with no reference to long-term outcomes, despite evidence that investments in early intervention and prevention are economically sensible when considering the long-term implications in reducing future service use and improving mental health (Rea & Burton, 2020). Previous research has not considered this as a factor in child protection investigations (Lauritzen et al., 2018). All interviewed professionals agreed that financial considerations impacted on service delivery, and some agreed these reduced options for the proposal of some available services.

The third theme was decision-making timescales. This was linked directly to the Children and Families Act 2014 which introduced a timescale of 26 weeks to permanency decisions within the Public Law Outline. The majority of participants agreed the timescale was important in supporting children by providing a degree of certainty and promoting timely permanency decisions. The introduction of the timescale is likely beneficial for children as it reduces the risk of high turnover in short-term foster placements whilst proceedings are ongoing which can have a detrimental impact on social and cognitive development (van Rooij et al., 2015). There was a concern amongst the professionals the court-imposed

timescale would risk rushed decision-making and prevent meaningful change for parents, although the primary focus of the participants appeared to be the acceptability of delays to the judiciary, with little reference to the impact of delays on children in the system. Mariscal et al. (2015) found children reported feeling uncertain about the future due to the length of time for permanency placement decisions and a timescale was beneficial in providing stability and assurance. Strength-based practices focusing on parental engagement in promoting change through evidence-based programmes can be achieved through collaborative relationships with professionals which can be carried out within legal timeframes (Kemp et al., 2014) and might lead to better outcomes following reunification (Biehal et al., 2015).

The permeating and overarching theme was "best interests of the child". Professionals viewed what was in the best interests of the child from different perspectives. The term is utilised interchangeably with references made to "risk and harm" and "safeguarding children" as acting in the child's best interests, referencing legislative terminology rather than considering "wellbeing" as in the "best interests of the child". One of the concerns raised was the Children Act 1989 (Schedule 2), which was considered to benefit the rights of the parents with regards to levels of contact between their children since local authorities must promote contact between each accommodated child and that child's family. Higher levels of contact are associated with shorter placements; a higher reunification rate with parents (McWey & Cui, 2021) and reduced rates of depression (McWey et al., 2010), however, factors including inconsistent contact, poor parent-child relationships and maltreatment histories can negatively impact on mental health outcomes and the formation of positive attachments with caregivers (Sen & Broadhurst, 2011). Participants raised concerns that contact is often for the benefit of the parent, possibly referencing Article 8 from the perspective of the adult and not of the child, superseding what would be in the best interest of the child (Kertesz et al., 2022). It could be the Children and Adoption Act 2006 which outlines the importance of promoting

contact caused further concerns about the impact of contact with biological parents when reunification is appearing increasingly unlikely. On the other hand, it could be regular and consistent contact is indicated as a viable option to support successful reunification and the court is satisfied this is a likely or an inevitable option for the child, which hinders permanency planning.

The Children Act 1989, Section 1(3) references the importance of the child's voice in proceedings as a paramount consideration to the child's welfare. The majority of professionals (excluding CAFCASS) agreed this was often lost, or not effectively represented in a legal context. Age was an important consideration, as CAFCASS appeared to reflect the best interest of the infant was in the care of the biological parent, despite limited research and few recommendations regarding the best interests of the infant (Gregory-Wilson et al., 2022). Typically, the earlier children are placed in adoptive or permanent placements the better their outcomes as this reduces the risk of attachment insecurity; exposure to further maltreatment, and reunification breakdowns (del Pozo de Bolger et al., 2018). Conversely, Dozier and colleagues (2001) suggest the opportunity for infants to develop secure attachments with their foster parent can support them to engage in a renewed and positive relationship with the birth parent following reunification. When considering the voice of the pre-verbal infant, video-feedback, close observation of body language and verbal indicators should be acknowledged to ensure their "voice" is heard as part of this process (McFadyen et al., 2022).

Finally, there is a risk of legislation and policy clashes when considering what is in the child's best interests in the context of the legal system. The Children Act 1989 (3), specifies the importance of partnership working with children and families in need. The role of the legal system is to act when Section 31 (ii) criteria regarding prevention from "significant harm" is fulfilled. For example, in *AL&ML v. Bristol County Court* [2006] 1 FLR 2050, the children returned to the care of their parents as the evidence to establish the

threshold for "significant harm" was not sufficiently met and while the children are likely to come to harm, this was not significant enough to breach Article 8 of the UNCHR. There is a concern parent's rights are the forefront of court proceedings and the "best interests of the child" are second. This could be due to the interchangeability of the definition as policies including "Every Child Matters" (UK Government, 2006) which references a holistic approach to child wellbeing with "safety" one of five key principals whereas the court references "welfare" and "safeguarding". It is likely children have poor reunification rates because biological parents are not equipped to manage the higher level of supports these children are more likely to require and meaningful change has not been evidenced (Biehal et al., 2015; Stovall & Dozier, 1998). This is often the challenge for the judge when balancing the rights of the child and the parent; not all children benefit from out-of-home care despite experiencing maltreatment in the home.

Limitations

First, the interview period coincided with the Covid-19 pandemic. Systemic factors were impacted, however, as some interviews were conducted prior to the pandemic it was felt this was not representative of the challenges facing professionals across the dataset. Second, professionals working within London referenced the diverse cultural background in which they work and potential cultural bias could have influenced the analysis as cultural factors may influence decision-making to a larger extent than observed. Finally, parents' solicitors have not been represented in this dataset. Despite every effort to encourage participation, those who were approached declined to participate. It could be by lacking the views of this professional group the data is skewed towards professional views more supportive of the child. Although all efforts were made to guard against researcher bias, there is always risk of this. A strength of the study was the rigorous reflective process to reduce the impact of researcher bias through reflective journaling and supervision sessions.

