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Interventions Targeting the Mental Health and Well-being of Care-Experienced Children and Young People: Mixed-Methods Systematic Review with Stakeholder Consultation to Inform Transportability and Adaptability to UK Context

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Abstract

Care-experienced children and young people are at increased risk of poor mental health and well-being, and suicide-related outcomes. There is an evidence-base for intervention effectiveness, but this is primarily from the USA. The present systematic review synthesised evidence for international interventions, exploring potential transportability and adaptability to the UK. We constructed an evidence map, and syntheses of intervention effectiveness, process evaluations and economic evaluations.

We conducted seven stakeholder consultations with care-experienced young people, carers and professionals, to appraise transportability and adaptability. We identified sixty-four interventions, with 124 associated study reports. Seventy-seven were from the USA. There was limited effectiveness in targeting mental health, although there were promising approaches. Few approaches targeted well-being and suicide. Context factors, identified by the review and confirmed by stakeholders, may inhibit delivery: insufficient resources; time, emotional and cognitive burden; challenging interprofessional relationships; non-responsiveness to young people's needs; and discounting of carers' knowledge. Stakeholders recommended peer mentoring by other care-experienced individuals and system-change models that facilitate an attachment and/or trauma-informed ethos. Adaptation of existing approaches may be required to account for the context factors. Further intervention work is needed to target well-being and suicide.

Keywords: adolescents, children, evaluation, foster care, intervention, mental health, residential care, systematic review

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Introduction

Care-experienced children and young people can include individuals who have been placed in kinship, foster or residential care. This population reports poorer mental health and well-being compared to the general population (Long *et al.*, 2017; Ford *et al.*, 2018; Engler *et al.*, 2022), and are at an elevated risk of attempted suicide (Evans *et al.*, 2017). Individuals with a history of care are also at increased risk of excess mortality in adulthood, which is attributable to higher rates of self-harm, accidents and other mental health and behavioural risks (Murray *et al.*, 2020).

International research on interventions promoting the mental health and well-being of this population is rapidly expanding, though the UK-specific evidence-base has historically been considered inadequate (National Institute for Health and Care Excellence, 2021). Evidence syntheses report mixed evidence for effectiveness (Everson-Hock *et al.*, 2011; Turner and Macdonald, 2011; Everson-Hock *et al.*, 2012; Luke *et al.*, 2014; Hambrick *et al.*, 2016; Marsh, 2017; O'Higgins *et al.*, 2018; Barnett *et al.*, 2019; Greeson *et al.*, 2020). Meanwhile, recent National Institute for Health and Care Excellence guidelines in the UK draw stronger conclusions about effective approaches from their evidence reviews, recommending delivery and evaluation of mentoring, parenting curricula and system culture change models (National Institute for Health and Care Excellence, 2021).

Whilst the evidence-base is growing, it is important to recognise key limitations, primarily that evaluations tend to solely focus on the

assessment of outcome effectiveness. This is an issue as it can overlook our understanding of interventions' underpinning causal mechanisms, and how they interact with contextual features in the generation of outcomes. Attending to context is imperative as the current evidence-base is predominantly USA-centric. If the effects of interventions are contingent on a specific constellation of contextual characteristics, potentially limited to a particular country's social and health care system, it is not clear if they can be directly transported to different countries or if some adaptation may be required.

A range of methodological guidance on intervention development and evaluation has increasingly foregrounded the importance of exploring the influence of context in intervention functioning (O'Cathain *et al.*, 2019; Skivington *et al.*, 2021). More recently, the ADAPT guidance has considered how evidence-based interventions may not be simply transported between countries, settings or populations where there are significant contextual dissimilarities, but require stakeholder-led adaptation sensitive to local conditions (Moore *et al.*, 2021).

Evidence review methods have been the subject of similar progression. This has included the adoption of complex-systems perspectives and calls to include syntheses of context features as part of systematic reviews of intervention research (Booth *et al.*, 2019; Petticrew *et al.*, 2019). Meanwhile, frameworks, such as the TRANSFER model (Munthe-Kaas *et al.*, 2020), integrate stakeholder engagement into systematic reviews in order to assess the relevance of an international evidence-base to local system needs.

To date, there has been limited consideration of how the impact of interventions targeting care-experienced individuals mental health is contingent on the contexts in which they are delivered. Moreover, there has been no significant stakeholder engagement to explore how evidence-based approaches could be successfully transported to the UK and the extent to which adaptation would be required.

Review aims and research questions

We undertook the Care-experienced cHildren and young people's Interventions to improve Mental health and wEll-being outcomes Systematic review (CHIMES), generating a synthesis of the international evidence-base for interventions targeting the mental health of care-experienced children and young people, in addition to preventing suicide (Evans *et al.*, 2021, 2023). It is the first methodologically robust review to explore the potential transportability and/or adaptability of evidence-based interventions to the UK social and health care context.

First, taking a mixed-methods approach, we synthesised evaluation evidence on intervention outcomes, implementation, acceptability, context and economics (Trubey *et al.*, 2024; Evans *et al.*, 2024; MacDonald *et al.*,

2024). Second, we undertook a comprehensive programme of stakeholder consultation to consider intervention transportability and/or adaptability. Specifically, we addressed the question:

> What do stakeholders think is the most feasible, acceptable and potentially effective intervention for the UK that could progress to further outcome or implementation evaluation?

