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CHILDREN'S SOCIAL CARE

Mapping the evidence about what works to safely reduce the number of children and young people in statutory care: A systematic scoping review

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About the What Works Centre for Children's Social Care

The What Works Centre for Children's Social Care seeks better outcomes for children, young people and families by bringing the best available evidence to practitioners and other decision makers across the children's social care sector. Our mission is to foster a culture of evidence-informed practice. We will generate evidence where it is found to be lacking, improve its accessibility and relevance to the practice community, and support practice leaders (e.g. principal social workers, heads of service, assistant directors and directors) to create the conditions for more evidence-informed practice in their organisations.

About CASCADE

CASCADE is concerned with all aspects of community-based responses to social need in children and families, including family support services, children in need services, child protection, looked after children and adoption. It is the only centre of its kind in Wales and has strong links with policy and practice.

To find out more visit the Centre at: **whatworks-csc.org.uk**, or CASCADE at: **sites.cardiff.ac.uk/cascade**

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EXECUTIVE SUMMARY

Introduction

The steadily increasing annual numbers of children and young people in care in the UK are of significant current concern. While there will always be some children who need out-of-home care, there are many legal, ethical, social and economic arguments for safely keeping children with their birth families where possible. Reducing the need for care is one of the research priorities for the first phase of the What Works Centre for Children's Social Care. Identifying effective approaches to reduce the need for care is complex but critically important. Despite a proliferation of different interventions and approaches, evidence summaries on this topic are limited. This study is a scoping review to explore what research evidence exists about what works in safely reducing the number of children and young people in care. This is the first stage of reviewing the evidence in a complex field – identifying what is out there.

What we did

The review utilises Arksey and O'Malley's scoping review methodology. We searched electronic databases and websites to identify studies targeting any one of three outcomes:

- reduction of initial entry to care
- reduction of re-entry to care
- increase in post-care reunification

We consulted with international experts as a supplementary searching technique. In deciding which studies to include in the review, abstracts and full-text studies were independently screened by two reviewers. For 10 per cent of the selected studies, two reviewers independently extracted the data; for the remainder, data was extracted by a first reviewer then verified by a second. This process resulted in numerical summaries and a thematic qualitative synthesis.

Evidence was categorised in three different ways: firstly, the primary outcome (initial care entry, re-entry or reunification); secondly, the level of intervention (community,

policy, organisation, family or child); and thirdly, the type of evidence, using the EMMIE framework (Effectiveness, Mechanisms of change, Moderators, Implementation, Economic evaluation).

What we found

In the report, we present evidence maps of the clusters of evidence in the published literature. We present these maps in terms of the level of intervention: community, policy, organisation, family or child. We came up with the following categories of intervention type. For each of these, the number of studies we identified is stated in brackets:

- family or child skills training (44 studies)
- service integration or coordination (43 studies)
- change in what a worker does (42 studies)
- change in/ new therapeutic approach (42 studies)
- structure change in the child welfare system (18 studies)
- meetings that include the family and relevant workers (16 studies)
- interventions that change a family's finances (13 studies)
- mentors (10 studies)
- supervision of social workers (three studies).

Next steps

The scoping review is only the first stage in reviewing the evidence on reducing the need for care. For each of the intervention themes listed above (except for supervision, where there are too few studies), we will now synthesise the evidence we have identified and write a report on what we find. We will consult with stakeholders to inform our interpretation of these clusters of evidence and work out their implications for social care practice. The findings from the evidence syntheses will also inform the primary research programme of the What Works Centre. For example, the evidence on change in a family's finances will be relevant to the Change Programme project on devolved budgets, and the evidence on service integration will be relevant to the project on social workers in schools.

INTRODUCTION

Preventing the need for children and young people to enter statutory care is a significant social, health and educational priority. In the past twenty years there has been a consistent increase in the number of children residing in the English care system, rising from 50,900 in 1997 to 72,670 in 2017 (DfE, 2017, Biehal et al., 2014). Care-experienced individuals experience a range of adverse outcomes across the life-course compared to the general population, including higher rates of psychological disorders, poorer educational attainment and lower rates of employment (Ford et al., 2007, Evans et al., 2017, Trout et al., 2008). Some consensus has emerged around the need to do more in preventing the problems leading to care entry (Family Rights Group, 2018). This will ensure compliance with the principles of the United Nations Convention on the Rights of the Child (UNCRC) 1989 and the Children's Act (UK, 1989), both of which emphasise the importance of a child being cared for by their parents. Supporting more children to remain within their families will also address economic considerations, such as where to target spending to best improve outcomes for children and families. Out-of-home placements incur significant costs, with an average annual spend per head of £29,000-£33,000 for foster care and £131,000-£135,000 for residential care in England (National Audit Office, 2014), whereas little is known about the cost of providing interventions at other points in the system.