Implications for Policy, Practice and Future Research

Several factors should be considered in policy and practice. First, the child's voice is often lost within the system, yet advocating for their opinions to be heard in the legal context will aid professionals in their judgement to make decisions and act in the child's best interests. Understanding how best to hear children's voices in the context of a legal setting is important to ensure this is collaborative and forms part of the decision-making. Due to the idiosyncratic nature of children's experiences and age it should not always be assumed biological families are best placed to meet the child's needs: enacting Article 8 may be about considering alternative families who are better suited to meeting the needs of the child. Timely decisions to support permanency planning are important for the child to improve certainty and ensure earlier permanent placements to promote secure attachments. Delays to decision-making would be appropriate when supporting parents to engage in strength-based approaches to improve parenting and therefore promote successful reunification. However, this delay should be reasonable and focus on the child's best interest in promoting successful reunification with the biological parent and should not be over-ruled if the child has expressed a wish to remain in care. Regular, frequent contact should be based on the quality of the parent-child interaction and the consistent nature of the contact. Should the child express they do not want contact this should be considered, as it may be more harmful to continue to pursue contact against the child's wishes. Reunification failures can be detrimental to the child, they risk repeated exposure to the care system, exacerbate difficulties and increase use of services and the financial burden. Early investment in supporting children in the care system to reduce repeated exposure would be beneficial and costs should be based on literature focused on long-term outcomes for children.

Significant progress has been made in exploring the confounding variables that likely influence the outcomes of these vulnerable children. Professionals are motivated to act in the

best interests of the child but may differ in their opinion of how best to enact the legislation resulting in an overcrowding in the system. However, the research is variable when considering the care-experienced viewpoints, with limited research focusing on children's views of the system and recommendations for improvement. Research would benefit from further exploration focusing on the themes above and identifying viewpoints of children and young people to consider how best to enact how children's rights are best represented in the legal system.

One of the challenges of enacting legislative powers to safeguard children is the consideration of the long-term aims. Many of the professionals discussed the challenges of working to promote the best interest of the child, however, they often referenced this in relation to short-term outcomes of safeguarding children and preventing harm. Long-term aims related to child wellbeing may indicate the best outcomes for these children may not be remaining under the care of their biological parents, however there is a risk that by separating a family this interferes with their legal rights.

Conclusions

Representing the rights of the child and the rights of the parent appear to conflict under current legislation. This is creating tensions between professionals who each have different aims in achieving the "best interests of the child". This creates a crowded field which is confusing for the child and contributes towards delays in the system. The primary consideration should be the safety of a child, since returning a child to the care of their parents when few changes have been made to address the risk of maltreatment reoccurring is not meeting the needs of the child at present. Furthermore, research conducted in partnership with legal and social care colleagues as well as care-experienced young people will be essential to resolve these differences in aims, and to develop a shared understanding of how best to achieve the best interests of the child.

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Children and Adoption Act 2006

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Appendices

Appendix A: Full list of search terms

ASSIA:

1. MAINSUBJECT.EXACT("Foster children")
2. MAINSUBJECT.EXACT("Foster young people")
3. MAINSUBJECT.EXACT("Adopted children")
4. MAINSUBJECT.EXACT("Abused children")
5. MAINSUBJECT.EXACT("Childhood psychological abuse")
6. MAINSUBJECT.EXACT("Childhood sexual abuse")
7. MAINSUBJECT.EXACT("Childhood abuse")
8. MAINSUBJECT.EXACT("Childhood maltreatment")
9. MAINSUBJECT.EXACT("Childhood neglect")
10. ti("looked after" N/5 (child* OR "young people")) OR ab("looked after" N/5 (child* OR "young people"))
11. ti(maltreat* N/5 child*) OR ab(maltreat* N/5 child*)
12. ti(child* N/10 abuse*) OR ab(child* N/10 abuse*)
13. ti(neglect* N/5 child*) OR ab(neglect* N/5 child*)
14. ti(child* N/5 remove*) OR ab(child* N/5 remove*)
15. ti("sexual* abuse*" N/10 child*) OR ab("sexual* abuse*" N/10 child*)
16. ti("children in care" OR "foster child*" OR "foster care child*" OR "adopted child*" OR "adverse childhood experiences") OR ab("children in care" OR "foster child*" OR "foster care child*" OR "adopted child*" OR "adverse childhood experiences")
17. ti("young people" N/5 care) OR ab("young people" N/5 care)
18. 1 OR 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 OR 16 OR 17
19. MAINSUBJECT.EXACT("Foster care")
20. MAINSUBJECT.EXACT("Kinship foster care")
21. MAINSUBJECT.EXACT("Adoption")
22. MAINSUBJECT.EXACT("Residential care")
23. ti("out of home care" OR "out of home placement*" OR "foster care*" OR "placement stability" OR "kinship care" OR "residential care" OR adopt*) OR

ab("out of home care" OR "out of home placement*" OR "foster care*" OR "placement stability" OR "kinship care" OR "residential care" OR adopt*)

24. ti("out of home" NEAR/3 care) OR ab("out of home" NEAR/3 care)
25. ti("out of home" NEAR/3 placement*) OR ab("out of home" NEAR/3 placement*)
26. ti(permanen* NEAR/20 care) OR ab(permanen* NEAR/20 care)
27. ti(stab* NEAR/5 placement*) OR ab(stab* NEAR/5 placement*)
28. ti("local authority" NEAR/5 care) OR ab("local authority" NEAR/5 care)
29. 19 OR 20 OR 21 OR 22 OR 23 OR 24 OR 25 OR 26 OR 27 OR 28
30. MAINSUBJECT.EXACT("Wellbeing")
31. ti(wellbeing or well-being OR "well being" OR "mental health" OR "mental illness") OR ab(wellbeing or well-being OR "well being" OR "mental health" OR "mental illness")
32. ti((outcome* OR behavior* OR behaviour* OR impact*) NEAR/20 care) OR ab((outcome* OR behavior* OR behaviour* OR impact*) NEAR/20 care)
33. ti((emotion* OR behavior* OR behaviour*) NEAR/5 outcome*) OR ab((emotion* OR behavior* OR behaviour*) NEAR/5 outcome*)
34. 30 OR 31 OR 32 OR 33
35. 18 AND 29 AND 34

