Report Supplementary Material 17: Summary of Thin Process Evaluations - Context, Implementation and Acceptability

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1. Table Summarizing Thin Process Evaluations

Intervention	Process Evaluation Design	Process Evaluation: Context, Implementation and Acceptability	Linked Outcome Evaluation(s)
Cognitively-Based Compassion Training (CBCT) [1] USA	Post-treatment, young people completed a 5-item feedback form assessing: 1) helpfulness; 2) frequency of thinking about CBCT principles outside of class; 3) whether they would recommend the intervention; 4) if they would like intervention in their schools; and 5) how they felt about intervention length. A 10-point Likert scale was used to assess student's feeling of connection to classmates and teacher. Higher scores indicate a stronger connection. Open-ended questions assessed lessons learned, use of CBCT in daily life, and how the intervention could be improved.	Context N/A Implementation N/A Acceptability *Children and young people:* Participants found intervention to be helpful (62%) or a little helpful (30%). They used CBCT concepts outside of the class a lot (41%) or once in a while (46%). 87% said they would recommend it for a friend. Some participants said they would like it in school (40%), some said they would not want it (14%) and almost half were unsure (46%). Majority (60%) said the length just about right. Participants reported feeling moderately connected to their classmates (mean = 6.86/10, SD = 2.49) and more strongly connected to their instructors (mean = 7.14/10, SD = 2.07).	*Direct evidence* Study design: RCT Outcome measure: Short-term outcomes (post-intervention; six weeks): • Emotional regulation • Depressive symptoms (DSM IV) • Trait anxiety Evidence: No evidence of effect
Connect-KP [2] Australia	Observational ratings of video recordings of group sessions, to assess fidelity. Post-intervention feedback from facilitators and parents/carers.	Context N/A Implementation *Fidelity:* Mean adherence was 100%. Mean competence score 2.85 (range = 2.50–3.00, SD= 0.19), indicating that facilitators demonstrated a high level of proficiency *Acceptability* *Facilitators:* Majority of participants strongly agreed (72%) or agreed (22%) that training met their expectations. They strongly agreed (88%) or agreed (12%) that they would recommend the training. *Parents and carers:* On a scale of 1 (not helpful) and 4 (very helpful), carers found programme concepts helpful (M = 3.67, SD = 0.43), felt more	*Direct evidence* Study design: RCT Outcome measure: Short-term and long-term CYP outcomes (post-intervention; six month follow up): • Behavioural and emotional adjustment • Affect dyscontrol Evidence: Uncertain effects

		confident in their ability to parent (M =3.37, SD = 0.50) and had been applying the skills discussed in the group when parenting (M = 3.42, SD = 0.51).	
Dojo: Biofeedback videogame [3] USA	Outcome data were collected for both conditions at three time points: week 1 prior to the intervention (i.e., baseline); week 5 immediately following the intervention (i.e., post- treatment); and at 4-months follow-up. Measurements consisted of participants' self-report and mentor-report (the group home worker with whom they had the most contact). Self-report measures were completed in an interview format. Interviews took 15 to 20 min and were conducted by the first author or a research assistant.	Context N/A Implementation *Recruitment/retention*: High rates of missing data for 4-month follow-up mentor reports (n=28 reports from a possible 41), due to children moving institutions in the interim. *Fidelity*: All participants attended all eight scheduled gameplay sessions. Participants reported high compliance during the relaxation tutorials. The mean scores for self-reported effort was 5.76 out of 7 for positive self-talk, (SD = 1.15), 6.12 for muscle relaxation (SD = 0.99), 5.95 for guided imagery (SD = 2.00), and 6.06 for deep-breathing techniques (SD = 1.09). The relaxation techniques that were rated as most used in participants' daily lives were deep-breathing relaxation (64.7%) and positive thinking (47.1%). Acceptability *Children and young people:* Likert-scale evaluation scores were 4.53 out of 5 for 'liked playing Dojo' (SD = 0.62), 4.00 for 'thinks other youths will like playing Dojo' (SD = 0.92), 3.88 for 'liked Dojo being a videogame intervention' (SD = 1.22), and 4.53 for 'Dojo is useful in daily life (SD = 1.07).	*Direct evidence* Study design: RCT Outcome evaluation: Short-term outcomes (post-intervention, 5 weeks; 4-month follow-up): • Externalizing problems (child reported) • Externalizing problems (carer reported) • Anxiety (child reported) • Anxiety (carer reported) Evidence: Uncertain effects
Fostering Changes [4] UK	Recruitment and retention rates measured. Acceptability data obtained from a short 'satisfaction questionnaire' given to foster carers during the last intervention session. Completed by 31/34 of the intervention participants.	Context N/A Implementation *Recruitment/retention*: In total, 63 foster carers completed the trial (34 intervention, 29 control) and 14 dropped out (8 intervention, 6 control). Two carers reported that their placement had	*Direct evidence* Study design: RCT Outcome evaluation: Short-term outcomes (post-intervention, 12 weeks): • Total carer-defined problems