Efforts to reduce care entry may be contested, however, due to evidence that pre-care experiences may be the primary contributory factor to adverse life-course outcomes (Forrester et al., 2009, Sebba et al., 2015). Indeed, for many individuals statutory care may be protective. Thus, there remains a complex challenge to statutory care systems in safely reducing care entry, while ensuring the appropriate identification and referral of those who necessitate intervention. A number of approaches have proliferated internationally, spanning the full range of socio-ecological interventions points (McLeroy et al., 1988). These include, but are not limited to: interpersonal interventions that focus on the communications within the family (for example, Intensive Family Preservation Services); organisational interventions that modify social work practice and ethos (for example, Reclaiming

Social Work); and national policy strategies (for example, Department for Education's (2016) Putting Children First). Despite such developments, however, there are limitations with the extant evidence base, which have prevented a comprehensive understanding of how best to prevent care entry. Understanding about this issue is important given the current public spending context, where there has been a substantial decrease in spending on preventative services, amid increases in the proportion of children services' budget being spent on statutory care and child protection (Children's Commissioner, 2018).

A key issue is the extensive variation in the methodological standards and quality of evaluations, which makes it difficult to clearly ascertain the evidence-base for any particular intervention. Information on much current social care practice is often limited to local descriptions of innovation (Schrader-McMillan and Barlow, 2017). Where efforts have been made to conduct robust evaluations, such as the widely implemented Family Group Conferencing (Dijkstra et al., 2016), the use of randomised controlled trials has been contested and difficult to implement (de Jong et al., 2015), so such trials are, therefore, extremely rare. This may be partially linked to debates about whether social care should be an evidence-based or experientially-based discipline (Axford and Morpeth, 2013, Petersén and Olsson, 2014). Furthermore, the heterogeneity in social care systems and resource structures makes it difficult to understand the international relevance and transferability of evidence-based approaches, and the likelihood of replicating effectiveness in new contexts. In line with realist and complex systems perspectives (Pawson, 2013, Pawson et al., 2005, Pawson and Tilley, 1997, Moore and Evans, 2017, Fletcher et al., 2016, Hawe et al., 2009, Pfadenhauer et al., 2017), interventions may be understood as disruptions to the system into which they are introduced and they are thus inseparable from the context in which they operate. As such, intervention implementation practices will likely vary across systems, leading to the differential activation of causal mechanisms, and hence the potential realisation of different outcomes. To redress these limitations there is a need to review the international evidence on what works in safely reducing the number of children and young people in care.

Study objectives

This scoping review maps the evidence base on what works in reducing the need for children and young people to enter into statutory care, to identify key evidence clusters, gaps and uncertainties (Armstrong et al., 2011). The review scopes the evidence across three areas: the reduction of the need for children and young people to enter statutory care; the reduction of the need for children and young people to re-enter care; and the safe increase in children and young people's re-unification with their family following a period in out-of-home care. We note that the review is not concerned with the absolute reduction of the number of individuals in care, but rather the 'safe' reduction, while ensuring the correct identification and support of those necessitating statutory intervention. Preliminary searches were undertaken, and no existing scoping reviews were identified.

METHODS AND ANALYSES

Conceptual model

As a result of the fact that the effectiveness of social care interventions is influenced by their complexity and their contextual location, the scoping review adopts a realist approach to evidence mapping (Pawson, 2013, Pawson and Tilley, 1997, Johnson et al., 2015). Rather than a focus on absolute measures of intervention effects, realist approaches consider the question of what works, for whom, in which circumstances, and in what way. Evidence reviewed is not then singly appraised or synthesised according to aggregate intervention effect sizes, but can be considered in relation to the composite assessment prescribed by the EMMIE framework (Johnson et al., 2015), which supports the interrogation of a heterogeneous and complex evidence base.

The EMMIE framework comprises five dimensions for evidence mapping according to the review questions: Effect (E) of an intervention; Mechanisms (M) through which an intervention is expected to have an effect; the contexts that Moderate (M) if mechanisms will be activated to generate the intended effect; system level Implementation (I) barriers and facilitators; and Economic (E) cost effectiveness

(Johnson et al., 2015). These dimensions have been identified as pragmatic and meaningful in presenting evidence for policy-makers and commissioners. To date, the framework has primarily been employed to review existing reviews or with systematic reviews of primary evidence (Sidebottom et al., 2017, Johnson et al., 2017), and we understand this to be the first example of its use with a scoping review.

Design

The scoping review methodology was structured and reported in accordance with Arksey and O'Malley's methodological guidance (Arksey and O'Malley, 2005) and Levac et al's (2010) methodological enhancement. There were six composite stages: (1) identification of the research question; (2) identification of relevant studies; (3) study selection; (4) charting of the data; (5) collation, summary and reporting of results; and (6) consultation with relevant stakeholders. Protocol components have been crossed referenced with the Preferred Reporting Items for Systematic review and Meta-Analysis Protocols (PRISMA-P) checklist to ensure completeness (Moher et al., 2015, Shamseer et al., 2015).

Stage one: Identification of the research questions

The broad remit of the scoping review was agreed with the funder of the What Works Centre (WWC) for Children's Social Care and the Department for Education (DfE). This remit was developed following a period of consultation with the sector on the aims and foci of the Centre. The multi-disciplinary research team that comprises the systematic review work package for the WWC distilled this policy interest into a set of operational research questions. Questions were refined through sector engagement by the WWC, consultation with the expert panel of the WWC, consideration of key publications and academic journals, and preliminary searching of relevant databases.