CENTRAL

1. ("LOOKED AFTER" NEAR/5 (CHILD* OR "YOUNG PEOPLE")):TI OR ("LOOKED AFTER" NEAR/5 (CHILD* OR "YOUNG PEOPLE")):AB
2. (MALTREAT* NEAR/5 CHILD*):TI OR (MALTREAT* NEAR/5 CHILD*):AB
3. (CHILD* NEAR/10 ABUSE*):TI OR (CHILD* NEAR/10 ABUSE*):AB
4. (NEGLECT* NEAR/5 CHILD*):TI OR (NEGLECT* NEAR/5 CHILD*):AB
5. (CHILD* NEAR/5 REMOVE*):TI OR (CHILD* NEAR/5 REMOVE*):AB
6. ("SEXUAL* ABUSE*" NEAR/10 CHILD*):TI OR ("SEXUAL* ABUSE*" NEAR/10 CHILD*):AB
7. ("CHILDREN IN CARE" OR "FOSTER CHILD*" OR "FOSTER CARE CHILD*" OR "ADOPTED CHILD*" OR "ADVERSE CHILDHOOD EXPERIENCES"):TI OR ("CHILDREN IN CARE" OR "FOSTER CHILD*"

OR "FOSTER CARE CHILD*" OR "ADOPTED CHILD*" OR "ADVERSE CHILDHOOD EXPERIENCES"):AB

8. ("YOUNG PEOPLE" NEAR/5 CARE):TI OR ("YOUNG PEOPLE" NEAR/5 CARE):AB
9. #1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8
10. ("OUT OF HOME CARE" OR "OUT OF HOME PLACEMENT*" OR "FOSTER CARE*" OR "PLACEMENT STABILITY" OR "KINSHIP CARE" OR "RESIDENTIAL CARE" OR ADOPT*):TI OR ("OUT OF HOME CARE" OR "OUT OF HOME PLACEMENT*" OR "FOSTER CARE*" OR "PLACEMENT STABILITY" OR "KINSHIP CARE" OR "RESIDENTIAL CARE" OR ADOPT*):AB
11. ("OUT OF HOME" NEAR/3 CARE):TI OR ("OUT OF HOME" NEAR/3 CARE):AB
12. ("OUT OF HOME" NEAR/3 PLACEMENT*):TI OR ("OUT OF HOME" NEAR/3 PLACEMENT*):AB
13. (PERMANEN* NEAR/20 CARE):TI OR (PERMANEN* NEAR/20 CARE):AB
14. (STAB* NEAR/5 PLACEMENT*):TI OR (STAB* NEAR/5 PLACEMENT*):AB
15. ("LOCAL AUTHORITY" NEAR/5 CARE):TI OR ("LOCAL AUTHORITY" NEAR/5 CARE):AB
16. #10 OR #11 OR #12 OR #13 OR #14 OR #15
17. (WELLBEING OR WELL-BEING OR "WELL BEING" OR "MENTAL HEALTH" OR "MENTAL ILLNESS"):TI OR (WELLBEING OR WELL-BEING OR "WELL BEING" OR "MENTAL HEALTH" OR "MENTAL ILLNESS"):AB
18. ((OUTCOME* OR BEHAVIO?R* OR IMPACT*) NEAR/20 CARE):TI OR ((OUTCOME* OR BEHAVIO?R* OR IMPACT*) NEAR/20 CARE):AB
19. ((EMOTION* OR BEHAVIO?R*) NEAR/5 OUTCOME*):TI OR ((EMOTION* OR BEHAVIO?R*) NEAR/5 OUTCOME*):AB
20. #17 OR #18 OR #19
21. #9 AND #16 AND #20

CINHAL:

1. (MH "Child, Foster")
2. (MH "Child, Adopted")
3. (MH "Child Abuse Survivors")
4. (MH "Adverse Childhood Experiences")
5. TI ("looked after" N5 (child* OR "young people")) OR AB ("looked after" N5 (child* OR "young people"))
6. TI maltreat* N5 child* OR AB maltreat* N5 child*
7. TI child* N10 abuse* OR AB child* N10 abuse*
8. TI neglect* N5 child* OR AB neglect* N5 child*
9. TI child* N5 remove* OR AB child* N5 remove*
10. TI "sexual abuse*" N10 child* OR AB "sexual abuse*" N10 child*
11. TI ("children in care" OR "foster child*" OR "foster care child*" OR "adopted child*" OR "adverse childhood experiences") OR AB ("children in care" OR "foster child*" OR "foster care child*" OR "adopted child*" OR "adverse childhood experiences")
12. TI "young people" N5 care OR AB "young people" N5 care
13. S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7 OR S8 OR S9 OR S10 OR S11 OR S12
14. (MH "Foster Home Care")
15. (MH "Residential Care")
16. (MH "Adoption")
17. TI ("out of home care" OR "out of home placement*" OR "foster care*" Or "placement stability" OR "kinship care" OR "residential care" OR adopt*) OR AB ("out of home care" OR "out of home placement*" OR "foster care*" Or "placement stability" OR "kinship care" OR "residential care" OR adopt*)
18. TI "out of home" N3 care OR AB "out of home" N3 care
19. TI "out of home" N3 placement* OR AB "out of home" N3 placement*
20. TI permanen* N20 care OR AB permanen* N20 care
21. TI stab* N5 placement* OR AB stab* N5 placement*
22. TI "local authority" N5 care OR AB "local authority" N5 care
23. S14 OR S15 OR S16 OR S17 OR S18 OR S19 OR S20 OR S21 OR S22
24. (MH "Psychological Well-Being")

25. (MH "Wellness")
26. TI (wellbeing or well-being OR "well being" OR "mental health" OR "mental illness") OR AB (wellbeing or well-being OR "well being" OR "mental health" OR "mental illness")
27. TI ((outcome* OR behavio#r* OR impact*) N20 care) OR AB ((outcome* OR behavio#r* OR impact*) N20 care)
28. TI ((emotion* OR behavio#r*) N5 outcome*) OR AB ((emotion* OR behavio#r*) N5 outcome*)
29. S24 OR S25 OR S26 OR S27 OR S28
30. S13 AND S23 AND S29

PsycINFO: Developed using focused terms for population and exposure and expanded terms for outcome (PsycINFO has a greater spread of terms for wellbeing and behavioural, emotional problems).