		ended and others had “second thoughts”. One dropped out after 5 weeks as they could not arrange childcare cover. Attendance varied between 8 and 12 sessions (M = 10.5, SD =1.2). *Fidelity:* Two of the courses had to be shortened to 11 weeks because of adverse weather conditions, but mean attendance rates in the intervention groups were good. Acceptability *Parent and carers*: Intervention was generally positively received by foster carers.	• Total problems • Emotional Symptoms • Conduct problems • Hyperactivity • Peer relationships • Pro-social behaviour Evidence: No evidence of effect *Indirect evidence* [5] Study design: RCT Outcome evaluation: Short-term and long-term outcomes (3 month; 12-month follow-up): • Emotional problems • Total difficulties • Peer Problems • Prosocial behaviour • Conduct problems • Hyperactivity-inattention Evidence: Uncertain effects
Fostering Healthy Futures (FHF) [6] USA	Assessed programme uptake and fidelity through monitoring attendance at skills group and mentoring sessions, and monitoring of completion of discrete activities during skills group sessions.	Context N/A Implementation *Recruitment/retention:* Of the 233 eligible intervention group children, 11 refused the intervention and 17 dropped out during intervention. 19 further children were lost to follow-up assessments (n=12 refused, n=7 unable to be located). Organisers provided transportation, dinner, and respite care twice a week, which they suggest probably helped retention of participants. *Fidelity:* In the intervention group, children attended an average of 25.6 of the 30 skills groups and 25.9 of the 30 targeted mentoring visits. The 30 intervention skills group sessions	*Direct evidence* [7] Study design RCT Outcome measure: Short and long-term outcomes (six-month follow up; 15 months): • Mental health functioning • Post traumatic symptoms • Dissociation symptoms • Quality of Life Evidence: Evidence of effects

		included 104 discrete activities. On average, 98 of the 104 group activities were completed Acceptability N/A	
Foster parent training [8] Belgium	Trainers kept a log of recorded contacts/actions and registered the degree of implementation of new skills by the foster parents.	Context N/A Implementation *Recruitment/retention*: 35% of foster families joined at least one group session and 20% joined follow-up group session *Fidelity:* Most mandatory modules were discussed by the trainer with the foster parents. There was variation in implementation of mandatory modules by carers, ranging from 100% for positive involvement and 20% for problem solving. Acceptability N/A	*Indirect evidence* [9] Study design: RCT Outcome measure: Short-term outcomes (post-intervention; 3 month follow up): • Internalizing problems • Externalizing problems Evidence: No evidence of effect
Incredible Years [10] USA	Foster carers completed weekly questionnaires giving feedback on the course using Likert-scale responses, from 'helpful' to 'not helpful'. Delivery agents completed an intervention checklist at the end of each session. A sub-set of intervention carers took part in post-intervention focus groups (n=9) and interviews (n=5).	Context N/A Implementation *Recruitment and retention:* 19 families participated in the intervention, with three dropping out due to a death in the family (n=2) or the child moved home (n=1). *Fidelity:* 16 foster carers completed the intervention and attended between 6-13 sessions (max = 13). Average attendance of 10.44 sessions. Five of the 16 carers attended fewer than 75% of sessions. Researcher-led checklist suggested that 74% of session tasks were completed across all sessions. Acceptability *Parents and carers:* Foster carers felt it was useful to have peer support from other carers. Weekly feedback was helpful when trying new approaches. They found the learning to be useful and picked up important parenting tools. Carers rated the content of sessions between helpful and very helpful (average rating 3.63/4)	*Direct evidence (Conn et al., 2018)* Study design: RCT Outcome measure: Short-term outcomes (6-month follow up): • Total problems • Internalizing problems • Externalizing problems Evidence: No evidence of effect *Indirect evidence* [11] Study design: RCT Outcome evaluation: Short-term outcomes (post intervention; 6-month follow up): • Disruptive classroom behaviour • Externalizing behaviour Evidence: No evidence of effect