The aim of the scoping review was to map the evidence-base in regard to the following three questions:

1. What is the nature and quantity of evidence for interventions that aim to safely reduce the number of children and young people entering statutory care?
2. What is the nature and quantity of evidence for interventions that aim to safely reduce the number of children and young people re-entering statutory care?
3. What is the nature and quantity of evidence for interventions that aim to safely increase the reunification of children and young people with their families following a period in out-of-home statutory care?

As part of a scoping review involved in identifying the definition and clarification of key variations in terminology, concepts and outcome measurements, we were also interested in mapping corollary and proximal outcomes that may support the reduction of children and young people in care. Some studies assess more specific aspects of the care process (for example, reduction in number of care and supervision orders or care plans), rather than the three main outcomes that we identified. With extensive international variation in legal frameworks and terms, it was therefore important to develop a map of intermediary measurements and how they might relate to the primary outcomes.

Stage two: Identifying relevant studies - Eligibility criteria, information sources and search strategy

Eligibility criteria

The eligibility criteria were developed in accordance with the PICO (Population, Intervention, Comparator, and Outcome) format (Moher et al., 2015). To incorporate the EMMIE framework an additional Evaluation (E) criterion was included, with studies being eligible if they reported evidence mapping onto one or more of the EMMIE dimensions (Table 1). To meet the aims of the scoping review, studies were only included where there was evidence of effect (first E in EMMIE), whereas other MMIE dimensions were not essential for inclusion.

Table 1: PICO (E) Scoping Review Eligibility

PICO (E)	Inclusion criteria
Population	Children and young people who are in need of care or have been in care when 18 years old or younger.
Intervention	Interventions were defined as a disruption to the system (Hawe et al., 2009, McLeroy et al., 1988). They can operate across a single or multiple socio-ecological domain(s): intra-personal, inter-personal, organisational, community, and policy.
Comparator	Usual care, alternative intervention, no comparator.
Outcome	1. Number of children and young people entering care 2. Number of children and young people (re-)entering care 3. Number of children and young people re-unified with their families following a period in statutory care Corollary or proximal outcomes that support three outcome measures.
Evaluation	Evaluation of the intervention is reported for one or more EMMIE dimensions: 1. Effectiveness (E) 2. Mechanisms through which the intervention generates intended or unintended effects (M) 3. Contexts that moderate effects (M) 4. System determinants of implementation (I) 5. Economic effectiveness (E)

To ensure review results were relevant to the UK setting, inclusion was limited to research conducted in the following countries: England, Wales, Scotland, Northern Ireland, USA, Canada, Australia, New Zealand, France, Germany, Sweden, Finland, Norway, Denmark, Netherlands and Ireland. While there are differences in the legal and social frameworks, research from these countries was deemed more likely to be applicable.

Information sources

The following eighteen databases were searched: ASSIA, British Education Index, Child Development and Adolescent Studies, CINAHL, Embase, ERIC, HMIC, IBSS, Medline (including Medline In-Process and Medline ePub), PsycINFO, Scopus, Social Policy and Practice, Social Services Abstracts, Sociological Abstracts and Web of Science (Social Sciences Citation Index, Conference Proceedings Citation Index-Social Science and Humanities, Emerging Sources Citation Index). Grey literature was identified through the following online resources: Action for Children, Barnardo's, Care Leavers' Association, Children's Commissioners' offices for four UK nations, Children's Society, Child Welfare Information Gateway, Department for Education, Early Intervention Foundation, Joseph Rowntree Foundation, National Institute for Health and Care Excellence (NICE), OpenGrey, REES Centre for Research in Fostering and Education, Samaritans, Thomas Coram Foundation for Children. Experts were contacted to identify relevant published and unpublished studies.

Stage three: selecting studies

Selection processes

A subset of studies was independently screened by all members of the review team to calibrate the inclusion criteria and ensure consistency in approach. Following this, study title and abstracts were independently appraised against the inclusion criteria by two reviewers. A safety first approach was adopted whereby if one reviewer included a title/abstract, then the full text was examined (Shemilt et al., 2016). Reasons for exclusion were recorded at full text. Discrepancies were resolved by consensus and, where this was not possible, a third reviewer arbitrated.

Stage four: charting the data

Data extraction

Data across the following domains were extracted: *Outcome* (care entry, care re-entry, reunification); *Intervention type* (intervention activities; socio-ecological domain of intervention (community- level, policy- level, organisational-level, family- level or interpersonal (child)-level); *EMMIE dimensions addressed* (Table 2); *Study characteristics* (authors, year of publication, country, study design, target population (for example, social workers, family, children, young people); *analysis approach*.