1. DE "Foster Children"
2. DE "Adopted Children"
3. DE "Childhood Adversity"
4. TI ("looked after" N5 (child* OR "young people")) OR AB ("looked after" N5 (child* OR "young people"))
5. TI maltreat* N5 child* OR AB maltreat* N5 child*
6. TI child* N10 abuse* OR AB child* N10 abuse*
7. TI neglect* N5 child* OR AB neglect* N5 child*
8. TI child* N5 remove* OR AB child* N5 remove*
9. TI "sexual abuse*" N10 child* OR AB "sexual abuse*" N10 child*
10. TI ("children in care" OR "foster child*" OR "foster care child*" OR "adopted child*" OR "adverse childhood experiences") OR AB ("children in care" OR "foster child*" OR "foster care child*" OR "adopted child*" OR "adverse childhood experiences")
11. TI "young people" N5 care OR AB "young people" N5 care
12. S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7 OR S8 OR S9 OR S10 OR S11
13. DE "Foster Care"
14. DE "Residential Care Institutions"
15. DE "Adoption (Child)"

16. TI ("out of home care" OR "out of home placement*" OR "foster care*" Or "placement stability" OR "kinship care" OR "residential care" OR adopt*) OR AB ("out of home care" OR "out of home placement*" OR "foster care*" Or "placement stability" OR "kinship care" OR "residential care" OR adopt*)
17. TI "out of home" N3 care OR AB "out of home" N3 care
18. TI "out of home" N3 placement* OR AB "out of home" N3 placement*
19. TI permanen* N20 care OR AB permanen* N20 care
20. TI stab* N5 placement* OR AB stab* N5 placement*
21. TI "local authority" N5 care AND AB "local authority" N5 care
22. S13 OR S14 OR S15 OR S16 OR S17 OR S18 OR S19 OR S20 OR S21
23. DE "Well Being"
24. DE "Subjective Well Being"
25. DE "Child Health"
26. DE "Behavior Problems"
27. DE "Emotional Disturbances"
28. TI (wellbeing or well-being OR "well being" OR "mental health" OR "mental illness") OR AB (wellbeing or well-being OR "well being" OR "mental health" OR "mental illness")
29. TI ((outcome* OR behavio#r* OR impact*) N20 care) OR AB ((outcome* OR behavio#r* OR impact*) N20 care)
30. TI ((Emotion* OR behavio#r*) N5 (outcome* OR problem* OR disturbance*)) OR AB ((Emotion* OR behavio#r*) N5 (outcome* OR problem* OR disturbance*))
31. S23 OR S24 OR S25 OR S26 OR S27 OR S28 OR S29 OR S30
32. S12 AND S22 AND S31

SocINDEX: Developed using focussed terms for population/exposure with existing terms for outcome. Added relevant thesaurus terms specific to SocINDEX.

1. DE "FOSTER children"
2. DE "ADOPTED children”
3. DE "ABUSED children"
4. DE "ADVERSE childhood experiences"
5. DE "ABANDONED children"

6. DE "SEXUALLY abused children"
7. TI ("looked after" N5 (child* OR "young people")) OR AB ("looked after" N5 (child* OR "young people"))
8. TI maltreat* N5 child* OR AB maltreat* N5 child*
9. TI child* N10 abuse* OR AB child* N10 abuse*
10. TI neglect* N5 child* OR AB neglect* N5 child*
11. TI child* N5 remove* OR AB child* N5 remove*
12. TI "sexual abuse*" N10 child* OR AB "sexual abuse*" N10 child*
13. TI ("children in care" OR "foster child*" OR "foster care child*" OR "adopted child*" OR "adverse childhood experiences") OR AB ("children in care" OR "foster child*" OR "foster care child*" OR "adopted child*" OR "adverse childhood experiences")
14. TI "young people" N5 care OR AB "young people" N5 care
15. S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7 OR S8 OR S9 OR S10 OR S11 OR S12 OR S13 OR S14
16. DE "FOSTER home care"
17. DE "INSTITUTIONAL care of children"
18. DE "ADOPTION"
19. DE "KINSHIP care"
20. TI ("out of home care" OR "out of home placement*" OR "foster care*" Or "placement stability" OR "kinship care" OR "residential care" OR adopt*) OR AB (("out of home care" OR "out of home placement*" OR "foster care*" Or "placement stability" OR "kinship care" OR "residential care" OR adopt*)
21. TI "out of home" N3 care OR AB "out of home" N3 care
22. TI "out of home" N3 placement* OR AB "out of home" N3 placement*
23. TI permanen* N20 care OR AB permanen* N20 care
24. TI stab* N5 placement* OR AB stab* N5 placement*
25. TI "local authority" N5 care OR AB "local authority" N5 care
26. S16 OR S17 OR S18 OR S19 OR S20 OR S21 OR S22 OR S23 OR S24 OR S25
27. DE "WELL-being"
28. DE "PSYCHOLOGICAL well-being"
29. DE "HEALTH"

30. TI (wellbeing or well-being OR "well being" OR "mental health" OR "mental illness") OR AB (wellbeing or well-being OR "well being" OR "mental health" OR "mental illness")
31. TI ((outcome* OR behavio#r* OR impact*) N20 care) OR AB ((outcome* OR behavio#r* OR impact*) N20 care)
32. TI ((emotion* OR behavio#r*) N5 outcome*) OR AB ((emotion* OR behavio#r*) N5 outcome*)
33. S27 OR S28 OR S29 OR S30 OR S31 OR S32
34. S15 AND S26 AND S33

Scopus: Developed using index terms from searches on CINAHL, PsycINFO, ASSIA and SocINDEX and keyword searches.