Methodology

We designed the review with three phases: (i) we created an evidence map charting intervention theories, components and outcomes, in addition to key evidence gaps and clusters (Evans *et al.*, 2023); (ii) we undertook method-level syntheses for each evidence type (outcome; process; and economic) (Trubey *et al.*, 2024; Evans *et al.*, 2024; MacDonald *et al.*, 2024); and (iii) we combined these method-level syntheses into a review-level synthesis, which was the basis of stakeholder consultation. To support the process of harmonising and integrating method-specific syntheses we adopted a convergent synthesis design (Hong *et al.*, 2017; Noyes *et al.*, 2019), which meant that method-level syntheses were designed to be complementary and contingent.

We report the CHIMES review with reference to the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) checklist (Liberati *et al.*, 2009), Good Reporting of A Mixed Methods Study Checklist (O'Cathain *et al.*, 2008) and Enhancing transparency in reporting the synthesis of qualitative research (ENTREQ; Tong *et al.*, 2012). The review is registered with PROSPERO (CRD42020177478).

Eligibility criteria

The eligibility criteria are reported in Box 1.

Box 1. CHIMES systematic review inclusion criteria
Participants: Care-experienced children and young people (≤ twenty-five years old), or their proximal relationships, organisations and communities. Care could include any voluntary transfer of parental responsibility to statutory services: foster care; residential care; and formal kinship care.
Intervention: Any attempt to disrupt existing system practices, including mono-component or multi-component strategies operating across socio-ecological domains: intrapersonal; interpersonal; organisational; community; policy.
Comparator: For outcome evaluations, treatment as usual, other active treatment, or no specified treatment.
Outcomes: Subjective well-being (eudaimonia; hedonia); mental, behavioural or neurodevelopmental disorders as specified by the ICD-11; suicide-related outcomes (self-harm; suicidal ideation; suicide).
Study design: Any report of: programme theory; outcome evaluation (randomised or non-randomised design); process evaluation (qualitative or quantitative); economic evaluation.

Information sources and search strategy

We identified study reports from sixteen bibliographic databases: ASSIA; British Education Index; Child Development & Adolescent Studies; CINAHL; Embase; ERIC; Cochrane Central Register of Controlled Trials; Cochrane Database of Systematic Reviews; HMIC; International Bibliography of the Social Sciences; Medline; PsycINFO; Scopus; Social Policy & Practice; Sociological Abstracts; and Web of Science. The search strategy was developed in Ovid Medline (Supplementary Appendix A). Searches were undertaken from 1990 and restricted to higher income countries. They were conducted May to June 2020 and updated April to May 2022.

We searched the websites of twenty-two relevant social and health care organisations. We contacted thirty-two subject experts and seventeen third sector organisations. We screened relevant systematic reviews and conducted forward and backward citation tracking.

Data selection

Retrieved citations were uploaded to the EPPI Reviewer version 4.0. Titles were screened and checked to identify clearly irrelevant retrievals. Title and abstracts, and then full texts, were screened independently and in duplicate by two reviewers. An inclusion criteria proforma guided selection.

Method-level synthesis: data extraction, risk of bias/risk to rigour and synthesis

We coded eligible study reports for the evidence map according to: country; publication date; intervention type; target population; intervention name; intervention characteristics; programme theory; evidence type; study design; and intervention outcome. Intervention characteristics were coded in accordance with the Template for Intervention Description and Replication (TIDieR) Checklist (van Vliet *et al.*, 2016). From the evidence map we identified evaluation study designs for each method-level synthesis. Data were then extracted and appraised according to a method-specific extraction pro-forma and appraisal tool. Grading of Recommendations, Assessment, Development and Evaluation (GRADE) and (GRADE-CERQual) were used to generate summaries for practice recommendations (Balshem *et al.*, 2011; Ryan and Hill, 2016; Lewin *et al.*, 2018). Extraction was conducted by one reviewer and checked by a second, whilst quality appraisal was conducted independently and in duplicate.

Outcome evaluations were synthesised via meta-analysis. Process evaluation data were synthesised via framework synthesis, with a focus on identifying context factors that might influence intervention functioning. There was an inadequate number of economic evaluations to synthesise findings. A summary of each method-level synthesis approaches is presented in Supplementary Appendix B.

Review-level synthesis: integration of method-level syntheses and stakeholder consultation

We conducted a review-level synthesis, exploring how process evaluation data on context, implementation and acceptability could support explanation of the outcome synthesis. We then presented this synthesis to stakeholder groups. This phase of work was supported by recommendations from the TRANSFER model (Munthe-Kaas *et al.*, 2020).

We conducted seven stakeholder groups (April to September 2022). These included: two groups of care-experienced young people (aged sixteen to twenty-five years; $n = 8$ participants); one group of experienced foster carers ($n = 7$); three groups of health care professionals associated with specialist roles in child welfare and safeguarding, ($n = 45$); and one group of policymakers ($n = 2$).