Table 2: Operationalisation of EMMIE for identifying whether a study has the type of evidence for each dimension of EMMIE (adapted from Johnson et al. (2015))

EMMIE dimension	Is *at least one* of the following reported in source?
Effect	Effect size
	Measurement / consideration of unanticipated effects
Mechanism / mediator	Map of possible mechanisms / logic maps
	Mediator or mechanism-based moderator analysis
	Assessment / statements of most likely mechanisms and any contextual conditions (these can be narratives)
Moderator / context	Context-based moderator analysis / subgroup analysis (analysis testing the differences that context makes to outcome; theoretically driven/conducted due to data availability/not theoretically driven/not mentioned prior to analysis
	Statements qualifying contextual variations (these can be narratives)
Implementation	A list/statement/description of key components affecting implementation success (including fidelity issues, barriers and

	facilitators to implementation, acceptability, feasibility and so on)
	A list/statement/description of key components deemed necessary for replication elsewhere
Economic	Quantification of inputs to the intervention/intervention outputs
	Quantification of intensity (e.g. spend per head)
	Estimate of cost of implementation (including by sub-group)
	Estimate of cost-effectiveness by unit output or by sub-group
	Estimate of cost-benefit (including by sub-group)

Data extraction was piloted and calibrated with a subset of included studies. Due to the complexity of the data extraction, four reviewers independently extracted outcome, EMMIE, intervention and socio-ecological data and then discussed decisions in a group of 10% of studies to ensure consistency. Data were extracted from the remaining studies independently by three reviewers, with a fourth reviewer to resolve issues. Regular meetings to discuss emerging issues ensured ongoing consistency. Study characteristics were extracted by additional research and administrative staff as available.

Data within each paper were coded with the support of NVivo 12 (QSR, 2012). A hierarchical coding tree was indexed according to these domains with a subset of studies and was refined and confirmed with the review team. Memos were generated to ensure reviewer reflexivity.

Risk of bias

In line with prescribed scoping review methodology, study quality was not appraised. Scoping reviews intend to map the concepts underpinning a research area and the main sources and types of evidence available (Jolley et al., 2017), rather than assess the quality of individual studies.

Stage five: collating, summarising and reporting the results

Included studies

There were 17,578 individual studies identified through the search strategy, which had their titles and abstracts screened. Of these, 645 were included and screened at full text, resulting in 170 final included studies (Appendix 1), from which data were extracted (see Figure 1 for the flow of studies through the scoping review).

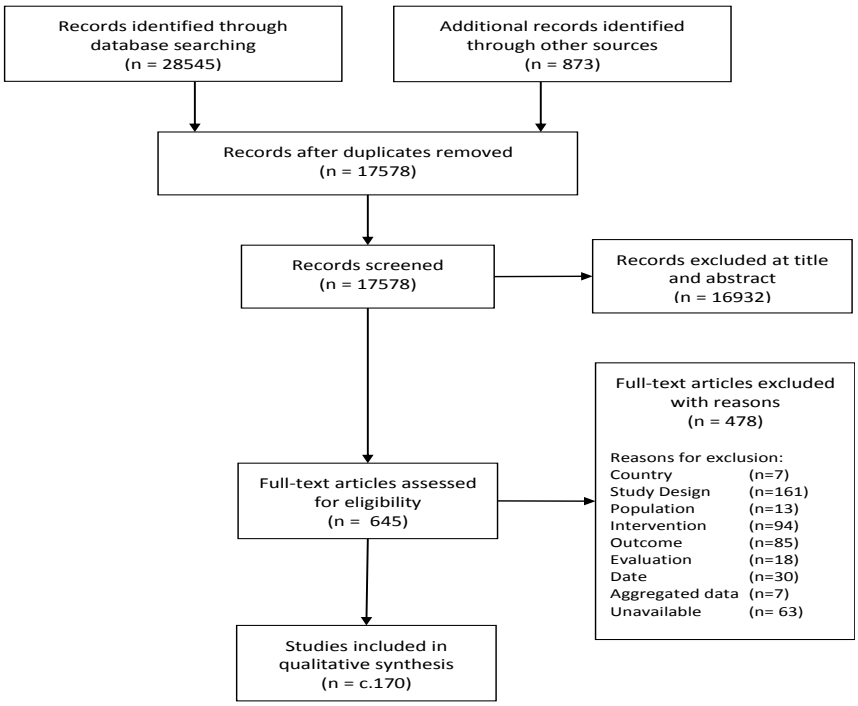

Figure 1: Flow of studies through the scoping review

Data analysis

A thematic analysis of intervention type and a descriptive numerical summary analysis of outcome, intervention type (activities/socio-ecological domain), and type of evidence available (EMMIE) produced groups of studies across these domains.

Thematic analysis of intervention activities/resources

Intervention type was analysed across two domains: socio-ecological domain and intervention activities/resources. Socio-ecological domains were predefined codes:

community-level interventions, policy-level interventions, organisational-level interventions, family-level interventions (working with families to improve child outcomes), and interpersonal-level interventions (working directly with the child to improve their outcomes). Due to the heterogeneity of interventions in the studies included in the review (even when sharing a name, intervention activities varied widely from study to study), it was not possible to meaningfully group interventions by named interventions. Instead, a thematic analysis of intervention activities was undertaken. The emergent groups of intervention activities across studies were: supervision of social workers, therapeutic approach, practice change (how or what a worker does), family or child skills building, meetings including both family and practice professionals, structure change (i.e. change to the child welfare system, such as the addition of a new type of court), service integration and/or coordination, mentors, and an increase or decrease in a family's financial situation. The 'other' category included studies with interventions that were not similar to others.