1. INDEXTERMS ("foster children")
2. INDEXTERMS ("adopted children")
3. INDEXTERMS ("adverse childhood experiences")
4. INDEXTERMS ("abandoned children")
5. INDEXTERMS ("childhood adversity")
6. INDEXTERMS ("childhood sexual abuse")
7. INDEXTERMS ("childhood abuse")
8. INDEXTERMS ("childhood maltreatment")
9. INDEXTERMS ("childhood neglect")
10. (TITLE ("looked after" W/5 (child* OR "young people")) OR ABS ("looked after" W/5 (child* OR "young people")))
11. (TITLE (maltreat* W/5 child*) OR ABS (maltreat* W/5 child*))
12. (TITLE (child* W/10 abuse*) OR ABS (child* W/10 abuse*))
13. (TITLE (neglect* W/5 child*) OR ABS (neglect* W/5 child*))
14. (TITLE (child* W/5 remove*) OR ABS (child* W/5 remove*))
15. (TITLE ("sexual* abuse*" W/10 child*) OR ABS ("sexual* abuse*" W/10 child*))
16. (TITLE ("children in care" OR "foster child*" OR "foster care child*" OR "adopted child*" OR "adverse childhood experiences") OR ABS ("children in care" OR "foster child*" OR "foster care child*" OR "adopted child*" OR "adverse childhood experiences"))

17. (TITLE ("young people" W/5 care) OR ABS ("young people" W/5 care))
18. 1 OR 2 OR 2 OR 4 OR 5 OR 6 OR 7 OR 8 OR 9 OR 10 OR 11 OR 12 OR 13 OR 14 OR 15 OR 16 OR 17
19. INDEXTERMS ("foster home care")
20. INDEXTERMS (adoption)
21. INDEXTERMS ("kinship care")
22. INDEXTERMS ("foster care")
23. INDEXTERMS ("kinship foster care")
24. INDEXTERMS ("residential care")
25. (TITLE ("out of home care" OR "out of home placement*" OR "foster care*" OR "placement stability" OR "kinship care" OR "residential care" OR adoption) OR ABS ("out of home care" OR "out of home placement*" OR "foster care*" OR "placement stability" OR "kinship care" OR "residential care" OR adoption))
26. (TITLE ("out of home" W/3 care) OR ABS ("out of home" W/3 care))
27. (TITLE ("out of home" W/3 placement*) OR ABS ("out of home" W/3 placement*))
28. (TITLE (permanen* W/20 care)OR ABS (permanen* W/20 care))
29. (TITLE (stab* W/5 placement*) OR ABS (stab* W/5 placement*))
30. (TITLE ("local authority" W/5 care) OR ABS ("local authority" W/5 care))
31. 19 OR 20 OR 21 OR 22 OR 23 OR 24 OR 25 OR 26 OR 27 OR 28 OR 29 OR 30
32. INDEXTERMS ("psychological well being")
33. INDEXTERMS (wellness)
34. INDEXTERMS (well AND being)
35. INDEXTERMS ("subjective well being")
36. INDEXTERMS ("child health")
37. INDEXTERMS ("behavior problems")
38. INDEXTERMS ("emotional disturbances")
39. INDEXTERMS (wellbeing)
40. INDEXTERMS ("well being")
41. (TITLE (wellbeing OR well-being OR "well being" OR "mental health" OR "mental illness") OR ABS (wellbeing OR well-being OR "well being" OR "mental health" OR "mental illness"))

42. (TITLE ((outcome* OR behavio#r* OR impact*) W/20 care) OR ABS ((outcome* OR behavio#r* OR impact*) W/20 care))
43. (TITLE ((emotion* OR behavio#r*) W/5 outcome*) OR ABS ((emotion* OR behavio#r*) W/5 outcome*))
44. INDEXTERMS (health)
45. 32 OR 33 OR 34 OR 35 OR 36 OR 37 OR 38 OR 39 OR 40 OR 41 OR 42 OR 43 OR 44
46. S18 AND S31 AND S45

TRoPHI: Developed using index terms from searches on CINAHL, PsycINFO, ASSIA and SocINDEX and keyword searches.

1. Freetext (All but Authors): "looked after" NEAR "child*" OR "young people"
2. Freetext (All but Authors): "maltreat*" NEAR "child*"
3. Freetext (All but Authors): "child*" NEAR "abuse*"
4. Freetext (All but Authors): "neglect*" NEAR "child*"
5. Freetext (All but Authors): "child*" NEAR "remove*"
6. Freetext (All but Authors): "sexual* abuse*" NEAR "child*"
7. Freetext (All but Authors): "children in care" OR "foster child*"
8. Freetext (All but Authors): "young people" NEAR “care”
9. Focus of the report: child neglect OR emotional abuse OR physical abuse OR sexual abuse
10. 1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7 OR 8 OR 9
11. Freetext (All but Authors): "out of home care"
12. Freetext (All but Authors): "foster care*"
13. Freetext (All but Authors): "placement stability"
14. Freetext (All but Authors): "residential care"
15. Freetext (All but Authors): adoption
16. Freetext (All but Authors): "out of home" NEAR care
17. Freetext (All but Authors): "local authority" NEAR care
18. 11 OR 12 OR 13 OR 14 OR 15 OR 16 OR 17
19. Freetext (All but Authors): wellbeing OR "well-being" OR "well being"
20. Freetext (All but Authors): "mental health" OR "mental illness"

21. Freetext (All but Authors): "outcome*" OR "behavio*" OR "impact*" NEAR care
22. Freetext (All but Authors): "emotion*" OR "behavio*" NEAR "outcome*"
23. Focus of the report: mental health
24. 19 OR 20 OR 21 OR 22 OR 23
25. 10 AND 18 AND 24

Appendix B: Reporting Checklist (PRISMA)

		Reporting Item	Page Number
Title			
Title	1	Identify the report as a systematic review	7
Abstract			
Abstract	2	Report an abstract addressing each item in the PRISMA 2020 for Abstracts checklist	8
Introduction			
Background/rationale	3	Describe the rationale for the review in the context of existing knowledge	9-13
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses	14
Methods			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses	15
Information sources	6	Specify all databases, registers, websites, organisations, reference lists, and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted	14
Search strategy	7	Present the full search strategies for all databases, registers, and websites, including any filters and limits used	89-99
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and, if applicable, details of automation tools used in the process	15-16
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or	15-16

		confirming data from study investigators, and, if applicable, details of automation tools used in the process	
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (for example, for all measures, time points, analyses), and, if not, the methods used to decide which results to collect	19-30
Data items	10b	List and define all other variables for which data were sought (such as participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information	19-21
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and, if applicable, details of automation tools used in the process	17, 31-32
Effect measures	12	Specify for each outcome the effect measure(s) (such as risk ratio, mean difference) used in the synthesis or presentation of results	22-30
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (such as tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5))	19-30
Synthesis methods	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics or data conversions	17
Synthesis methods	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses	17
Synthesis methods	13d	Describe any methods used to synthesise results and provide a rationale for the choice(s). If meta-analysis was performed, describe the	17

		model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used	
Synthesis methods	13e	Describe any methods used to explore possible causes of heterogeneity among study results (such as subgroup analysis, meta-regression)	17
Synthesis methods	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesised results	NA
Reporting bias assessment	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases)	31-32
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome	31-32
Results			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram (http://www.prisma-statement.org/PRISMAStatement/FlowDiagram)	14 and 16
Study selection	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded	NA
Study characteristics	17	Cite each included study and present its characteristics	19-21
Risk of bias in studies	18	Present assessments of risk of bias for each included study	31-32
Results of individual studies	19	For all outcomes, present for each study (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (such as confidence/credible interval), ideally using structured tables or plots	19-30
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies	31-32