The planning and delivery of sessions were supported by the review's collaborating partners, The Fostering Network in Wales and Cardiff University's and Voices from Care Cymru's CASCADE Voices care-experienced research advisory group. At each session a member of the review team provided a PowerPoint presentation summarising review findings and discussion points. Consultations lasted between thirty and ninety minutes.

Stakeholders were asked to discuss: (i) if the context factors identified by the process evaluation synthesis, which may support or inhibit intervention functioning, would be relevant to the UK context, and if other factors would need to be considered; (ii) if current theories of change and components align with their priorities for the UK context, based on their understanding of what might be effective, feasible and acceptable; and (iii) if the outcomes targeted by current interventions align with their priorities. As part of these discussions, we considered if existing evidence-based approaches could be directly transported to the UK, if they might be adapted to fit better with the context, or if new intervention development would be required. These discussions were captured through summary notes that were narratively summarised.

On completion of the stakeholder consultations, we constructed two integrative matrices, with the method adapted from an approach used in a recent Cochrane review (Munabi-Babigumira *et al.*, 2017). The first of these 2×2 matrices mapped interventions and their evidence-base by stakeholders' priority theories and components. The second matrix mapped

intervention outcomes by stakeholders' priority outcomes. For the purposes of classifying the evidence-base, we categorised evaluations as reporting evidence of effectiveness, mixed evidence, no evidence, process and feasibility data, and studies only included in the evidence map. Together these matrices helped to identify gaps in the extant evidence-base, and mismatch between current practice and stakeholders' preferences.

Results

Following a summary of the method-level syntheses, we present the results in three sections. First, we describe stakeholders' reflections on the context factors identified as influencing intervention functioning, and their relevance to the UK. Second, we explore their perceptions of identified theories of change and components. Third, we look at the congruence between the outcomes targeted by current interventions and stakeholders' priorities.

Study retrieval

We identified a total of 15,068 unique study reports. Of these 124 study reports associated with 64 interventions were eligible for inclusion. The PRISMA flow diagram is presented in Figure 1, with descriptions of eligible interventions in Supplementary Appendices C and D.

Evidence-base for interventions targeting the mental health and well-being of care-experienced children and young people

Meta-analysis of forty-four randomised controlled trial evaluations reported that for interventions where outcome measurements were conducted up to six months post-baseline, there was a positive impact on total social, emotional and behavioural problems, internalising problem behaviours, externalising problem behaviours, depression and anxiety and social-emotional functioning difficulties (Trubey *et al.* 2024). For interventions where outcomes were measured for more than six months post-baseline, there was no evidence of longer-term effectiveness. There were insufficient evaluations of interventions targeting subjective well-being and suicide-related outcomes to conduct meta-analysis. Assessment of evidence using GRADE showed low or very low certainty for outcome evaluations.

The process evaluation synthesis reported in MacDonald *et al.* (2024) comprised fifty study reports, including twenty-three conceptually and empirically rich evaluations ($n = 23$) and twenty-seven conceptually and empirically thin evaluations ($n = 27$; Ames *et al.*, 2017, 2019).