Descriptive numerical summary analysis

A descriptive numerical summary analysis was undertaken (Levac et al., 2010). Studies were grouped according to outcome, intervention type (activities/socio-ecological domain), and evidence type (EMMIE: Effect, Mechanisms and Moderators, Implementation, and Economic). This mapping quantified the spread of the extant research evidence and identified key evidence clusters and gaps, highlighting the types of intervention and the spread of types of evidence for interventions to reduce care entry or improve reunification/reduce care re-entry. Some studies were included more than once as they measured more than one outcome of interest.

All studies had to report Effect to be included (E = 173). Most were descriptive (161), some presented effect sizes (70), and five measured proximal outcomes, such as number of care plans, that were considered close enough outcomes to code to care entry. The majority of studies also provided at least some evidence about how an intervention works (MM = 161), describing mechanisms through which it is thought to affect change and the contexts that moderate their effect, in the form or narrative descriptions (164), logic models (8), or mediator/moderator analysis (67). Ninety-three studies described implementation issues, including barriers/facilitators

(70) and activities (49). Thirty-seven described economic considerations, mostly related to cost-benefit analysis. This pattern was the same across the two outcomes.

The main groups of intervention activities that studies reported evidence for were as follows (see Table 3): family or child skills building (44 studies), including life, financial, conflict resolution, and parenting skills (these include The Strengthening Families Programme, Homebuilders, some intensive family preservation services, some reunification services); service integration/coordination (43 studies: mostly family drug courts, and also including Multi-Systemic Therapy, multi-systems approaches, some family preservation services, intensive case management, intensive home-based services, family-centred out-of-home care); change in what a worker does (42 studies: particularly diverse 'type' by nature, but including some family preservation and family reunification services, Triple P Positive Parenting Programme, Promoting First Relationships, Family Partnership Model, sobriety treatment and recovery teams); and change in new therapeutic approach (42 studies: including Multi-Systemic Therapy, Multi-Dimensional Family Therapy, cognitive-behavioural approach, CAT, couple and family therapy, treatment foster care, Child-Parent Psychotherapy, Families First – intensive in-home therapy, Building Blocks Psychodynamic Treatment Approach, Functional Family Therapy).

Smaller clusters of studies were found for structure change in the child welfare system (18: including mostly drug-related court interventions for parents); meetings that included the family and relevant workers (16: including Family First, team decision making, family group conferences, and family group decision-making); interventions affecting family finances (13: including mostly add-on elements of larger interventions such as family preservation services - emergency assistance funds, Family Assistance Fund, and a welfare reform); mentors (10: including mentors/life coaches/recovery coaches as add-on to larger intervention, such as family, drug and alcohol courts or No Wrong Door; and community mentoring interventions, such as foster-carer to parent, community member to parent, family to family, previous drug user to parent with drug misuse); and supervision of social workers (3 studies: including supervision as part of the On The Way Home program, Building Blocks, and Functional Family Therapy-Child Welfare). Thirty-nine studies were not grouped by intervention activity.

Table 3: Named interventions included within each group of intervention activities that emerged from the thematic analysis

Intervention Activity group (thematic analysis results)	No. sources	Named interventions within this group
Family/Child Skills Training	44	The Strengthening Families Programme, Homebuilders, some Intensive Family Preservation Services, some Reunification Services, Parent Mutual Aid, Shared Parenting program, Functional Family Therapy-Child Welfare.
Service Integration/Coordination	43	Dependency Drug Courts (DDC), Family Drug Courts/ Family Treatment Drug Courts (FDC/FTDC), Family Drug and Alcohol Courts (FDAC), Multi-Systemic Therapy, multi-systems approaches, Delta Method, some (Intensive/) Family Preservation Services, Differential Response, Intensive Family Support, Transitioning Youth to Families, Intensive Case Management, Intensive Home-Based Services, Family-Centred Out-of-Home Care, and Shared Parenting.
Change in what a worker does (practice change)	42	Particularly diverse 'type' by nature but including: some (Intensive/) Family Preservation Services, some Family Reunification Services, Homebuilders, Triple P Positive Parenting Programme,

		Promoting First Relationships, Family Partnership Model, Sobriety Treatment and Recovery Teams.
Change in or new therapeutic approach	42	Multi-Systemic Therapy (MST), MST-Building Stronger Families, MST–Child Abuse and Neglect, Multi-Dimensional Family Therapy, Cognitive-Behavioural Approach, CAT, couple and family therapy, Treatment Foster Care, Child-Parent Psychotherapy, Families First – intensive in-home therapy, Building Blocks Psychodynamic Treatment Approach, Functional Family Therapy (FFT), FFT-Child Welfare.
Structure change in the child welfare system	18	Mostly drug-related court interventions for parents, such as DDC, FDC, FTDC, Dependency Treatment Court, and Unified Family Courts.
Meetings that included the family and relevant workers	16	Family First, Team Decision Making, Family Group Conferences, Family Group Decision-Making, Family Team Conferencing, Family Involvement Meeting, and Family Group Engagement.
Interventions that increase/decrease a family's finances	13	Mostly add-on elements of larger interventions such as Family Preservation Services: Emergency Assistance Funds (e.g. Homebuilders), Family Assistance Fund, and some welfare reforms.