Results of syntheses	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (such as confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect	22-30
Results of syntheses	20c	Present results of all investigations of possible causes of heterogeneity among study results	23 and 33
Results of syntheses	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesised results	NA
Risk of reporting biases in syntheses	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed	NA
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed	35-36
Discussion			
Results in context	23a	Provide a general interpretation of the results in the context of other evidence	35-40
Limitations of included studies	23b	Discuss any limitations of the evidence included in the review	35-40
Limitations of the review methods	23c	Discuss any limitations of the review processes used	40-41
Implications	23d	Discuss implications of the results for practice, policy, and future research	41-43
Other information			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered	14
Registration and protocol	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared	14

Registration and protocol	24c	Describe and explain any amendments to information provided at registration or in the protocol	NA
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review	NA
Competing interests	26	Declare any competing interests of review authors	NA
Availability of data, code, and other materials	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review	14-35

Appendix C: Final Approved MRP Proposal [Online]

https://osf.io/ytsvj

Appendix D: Topic Guides

Generic Interview Schedule re LAC and legal process

Be guided by the participant and probe to get as much info re the process as possible

Aim: to be able to describe the process in detail.

1. Please outline your job and your day to day role?
    a. **Prompt:** Specifically re children.

2. Please describe the process that's followed for a child from the point they become known, through to being brought into care to the end point- whatever that may be. **Prompts** (what meetings are done, Set points in the process, Timescales)

3. Has this process changed in the time since you've been social worker/ lawyer etc?
    a. If yes, can you describe the changes?

4. Is it likely to change again in the future?
    a. If yes, how and why?

5. Is there anything external that affects the process? (i.e. how does the wider system impact on CM?)

6. Please describe the legal process?

7. Are there particular challenges within this process? (**prompt:** social work **and** legal)
8. Are there any parts that run smoothly?

Probe re types of children (i.e. are there any particular strengths or vulnerabilities that contriubute to any of the issues raised)

BeST? Q's

9. Have you had any dealings with the BeST? Trial?
    a. Please expand?
10. Do you have any views about how the trial is operating in [**name local authority]**? (**prompt**: implication for foster care)
11. Do you have any views about LIFT?

Legal interview schedule- Local authority Social Workers in London Boroughs

We are conducting these research interviews with Social work practitioners in order to better understand and illuminate the process for children taken into care in London – this work is part of the BeST? services trial and forms a key stage of the qualitative work we are doing with the various groups involved in, and affected by, the trial.

The research will also form part of a wider enquiry into the impact of the legal system on the mental health of children who are looked after and accommodated.

As the social workers, we would like to understand how you might use your expertise within the system at the various stages of a looked after child's journey.

All the data will be anonymised. Thank you for consenting to have this interview recorded. It may be that we ask you to expand on certain topics- we are approaching this as researchers, not as practitioners in the field so some explanation of some of the themes may be important.

Knowledge and role

1) Can you tell me a bit about your role? A) Generally; B) in relation to children removed from their parents in your borough C) How much of your time is spent in this type of work? (prompt: which parts of the process are you involved in?)

2) Can I just firstly start of by asking you what you know about the BeST? services trial?

3) Have you had any involvement with LIFT? (brief & general explanation if needed – being aware of not prejudicing any opinions)

Parts of the process: but be guided by responses to the last section.

4) Pre Proceedings work. Can you tell me about your role here?

5) What is your role in accommodating a child (i.e. legal and social work process up to children coming into care)

6) Once a child has been accommodated- what is your role. Can you talk me through the process?

7) What is your role in permanence decisions/recommendations? (prompt: permanence recommendations by social work Vs work in adoption orders Vs work in other types of order- what are these?)

8) What is your role in the legal processes around permanence or rehabilitation?

Specific issues if they do not come up before

9) Can you tell me about the rights of parents and children when children become accommodated by the local authority? (probe: is there a clash? Is one given more weight than the other?)

10) Can you tell me about Timescales? How long do things take to happen? Why is this the case? Do you think this has any bearing on the outcomes for a child?

11) Can you tell me about relationships with the following:

    a. LA lawyers
    b. Family solicitors
    c. solicitors for adoptive families
    d. Judges
    e. CAFCAS
    f. Independents (differentiate between SW and other professions)
    g. families themselves
    h. Looked After Children

12) Can you tell me about family contact? What are the main issues around family contact? What is your role in discussions around family contact? What informs your input? How the issue of family contact viewed by the courts?

13) What are the various permanence outcomes- why would you opt for one over the other?

14) Can you tell me about social work assessments? What weight do you attach to those assessments? How are they viewed in court?

15) How do you view LIFT assessments? What weight do you think the courts attach to them?
    a. Prompt: how do courts view each profession?

16) What are your views with regard to kinship care and how it relates to permanence?

17) Do you have any views with regard to placement stability?

18) What do you think are the aims of the system? What is the system trying to achieve? What is the optimum end point? How well do you think it does this?

What are you trying to achieve? Why? What are the main successes of the legal system and the main deficits? (prompt: blockages? Conflicts?)

Legal interview schedule- Local authority solicitors in London Boroughs

We are conducting these research interviews with experts in the legal profession in order to better understand and illuminate the process for children taken into care in London – this work is part of the BeST? services trial and forms a key stage of the qualitative work we are doing with the various groups involved in, and affected by, the trial.

The research will also form part of a wider enquiry into the impact of the legal system on the mental health of children who are looked after and accommodated.

As the solicitors representing the local authority, we would like to understand how you might use your expertise within the system at the various stages of a looked after child's journey.