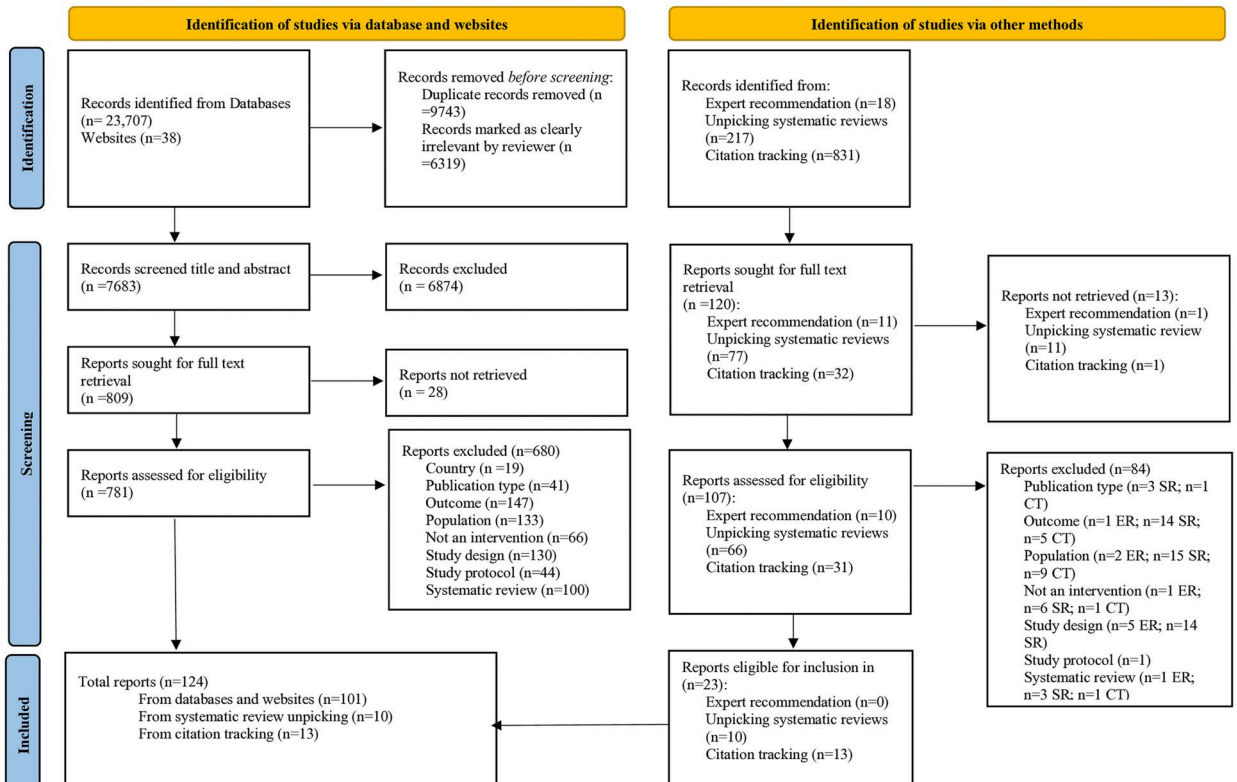

Figure 1: PRISMA flow diagram reporting study retrieval.

From the rich process evaluations, we generated five key context factors, which reflect wider system characteristics that might influence intervention functioning through their impact on implementation and acceptability: (i) lack of system resources for intervention training and delivery, with mental health promotion not being 'core business'; (ii) intervention burden, which includes the ongoing time, cognitive and emotional burden associated with implementation and participation; (iii) interprofessional relationships, with historic tensions between health and social care professionals preventing effective multi-agency collaboration; (iv) the structural disadvantage and marginalisation of care-experienced young people, where their disempowerment and lack of opportunity to communicate discontent could lead to disengagement; and (v) the non-prioritisation of carers' knowledge and experiences. Assessment of evidence using GRADE-CERQual showed medium to high confidence for the evidence.

Integration of the outcome and process evaluation data offers some explanation of the outcome synthesis results. However, there was not complete alignment between method-level syntheses, and so this explanation is somewhat tentative and should be treated with caution. Process evaluations that indicated high levels of implementation and acceptability often focused on the immediate training and delivery period of parenting interventions, with little regard to the longer-term integration of newly acquired parenting knowledge and skills into the wider context of their lives. This might offer some support as to why shorter-term interventions can be impactful. In contrast, the context factors demonstrate entrenched structural barriers to implementation and acceptability, which may lead to the longer-term wash out of the intervention from the system.

Stakeholder consultation reflections and intervention priorities

An overview of the stakeholder consultations, and how they map onto the evidence-base, is presented in Figure 2.

Context factors and relevance to UK social and health care systems

We asked stakeholders to reflect on the key context factors, and explore their relevance to their experiences of the UK context. To note, eight of the sixteen interventions included in development of the factors were delivered and evaluated in the UK context. As such, this phase was as much about confirming they reflected the UK experience.

Overall, stakeholders endorsed the context factors. Lack of resource was cited as a central system issue, with social work teams and carers

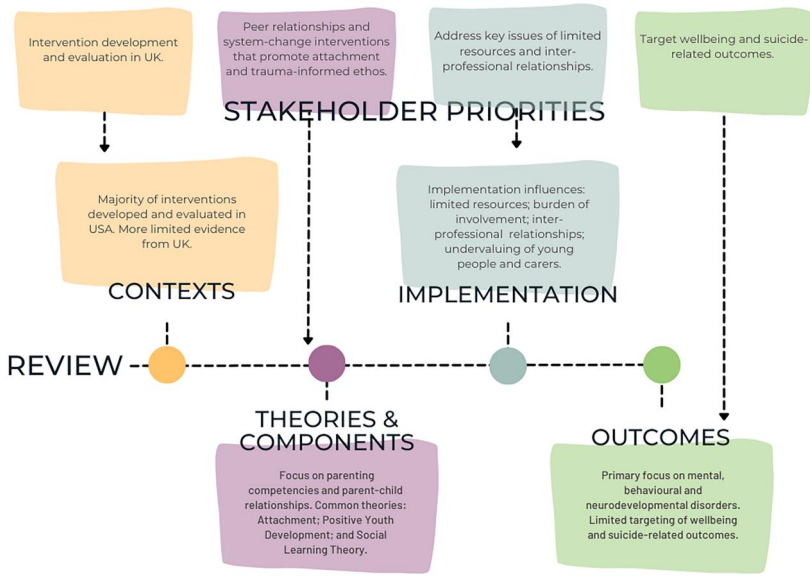

Figure 2: Integration of CHIMES review evidence-base and stakeholder priorities to inform future transportation and/or adaptation of intervention to UK context.

managing high and complex placements within a context of decreasing budgets. Both young people and carers raised issues around the potential burden of interventions. This related to both mentoring and parenting interventions, where it may be emotionally challenging for the mentor/carer to manage difficult disclosures or experiences, and there may be a lack of system capacity to provide supervision. No significant additional context factors emerged.

A central query amongst young people during this part of the discussion was why interventions were being considered for transportation or adaptation from other countries. Given the perceived disregard for care-experienced young people, they wanted to be involved in the coproduction of new interventions.