Mentors	10	Mentors/life coaches/recovery coaches as add-on to larger interventions, such as FDAC or No Wrong Door; and community mentoring interventions, such as foster-carer to parent, community member to parent, family to family, previous drug user to parent with drug misuse.
Supervision of social workers	3	Supervision as part of the On the Way Home program, Building Blocks, and Functional Family Therapy-Child Welfare.

Interventions to safely reduce care entry

Ninety-nine studies examined interventions to reduce care entry (Figure 2, and see Appendix 2 for data table), the majority focused on affecting change in parents/families or in children themselves.

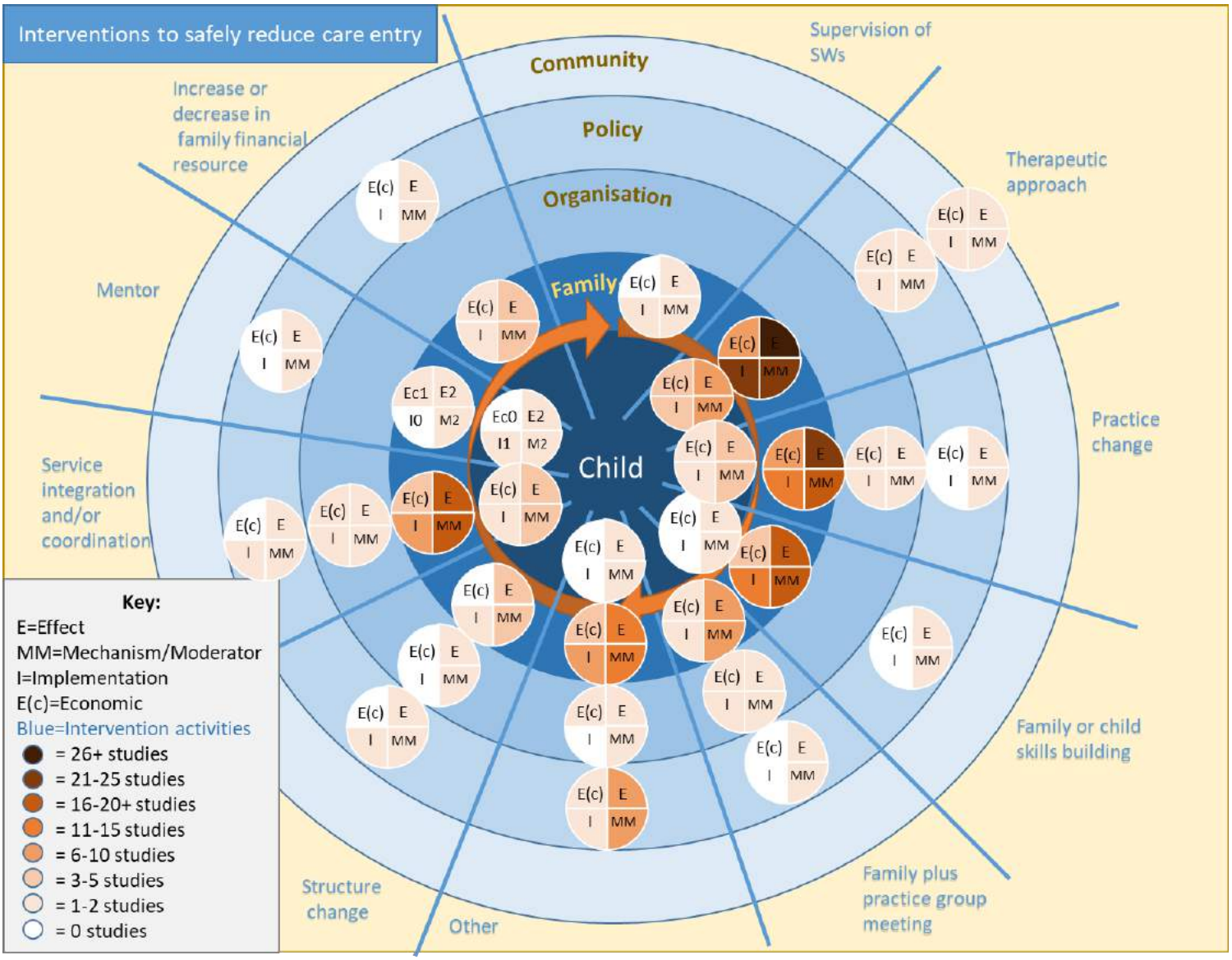

Figure 2: Type of interventions (activities/socio-ecological domain) to safely reduce care entry and the gaps and clusters in their evidence base for Effect (do they reduce care entry?), Mechanisms/Moderators (how they work), Implementation (barriers/facilitators) and Economic considerations

Family-level interventions – safely reducing care entry

Interventions to safely reduce care entry clustered around family-level interventions (Figure 2), with studies examining interventions that worked with the immediate or wider family to safely reduce the entry of children to care (68 studies). The majority of these studies examined a therapeutic approach (Effect = 26 studies, how it works (MM) = 25 studies, Implementation = 21 studies, Economic considerations = seven studies).