All the data will be anonymised. Thank you for consenting to have this interview recorded. It may be that we ask you to expand on certain topics- we are approaching this as researchers, not as practitioners in the field so some explanation of some of the themes may be important.

Knowledge and role

1) Can you tell me a bit about your role? A) Generally; B) in relation to children removed from their parents in your borough C) How much of your time is spent in this type of work? (prompt: which parts of the process are you involved in?)

2) Can I just firstly start of by asking you what you know about the BeST? services trial?

3) Have you had any involvement with LIFT? (brief & general explanation if needed – being aware of not prejudicing any opinions)

Parts of the process: but be guided by responses to the last section.

4) Pre Proceedings work. Can you tell me about your role here? What advice do you offer social workers?

5) What is your role in accommodating a child (i.e. legal process up to children coming into care)

6) Once a child has been accommodated- what is your role. Can you talk me through the process?

7) What is your role in permanence decisions/recommendations? (prompt: permanence recommendations by social work Vs work in adoption orders Vs work in other types of order- what are these?)

8) What is your role in the legal processes around accommodation or rehabilitation?

9) Can you tell me about your role in providing general advice to social workers? What kinds of issues come up? Is this part of your role?

Specific issues if they do not come up before

10) Can you tell me about the rights of parents and children when children become accommodated by the local authority? (probe: is there a clash? Is one given more weight than the other?)

11) Can you tell me about Timescales? How long do things take to happen? Why is this the case? Do you think this has any bearing on the outcomes for a child?

12) Can you tell me about relationships with the following:

    a. Social Workers
    b. Family solicitors
    c. solicitors for adoptive families
    d. Judges
    e. CAFCAS
    f. Independents (differentiate between SW and other professions)
    g. families themselves
    h. Looked After and Accommodated children

13) Can you tell me about family contact? What are the main issues around family contact? What is your role in discussions around family contact? What informs your input? How the issue of family contact viewed by the court viewed by the courts?

14) What are the various permanence outcomes- why would you opt for one over the other?

15) Can you tell me about social work assessments? What weight do you attach to those assessments? Are they useful from a legal point of view?

16) How do you view LIFT assessments? What weight do you think the courts attach to them?
    a. Prompt: how do courts view each profession?

17) What are your views with regard to kinship care and how it relates to permanence?

18) Do you have any views with regard to placement stability?

19) What do you think are the aims of the system? What is the system trying to achieve? What is the optimum end point? How well do you think it does this? What are you trying to achieve? Why? What are the main successes of the legal system and the main deficits?

Judge Interview

- How are things going?
- Have you seen a difference over time (consents/processes)
    - If so what are the differences
    - Why do you think this is?
- Is there a change in the landscape?
    - Nos of kids being removed?
    - Changes in London context?
        - LA processes?
        - Legal context?
        - Policy direction?
    - Where does BeST? Fit into this?
- Who are the BeST? Eligible children?
- Which children are not eligible for BeST?
    - Why?
- How does recruitment in the court setting work?
    - What are your expectations of the trial team?
    - Where does recruitment fit into the court process?
    - What is the process from start to finish in court?
- Roles of judges
    - What is the role of the judges in the family court in the trial?
    - What is the role of HHj Carol Atkinson?
        - In the research?
        - As a decision maker? [i.e. in terms of childen beuig removed? Elgibile for the trial?
- Consent at court
    - Why do it?
    - Are there any ethical issues/ coercion? [do parents understand? Is consent informed?]

    - What is required for this to work?[talk me through a good journey-perhaps case example]
    - When does this not work?[talk me through a journey where it hasn't worked- case example]
- Consent elsewhere
    - Why do it?
    - Are there any ethical issues/ coercion?
    - What is required for this to work? ?[talk me through a good journey-perhaps case example]
    - When does this not work? [talk me through a journey where it hasn't worked= case example]
- Do you have a preference (court or elsewhere)?
- LIFT cases outwith 26 weeks. What happens if there is a waiting list?

LIFT management focus group

Topics to cover:

- General catch-up
    - How are things? Can you give us an overview of how lift is operating right now?
    - What are the major issues for LIFT right now

- Operations/Waiting List/Throughput
    - How do you fit into the wider system?
        - What is the relationship with the local authority?
            - Is the service different from what LA's offer? Do lift see themselves as different?
        - What is your relationship with the courts (timescales)?
        - How does the way LIFT relates compare with the way local authority colleagues relate to the courts?
        - Does NIM fit with the English legal system
            - Link to q about how the legal system influences mental health.
    - How long are cases working what are the timescales for your work?
        - What work do you do post treatment?
        - How does fit with the model?
    - When do you know enough to make a decision?
        - HAS THIS CHANGED AS TIME HAS PASSED?
    - What is current waiting list?
    - WHAT IS THE IMPACT OF ATTENDANCE AT HEARINGS OR COURT?
    - Have there been any contextual changes in terms of the families coming in?

        - Fewer children coming into foster care. May be the more entrenched difficulties. Families more difficult to engage with? What does this mean for you and your recommendations
    - Is there a difference in working with the various different types of order? (kinship, Mother and baby etc..)

- Interactions/engagement with other groups

    - Legal system
        - Specific issues with legal system e.g. laws, policy direction etc
    - Area teams
    - Foster carers
        - WHAT WORK IS NEEDING TO BE DONE? HAS THIS CHANGED
    - Parents

- Reports and recommendations

    - How are LIFT reports being received?
        - SW/Lawyers/judges
    - Any changes in recommendation patterns?

- New Orleans Model
    - Links to NO
    - Links with GIFT
    - Differences in model
- Changes over time?
    - Changes in context?
    - Changes in practice?