Stakeholder priority intervention theories of change and components

We constructed a matrix mapping the intervention theories and components prioritised by stakeholders against those included in the review (Table 1). Stakeholders identified two central clusters of intervention theories and components that they would consider to be potentially effective, feasible and acceptable within the UK context: mentoring, and organisational and community interventions.

Table 1. Matrix comparing stakeholders' perspectives on priority intervention theories and components and CHIMES review evidence-base.

Type of evidence	Priority intervention theories and components			
	Interpersonal		Organisational/Community/Policy	
	Mentoring relationships with peers Theories: Attachment; Positive Youth Development; Social Learning Theory; social network support	Mentoring relationships with key others Theories: Attachment; Positive Youth Development; Social Learning Theory; social network support	Interprofessional/multi-agency relationships and ethos Theories: Attachment; Trauma-informed practice; generic system change	Funding for mental health and social care services None
Evidence of effectiveness	*TAKE CHARGE* (Geenen *et al.*, 2012)	Fostering Healthy Futures (Taussig *et al.*, 2007, 2013, 2015, 2019; Weiler and Taussig, 2019; Weiler *et al.*, 2021)		
Mixed evidence of effectiveness		Family Finding (Leon Scott *et al.*, 2016; Shklarski, 2020; Vandivere *et al.*, 2017)	CARE (Izzo *et al.*, 2016, 2020); TST (Murphy *et al.*, 2017)	
No evidence of effectiveness	Mentoring intervention (Mezey *et al.*, 2015)			Choice and availability of different community outpatient mental health services (Bellamy, 2013)
Theory and process evidence only (e.g., feasibility, acceptability)	SuppOrting Looked after children In Decreasing Drugs, and alcohol (SOLID; Alderson *et al.*, 2020a,b, 2021)	Therapeutic mentoring (Johnson *et al.*, 2010); Youth-Initiated Mentoring (YIM; Spencer *et al.*, 2018)	New Orleans/Glasgow Infant Family Team (GIFT)/London Infant Family Team (LIFT; Baginsky *et al.*, 2017; Turner-Halliday *et al.*, 2016; Turner-Halliday *et al.*, 2017); Optimising CAMHS (Callaghan *et al.*, 2003)	
Included in evidence map				

Mentoring was recommended, with much discussion of Fostering Health Futures, which combines social and emotional curricula with mentoring by a social worker or psychology graduate student (Taussig *et al.*, 2007; Taussig and Culhane, 2010; Taussig *et al.*, 2013, 2015, 2019; Weiler and Taussig, 2019; Weiler *et al.*, 2021). Whilst stakeholders did not explicitly articulate the underpinning theories linked to this approach, their views resonated with ideas around attachment theory (Bowlby and Ainsworth, 2013), positive youth development (Waid and Uhrich, 2019) and social learning theory (Bandura and Walters, 1977). Together these foreground the importance of positive social modelling and developmental contexts for children and young people.

Young people in particular felt it would be supportive to introduce mentoring, particularly from the age of ten, when children start to be aware of their identity as 'being in care'. However, whilst the Fostering Healthy Futures delivery agent is social work and psychology students, young people preferred mentors with direct experience of care, potentially care-experienced peers. This was because they could understand their complex life events and young people may be more inclined to replicate prosocial behavioural models from individuals with whom they could relate. Stakeholders also considered that young people already struggled to secure time with a social worker, and so fostering this type of relationship with any new 'professionals' might not be feasible. There was also caution about the risks of terminating the relationship and potential feelings of abandonment.

Organisational and community interventions focusing on facilitating a shared ethos (e.g., trauma-informed practice) across social and health care teams was also deemed a priority. Young people in particular favoured a system culture that moved away from a deficit model of mental health, where professionals are 'quick to judge' behaviour without understanding causal factors. However, it should be noted that stakeholders from policy and practice groups felt that there were already key efforts in this vein the UK (Children's Commissioner for Wales, 2020). As such intervention efforts may focus more on optimising awareness, access and delivery around existing practice.

To note, intervention theories and components identified through the review had limited alignment with stakeholders' preferences, with Fostering Healthy Futures being one of a limited number of mentoring approaches suggesting positive impacts. Generally, mentoring approaches struggled to progress to outcome evaluation, especially in the UK, as they encountered significant implementation issues at piloting stage (Mezey *et al.*, 2015; Alderson *et al.*, 2020a,b, 2021). A limited number of structural interventions targeted organisations, communities or policies ($n = 6$). Key examples such as Trauma Systems Therapy (TST; Murphy *et al.*, 2017) and Children and Residential Experiences (CARE; Izzo *et al.*, 2016, 2020) indicated mixed evidence.

Stakeholder priority outcomes

We constructed a matrix mapping the outcomes prioritised by stakeholders against the outcomes targeted by interventions (Table 2). Stakeholders, particularly young people, stated that they wanted interventions that had a clearer focus on well-being and suicide-related outcomes. Perhaps linking to preferences around theories and components, stakeholders also recommended interventions that addressed relationship-based outcomes. Existing interventions do not reflect these priorities, with only eleven targeting subjective well-being and four targeting suicide-related outcomes.