The next cluster of evidence for family-level interventions was around practice change, with studies examining workers changing what they do when they work with parents/families (Effect = 21 studies, how it works (MM) = 20 studies, Implementation = 13 studies, Economic considerations = six studies).

A cluster of studies occurred around parent education and/or skills building (Effect = 20 studies, how it works (MM) = 20 studies, Implementation = 11 studies, Economic considerations = five studies).

Studies examining service integration or coordination around the needs of the parents/family formed another cluster (Effect = 17 studies, how it works (MM) = 16 studies, Implementation = eight studies, Economic considerations = five studies).

Smaller clusters were found around meetings of social workers and other professionals that included parents as partners (Effect = six studies, how it works (MM) = six studies, Implementation = one study, Economic considerations = one study); and interventions that increase/decrease a family's financial situation (Effect = four studies, how it works (MM) = four studies, Implementation = two studies, Economic considerations = one study).

Child-level interventions – safely reducing care entry

There was a smaller cluster of evidence around child-level interventions to reduce care entry (10 studies). In particular, therapeutic approaches, with seven studies with evidence about Effect, seven about how they worked (MM), five about Implementation barriers/facilitators and four related to Economic considerations. Interventions focusing on service integration around the needs of the child were examined for Effect in three studies, for how they worked (mechanisms/moderators) in two studies, and one study each for implementation and economic considerations. Interventions that involved a change in the way workers work with children were examined for Effect in four studies, how they work (MM) in two studies, and in one study for Implementation and one for Economic considerations.

Community-level interventions – safely reducing care entry

It is interesting to note that to reduce care entry, there was only one study examining interventions that made changes to the community around children to support reduction in care entry.

Organisational-level interventions – safely reducing care entry

All types of evidence (EMMIE) were limited in relation to organisational-level interventions to reduce care entry (five studies). Those found related to practice change, meetings with family and practitioners together, structure change, and service integration. All of these had no more than one or two studies for any evidence type.

Policy-level interventions – safely reducing care entry

There was limited evidence related to policy-level interventions to safely reduce care entry (10 studies) and it was evenly spread with one or two studies for each intervention activity, except for supervision of social workers. Policy-level interventions were the most heterogeneous, reflected in the largest cluster of policy-level studies in 'other' (E = 6, MM = 6).

Interventions to improve reunification/safely reduce care re-entry

Ninety-two studies were found that examined interventions to safely reduce care re-entry and improve reunification. Few studies looked at care re-entry (19 studies) with only five exclusively looking at re-entry and not reunification (87 studies). Initially, point on care pathway was coded (in care, at home but recently in care, at risk of care entry, at risk of care re-entry. The literature was heterogeneous in the way that it defined/ reported point on care pathway and very few studies separated care entry from re-entry (for example, when measuring care entry rates, not capturing whether a child had been in care previously; also only eight studies identified children as being at risk of care re-entry specifically, and only six identified children as at home but recently in care). Due to this lack of clarity in the literature, studies that were coded to reunification were typically also coded to re-entry. For this reason, in this analysis we have collapsed reunification/re-entry in to one outcome (Figure 3; see also Appendix 3 for data table).