Appendix G: Reflective Log

Chosen Theme and Description	Code	Relevant Quote	Reflective Rationale
1. Decision making – decisions made at any stage of the child's journey. References to rationale, consequences, the impact or who might make the decisions.	Legal framework for decisions	Solicitor (Barking and Dagenham) – "so we are talking about the legal threshold, so it is all governed by the Children Act, so Children Act 1989" …. "So, under Section 31 have we proved, or can we prove that there is emotional harm?" Social worker (Tower Hamlets) – "other side for social workers is that sometimes when you have been dealing with a lot of uncertainty around the child protection and managing risk when you then go into the court proceedings it can be quite structured and that can give its own benefit because you think 'right this is where we are going', 'we know now what we are doing, we are going to remove the child', and then there can be some sense of relief around that, you know we are now in a structured environment and we are following the law"	In the thematic maps this theme would often feature as a way of considering the justification of decision making, the impact of this on best interests of the child, but also, I wondered about the impact of personal views on decision making e.g. "removal of children as a bad thing". This being linked to research etc and wondered if this was possibly a personal view rather than a professional view. I wondered about my views in relation to this. Whilst, separating a family has significant consequences – surely this cannot trump the "best interests of the child?" The complexities of working within a system in which there is a likelihood that personal and professional boundaries could overlap? – e.g. the attitude of the judiciary as a reason for the removal of a child. "A good reason". Does the threshold vary between age and developmental stage of the child? Approach to risk – Children Act 1989 "promoting the welfare of a child". Challenging considering that "every child matters" framework relates to ensuring every children are "safe" and "healthy". The level in which this can be achieved is subjective in nature – appears influenced by individual and organisation level understanding of what is "acceptable risk" Tension between rights - European convention of human rights (Article 8 - protects your right to respect for your private and family life) and balancing this with the best interests of the
	Removal as positive	Guardian Team Lead (CAFCASS) - "I am always consoled with the fact that if we've recommended that the child doesn't go home it is for the best, it is for good reason"	
	Preventing removal as good	Solicitor (Barking and Dagenham) – "but ultimately the goal is to get these children back	

		with or to remain with their parents and we will do what we can"	child. In order to take this right away the decision and action is "proportionate" and justifiable in the pursuit of a stated aim". This is an important consideration and may be why levels of contact are so high or why the parents needs are considered over the child's needs? Reflective supervision (25/01/22): it could be the interpretation of "right to a family life" is based on the biological family and not a family unit which would include foster families. Guardian was able to reflect on both the positive and negative impact removal would have on the child. This was where there were a lot of statements to "risk aversion". This was frustrating in the context of child wellbeing as it felt irrelevant to wellbeing and more to "safeguarding". "Prevent court proceedings" was moved from "best interests of the child" as it explains the rationale for decision making and therefore the impact this may have on the best interests of the child which became an overarching theme. The prevention of court proceedings likely impacts on the best interests of the child but this was an inductive researcher process throughout the analysis. Frustration that in order to prevent court proceedings decisions were being made to allow children to remain home and for authorities to "hold the risk". Is this in the best interests of the child (linked to best interests theme)
	Removal of children as bad	Solicitor (Barking and Dagenham)- does that model allow or does it put a crack down the middle of families	
	Prevent court proceedings	Guardian (CAFCASS) – "let's make an agreement to avoid, you know, a five day final hearing". Judge – "renewed effort lead by the president to push the cases back to local authorities and invite them to consider holding the risk" Judge – "I think local authorities have worked really hard in looking at themselves and trying to hold more of the risk" (is this really in the best interests of the child?" Solicitor (Barking and Dagenham) – "possibly going into proceedings isn't always the best method of dealing with those problems, so that's quite a big a thing."	

Appendix H: Standards for Reporting Qualitative Research (SRQR)

Standards for Reporting Qualitative Research (SRQR)*

http://www.equator-network.org/reporting-guidelines/srqr/

Page/line no(s).

Title and abstract

Title - Concise description of the nature and topic of the study Identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended	Page 49
Abstract - Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusions	Page 53

Introduction

Problem formulation - Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement	Pages 54-57
Purpose or research question - Purpose of the study and specific objectives or questions	Page 57

Methods

Qualitative approach and research paradigm - Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/ interpretivist) is also recommended; rationale**	Pages 62-63
Researcher characteristics and reflexivity - Researchers' characteristics that may influence the research, including personal attributes, qualifications/experience, relationship with participants, assumptions, and/or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results, and/or transferability	Pages 63 and 119-120
Context - Setting/site and salient contextual factors; rationale**	Pages 58

Sampling strategy - How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale**	Pages 58 and 61-63
Ethical issues pertaining to human subjects - Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues	Pages 62; 114-118
Data collection methods - Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale**	Pages 58 and 61
Data collection instruments and technologies - Description of instruments (e.g., interview guides, questionnaires) and devices (e.g., audio recorders) used for data collection; if/how the instrument(s) changed over the course of the study	Pages 61 and 106-113
Units of study - Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results)	Pages 58-60
Data processing - Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymization/de-identification of excerpts	Pages 61-62 and 119-120
Data analysis - Process by which inferences, themes, etc., were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale**	Pages 62-63 and 119-120
Techniques to enhance trustworthiness - Techniques to enhance trustworthiness and credibility of data analysis (e.g., member checking, audit trail, triangulation); rationale**	Pages 62-63

Results/findings

Synthesis and interpretation - Main findings (e.g., interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory	Pages 64-80
Links to empirical data - Evidence (e.g., quotes, field notes, text excerpts, photographs) to substantiate analytic findings	Pages 64-80

Discussion

Integration with prior work, implications, transferability, and contribution(s) to the field - Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application/generalizability; identification of unique contribution(s) to scholarship in a discipline or field	Pages 74-80
Limitations - Trustworthiness and limitations of findings	Page 80

Other

Conflicts of interest - Potential sources of influence or perceived influence on study conduct and conclusions; how these were managed	Page 62-63
Funding - Sources of funding and other support; role of funders in data collection, interpretation, and reporting	NA

*The authors created the SRQR by searching the literature to identify guidelines, reporting standards, and critical appraisal criteria for qualitative research; reviewing the reference lists of retrieved sources; and contacting experts to gain feedback. The SRQR aims to improve the transparency of all aspects of qualitative research by providing clear standards for reporting qualitative research.

**The rationale should briefly discuss the justification for choosing that theory, approach, method, or technique rather than other options available, the assumptions and limitations implicit in those choices, and how those choices influence study conclusions and transferability. As appropriate, the rationale for several items might be discussed together.

Reference:

O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. **Standards for reporting qualitative research: a synthesis of recommendations.** *Academic Medicine*, Vol. 89, No. 9 / Sept 2014. DOI: 10.1097/ACM.0000000000000388