Discussion

As part of the CHIMES systematic review we synthesised international evidence for interventions targeting the mental health and well-being of care-experienced children and young people, in addition to suicide-related outcomes (Evans *et al.*, 2021, 2023, 2024; MacDonald *et al.*, 2024; Trubey *et al.*, 2024). We took a novel approach to reviewing the evidence, with a focus on understanding the potential transportability of the international evidence-base to the UK context and where adaptation might be needed. This was supported by a comprehensive programme of stakeholder engagement to explore if review findings resonate with their own contextually situated priorities and perceived constraints (Munthe-Kaas *et al.*, 2020).

Reflecting on the method-level syntheses, the review offers new and important findings on intervention effectiveness and processes. Centrally, we found that whilst approaches targeting mental health, behavioural and neurodevelopmental problems demonstrate positive impacts in the shorter term, these are not realised in the longer-term (Trubey *et al.*, 2024). Additional data integration did not offer a clear explanation for this, but insights from the conceptually and empirically rich process evaluation synthesis suggest system-level factors linked to resources, interprofessional relationships and stakeholder identities, may inhibit implementation and acceptability (MacDonald *et al.*, 2024). Significantly, the majority of evaluations reporting system inhibitors and facilitators have been conducted in the UK, increasing confidence in the relevance of our findings on system factors influencing transportability.

The central question addressed by the present article, is whether the identified evidence-base responds to stakeholder priorities and if approaches might be potentially effective, feasible and acceptable in the UK context. Through the stakeholder consultation, we identified some misalignment between the evidence-base and stakeholders needs and values.

Table 2. Matrix comparing stakeholders' perspectives on priority outcomes and CHIMES review evidence-base.

	Priority intervention outcomes				
	Subjective well-being	Child-peer relationships	Child-carer/other adult relationships OR Carer-child relationships	Life skills	Suicide-related outcomes
Evidence of effectiveness	Fostering Healthy Futures (Taussig and Culhane, 2010; Taussig *et al.*, 2013, 2015, 2019; Weiler *et al.*, 2021)		Fostering Healthy Futures (Taussig *et al.*, 2015)		
Mixed evidence of effectiveness	KEEP (Walsh Natalia, 2017)	CARE (Izzo *et al.*, 2020)	Connect-KP (Pasalich *et al.*, 2021); CARE (Izzo *et al.*, 2020); Family Finding (Shklarski, 2020; Vandivere *et al.*, 2017); Fostering Changes (Briskman *et al.*, 2012; Moody *et al.*, 2020)		CARE (Izzo *et al.*, 2016)
No evidence of effectiveness	Wave by Wave (Pereira *et al.*, 2020)	Multi-dimensional Treatment Foster Care (MTFC; Leve *et al.*, 2009)	Child Directed Interaction Training (CDIT; N'Zi *et al.*, 2016); Incredible Years (Furlong *et al.*, 2021) *k*Contact (Suomi *et al.*, 2020); Multi-dimensional Treatment Foster Care (MTFC; Leve *et al.*, 2009); Triple P for Foster Carers (TPFC; Job *et al.*, 2022)		HealthRHYTHMS (Bittman *et al.*, 2009); Mentoring for teenage pregnancy (Mezey *et al.*, 2015)

(continued)

Table 2. (continued)

	Priority intervention outcomes				
	Subjective well-being	Child-peer relationships	Child-carer/other adult relationships OR Carer-child relationships	Life skills	Suicide-related outcomes
Theory and process evidence (feasibility, acceptability) only	Intensive Permanence Systems (IPS; Hall *et al.*, 2018); Kundalini Yoga (Vallejos Elvira *et al.*, 2016); SOLID (Alderson *et al.*, 2020a,b, 2021); Youth Initiated Mentoring Relationships (YIM; Spencer *et al.*, 2018)	Youth Initiated Mentoring Relationships (YIM; Spencer *et al.*, 2018)	Treatment Foster Care (Southerland *et al.*, 2009); Youth Initiated Mentoring Relationships (YIM; Spencer *et al.*, 2018); GIFT (Boyd *et al.*, 2016); Treatment Foster Care (TFC; James and Meezan, 2002); Solution-Focused Parent Group (Triantafillou, 2002); Together Facing The Challenge (TFCT; Murray *et al.*, 2014)	Treatment Foster Care for Older Youth (TFC-OY; McMillen *et al.*, 2015)	
Included in evidence map only	Equine-facilitated Psychotherapy (EFP; Bachi *et al.*, 2012); Opportunities Box (Silva *et al.*, 2017); Registered Education Savings Plan (Marquis, 2014); Type of care placement (McCrae *et al.*, 2010)	Opportunities Box (Silva *et al.*, 2017)	Sanctuary Model (Rivard *et al.*, 2003); Equine-facilitated Psychotherapy (EFP; Bachi *et al.*, 2012); Head Start (Lipscomb *et al.*, 2013); Prevention intervention (Smith Dana *et al.*, 2011)		Cognitively-Based Compassion Training (CBCT; Reddy *et al.*, 2013)

Stakeholders prioritised interventions with relationship-based approaches that foster stronger connections with care-experienced peers or other adult figures. Whilst the extant evidence-base does have a focus on interpersonal relationships, these interventions primarily target the knowledge, skills and practices of foster carers, with flagship branded interventions including Multi-dimensional Treatment Foster Care (Leve *et al.*, 2009; Green *et al.*, 2014; Åström *et al.*, 2020), and its derivative Keeping Foster and Kinship Parents Supported and Trained (KEEP; Price *et al.*, 2012, 2019). Stakeholders also recommended structural-level interventions that could facilitate interprofessional multi-agency collaboration through shared culture and ethos, which were largely absent from the review. Further, there was some incongruence between priority outcomes and intervention-evaluated outcomes, with a lack of focus on subjective well-being and suicide-related outcomes. Self-harm and suicide has been increasingly recognised as an understudied outcome for child welfare populations, with a significant lack of intervention research in this area (Russell *et al.*, 2021).