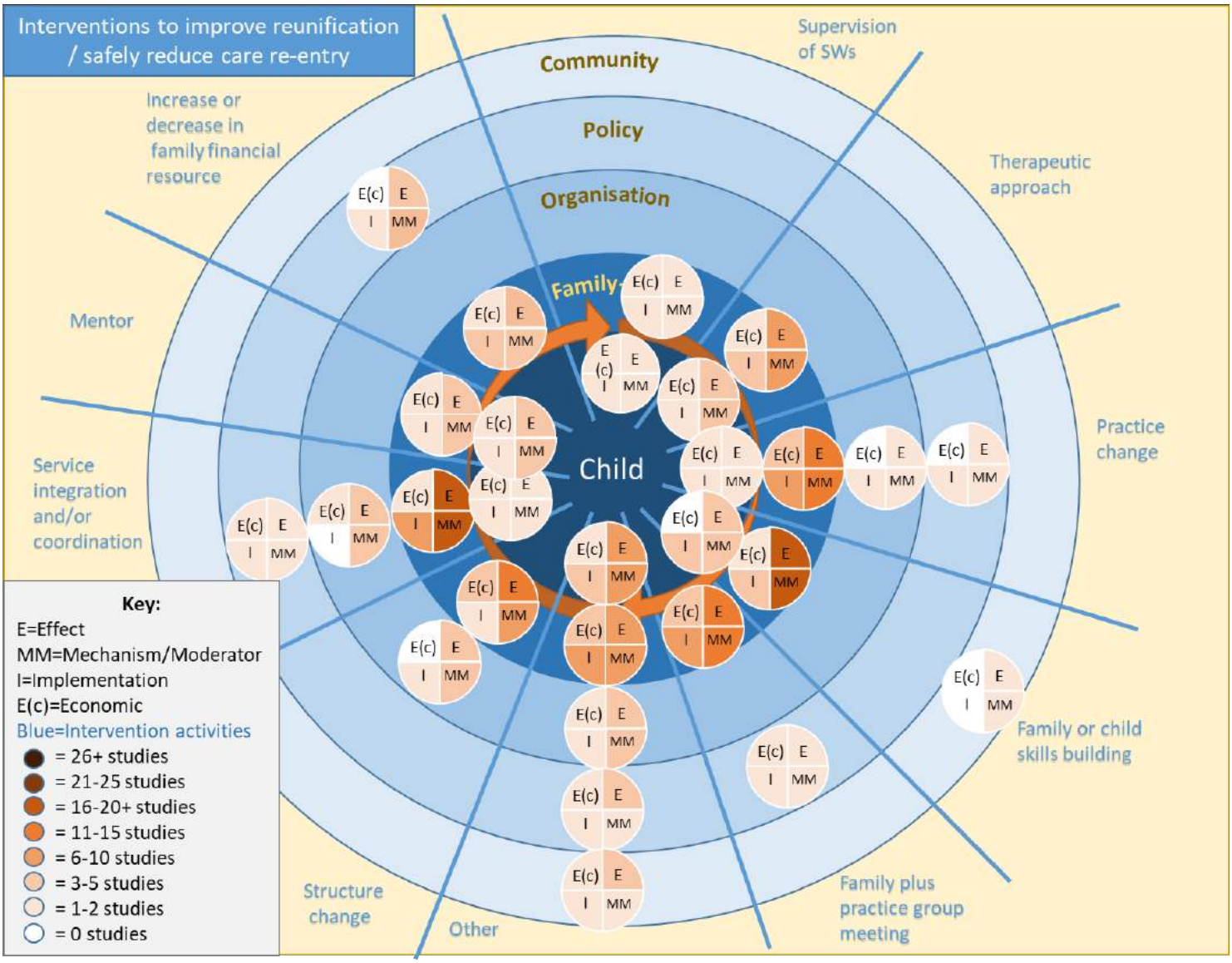

Figure 3: Type of interventions (activities/socio-ecological domain) to improve reunification/safely reduce care-re-entry and the gaps and clusters in their evidence base for Effect (do they reduce care entry), Mechanisms/Moderators (how they work), Implementation (barriers/facilitators) and Economic considerations

The spread of studies providing evidence about interventions to improve reunification/reduce care re-entry (Figure 3) is similar to that for care entry, with clusters around interventions focused on working with the parents/family or with the child themselves.

Family-level interventions – improving reunification/safely reducing care re-entry

Family-level interventions (64 studies) tended to cluster around parent skills building (Effect = 18 studies, how it works (MM) = 17 studies, Implementation = five studies, Economic considerations = zero studies), service integration around parents'/family's needs (E = 17 studies, MM = 17, I = 8, Ec = 2), and changes to what a worker does with the parents/family (E = 15 studies, MM = 14, I = 9, Ec = 3).

There were also notable evidence clusters around family plus practice meetings (E = 11 studies, MM = 11, I = 8, Ec = 5), therapeutic approaches with parent(s) (E = 10 studies, MM = 9, I = 3, Ec = 1), and structure change (E = 11 studies, MM = 10, I = 2 Ec = 3).

Similar to care entry, there were just a few studies available (one - five) around increase/ decrease in family financial situation, supervision of social workers, and mentors for the parents/ family.

Child-level interventions– improving reunification/safely reducing care re-entry

Evidence available for child-level interventions to improve reunification/reduce re-entry was limited (11 studies) and the spread across intervention types was homogenous, with most types of intervention activity studied in one - six studies, except for family plus practice meetings, structure change, or changes to family financial situation (zero studies).

Organisational-level, policy-level and community-level interventions - improving reunification/safely reducing care re-entry

There were few studies of organisational-level interventions (nine), policy-level (eight), and community-level (one), with an intriguing cluster around policy-level interventions that effect the financial situations of families (three studies).

Stage six: Consulting with relevant stakeholders

Patient and public engagement

The What Works Centre will consult on the review findings with the English social care sector via policy and practitioner panels and continued knowledge translation events. From the scoping review, the review team will conduct realist synthesis of studies by intervention theme. There will be dialogue with care-involved families and frontline social care practitioners about the interpretation of review findings and their implications for social care practice. Stakeholders will also be invited to support the presentation and dissemination of review findings to ensure relevance to the diverse range of policy and practitioner audiences.

The scoping review findings and subsequent systematic reviews will also inform the research agenda for the wider Centre. They will support the identification of de novo interventions that warrant robust scientific evaluation by the Centre or evidence-based interventions that have demonstrated effectiveness elsewhere and require adaptation and/or evaluation replication within the UK context.

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