A central reflection based on the evidence-base, is whether existing promising interventions can be directly transported to the UK. Given that the evidence has been primarily generated in the USA, this would largely entail a USA to UK transfer. Equally, the recommendation may be for intervention adaptation to ensure sensitivity to different contextual constraints and experiences (Moore *et al.*, 2021). Alterantively, and based on stakeholder consultation, new intervention development could be an important approach given that young people can feel structurally disadvantaged and would welcome approaches that are designed with their specific needs in mind.

Reflecting on the stakeholders' discussion, there are candidate mentoring interventions in the USA (e.g., Fostering Health Futures) that could possibly function in the UK, but these would need adaptation rather than direct transportation (Taussig *et al.*, 2007; Taussig and Culhane, 2010; Taussig *et al.*, 2014, 2015, 2019; Weiler and Taussig, 2019; Weiler *et al.*, 2021). The adaptation process would need to take specific account of the potential inadequacy of resources experienced by previous mentoring programmes tested in the UK (Mezey *et al.*, 2015).

Approaches such as CARE or TST might provide a useful departure point for adaptation in order to tackle organisational drivers of the problem, though the effectiveness of such interventions is less clear (Izzo *et al.*, 2016; Murphy *et al.*, 2017; Izzo *et al.*, 2020). Such approaches would need to interact with other programmes and processes already in the system, and could be challenged by historic tensions in interprofessional working.

It is also important to consider the potential integration of these two sets of interventions to create a harmonised approach as part of any adaptation process. Whilst mentoring and system change approaches have

not been tested as a multi-component intervention to date, they are not theoretically discordant. Given that reported barriers to the implementation of mentoring often link to lack of system resource or interprofessional working, intervention activities to support system change may be complementary and potentially facilitate necessary contextual restructuring. Some interpersonally focused approaches, such as parenting interventions, have tested the delivery of system change approaches to enhance and sustain implementation (Chamberlain *et al.*, 2008; Brown *et al.*, 2014).

Whilst Fostering Healthy Futures does currently target subjective well-being, and CARE also addresses self-harm, additional theoretical work and empirical testing might also explore and evaluate if and how mentoring and system-change approaches can work for a wider range of outcomes, both individually and potentially combined.

Review findings also offer clear direction for future research. In the first instance, there is an evident need to work with local stakeholders to identify priority outcomes and theorise their causes within the context of interest (Skivington *et al.*, 2021). There is also a need for more robust and comprehensive coproduction that focuses on generating appropriate intervention responses. There are a range of intervention development frameworks that can support this process (O'Cathain *et al.*, 2019; Skivington *et al.*, 2021).

Equally, clear understanding of the contextual contingency of intervention effects is central to evaluation and systematic reviews (Pfadenhauer *et al.*, 2017; Craig *et al.*, 2018; Booth *et al.*, 2019). Frameworks such as TRANSFER can be helpful in assessing the extent to which existing interventions can be transported between contexts, with this process driven by stakeholder engagement and reflection (Munthe-Kaas *et al.*, 2020). Where adaptation is required due to contextual dissimilarities, frameworks such as ADAPT, have much to offer (Moore *et al.*, 2021).

The findings of the review also have important implications for policy and practice. These relate both to future intervention development, and to the optimisation of existing practice. Adopting an approach developed in previous Cochrane reviews (Munabi-Babigumira *et al.*, 2017), we identified ten key questions that might guide the delivery of interventions targeting the mental health and well-being of care-experienced children and young people (Figure 3). These were supported by the evidence synthesis, GRADE and GRADE CERQual statements with high to moderate certainty or confidence, and the stakeholder consultations.

Limitations

There are two central limitations of the review. First, as a consequence of the ongoing Coronavirus (COVID-19) pandemic, we were able to

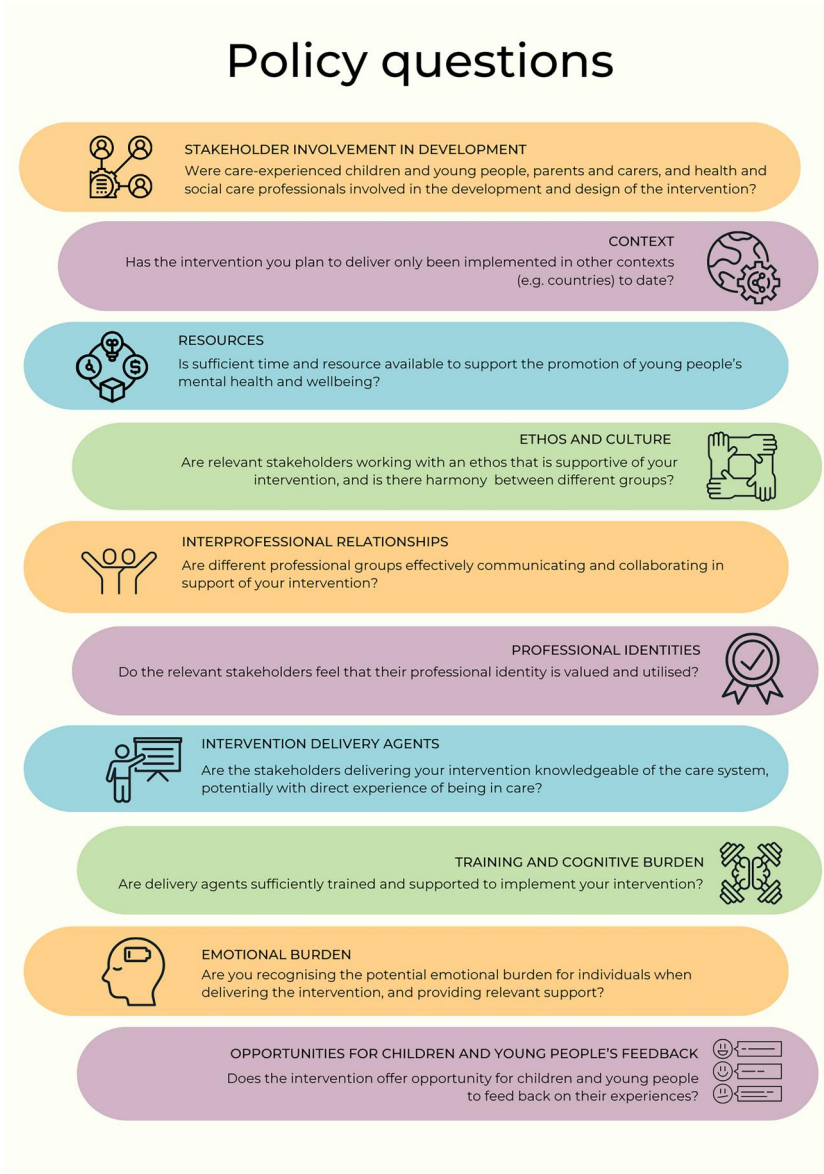

Figure 3: Key questions for policymakers and practitioners to optimise future delivery of mental health and well-being interventions for care-experienced children and young people.

engage with fewer stakeholders than intended as organisations struggled to recruit participants to planned consultations in England. Second, whilst we provided the discussion questions to all stakeholder groups, they were led by different facilitators, meaning that there were variations in content in the consultations and not all themes were covered by each group.

Conclusion

The present CHIMES review makes a significant and novel contribution to our understanding of mental health and suicide prevention interventions for care-experienced children and young people, as it is one of the first to explore the potential transportability and adaptability of evidence-based approaches to the UK. This was achieved through a robust mixed-method approach that drew upon a comprehensive programme of stakeholder consultations to explore their localised priorities. We found that existing peer mentoring and social and health care system change models could potentially function and create positive change in the UK, but some adaptation would likely be required to ensure contextual sensitivity. This review has scope to meaningfully impact the mental health and well-being of care-experienced individuals in the UK, by ensuring that interventions are responsive to the characteristics and constraints of the system in which they will be delivered. It has also provided useful methodological guidance on how to conduct a systems-informed systematic review that prioritises the role of context in intervention functioning.

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Supplementary material

Supplementary material is available at *British Journal of Social Work Journal* online.

Authors' contributions

Dr Rhiannon Evans conducted the conception of the study design, screening of study reports, extracting and appraising of study reports,

review synthesis, stakeholder consultations, drafting of the publication and confirming of the publication. Dr Sarah MacDonald conducted the screening of study reports, extracting and appraising of study reports, review synthesis, conducting of stakeholder consultations and confirming of the publication. Dr Rob Trubey conducted the screening of study reports, extracting and appraising of study reports, review synthesis and confirming of the publication. Professor G.J. Melendez-Torres conducted the conception of the study design, screening of study reports, extracting and appraising of study reports, review synthesis, notably the meta-analysis, and confirming of the publication. Professor Mike Robling conducted the conception of the study design, review synthesis, and confirming of the publication. Simone Willis (Systematic Reviewer) conducted the conception of the search strategy, conducting of searches for study reports, conducting of all related information specialist tasks, screening of study reports, extracting and appraising of study reports and confirming of the publication. Maria Boffey conducted the stakeholder consultations and confirming of the publication. Charlotte Wooders conducted the stakeholder consultations and confirming of the publication. Soo Vinnicombe conducted the screening of study reports, extracting and appraising of study reports and confirming of the publication. Professor Jane Noyes conducted the conception of the study design, review synthesis, drafting of the publication and confirming of the publication.

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Competing interests statement

The authors declare that they have no competing interests.

Ethical approval statement

The CHIMES review was exempted from ethical approval from Cardiff University's School of Social Sciences Research Ethics Committee.

Data availability statement

Data extraction, analysis and synthesis are available from the corresponding author on reasonable request.

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