		and the video examples as helpful (average rating 3.23/4). They were most satisfied with the group leader's teaching and the group discussions, which were both rated closest to very helpful (average rating 3.83/4 for both).	
Incredible Years [12] Ireland	Semi-structured interviews with biological parents (n = 12) and foster carers (n = 11) following intervention delivery. Fourteen of 23 participants were linked pairs of parents to the same foster child. Focus group with delivery agents (n = 5) who were social workers and family support workers.	Context Socio-cultural contextual differences between the USA where intervention originated and Ireland. Ireland had historic social welfare structures that did not easily facilitate the necessary interprofessional working. Implementation *Recruitment/retention:* Recruitment hindered by compartmentalization and conflict of roles in social work department. They were also not aware of the intervention's evidence-base and there was no buy-in. Foster carers' status as professional caregivers may have reduced openness to training in parenting skills. *Fidelity:* Difficulties for biological parents to implement parenting skills during access visits as they were infrequent. Parents also felt monitored. Twelve parents and carers said they had to overcome personal and cultural barriers to implementing the programme (e.g. focus on positive attention was inconsistent with their general approach of punishing bad behaviour). Participants were also uncomfortable with 'cheesy' tone. Acceptability *Parents and carers*: Carers satisfied with the intervention in terms of benefits achieved for the parent–child relationship. Perceived complementary benefits of involving both biological parents and foster carers as it reduced parental stress and improved child behaviour. They felt the groups were enjoyable and felt safe. Some participants felt it was not sufficiently trauma-informed to meet the needs of children and carers.	

		Delivery agents: Felt the intervention enhanced standard service supports and could help reduce placement breakdown. It was also unique in providing a service for biological parents.	
Incredible Years [13] UK	Supervision with delivery agents for two hours per week. Intervention sessions were video-recorded and reviewed at supervision. Delivery agents brought carer feedback from sessions. Reports reflections on the intervention based on supervision notes recorded immediately after the supervision.	Context N/A Implementation *Fidelity:* Foster carers found it difficult to implement certain skills due to perceived conflicts with local authority guidelines. These included the use of small incentives to reinforce positive behaviour, and suggested 'time out' approach. Acceptability: *Parents and carers:* Delivery agents reflected that kinship carers found it hard to fit into groups alongside professional carers due to issues about relating to birth parents in their own family and contact were different. Foster carers welcomed social workers attending sessions, as they then felt supported in implementing a 'parenting toolkit'. Less experienced carers welcomed presence of more experienced carers in group sessions. Foster carers experienced difficulty in implementing parenting strategies that were successful with their biological children with the foster children due to fostering agency rules (e.g., social services would provide pocket money provision, so parents were told that they must give it to the foster children). Discussed importance of maintaining quality/play time with their own children and the challenges for biological children of having a fostered child in their home. *Delivery agents:* Supervisors felt that sessions were more successful when involving Local Authority staff, due to the potentially conflicting advice that carers perceived between programme aims and local guidance or rules on children in care.	

Incredible Years [14] USA	Carers completion of Parent Satisfaction Questionnaire and treatment fidelity checklist completed by group leader.	Context N/A Implementation *Retention and recruitment:* Ten of 11 treatment families came to 9 or more sessions. *Fidelity:* Topics areas were covered in all but one session. Acceptability *Parents and carers:* Average satisfaction 'overall feelings about the program' was 6.13/7 (with 7 being 'very positive').	
Incredible Years [15] Portugal	Satisfaction data collected from the staff group during: 1) weekly evaluations of the programme sessions on 1-4 Likert scale (1 not helpful – 4 very helpful; and 2) at the last group session where they were asked to complete a Satisfaction Questionnaire that assessed overall views of the programme, usefulness of teaching methods, and usefulness of educative techniques.	Context N/A Implementation N/A Acceptability *Parents and carers:* Residential care staff rated each session between helpful (3) and very helpful (4) for following aspects: content 3.95 (SD = 0.10); videotape vignettes 3.85 (SD = 0.19); role-playing 3.68 (SD = 0.35); group leaders' teaching 3.93 (SD = 0.12); and group discussion 3.80 (SD = 0.23). Participants' feelings towards the programme were very positive (59.3%) or positive (40.7%). 74.1% said they would strongly recommend the programme, 25.9% said they would recommend it. They stated children's behaviour was greatly improved (11.1%) or improved (66.7%). 92.6% reported the information was extremely useful (63%) or useful (29.6%). They rated the group leaders positively in terms of teaching skills (55.6% 'superior' and 44.4% responded 'high') and preparedness (37% responded 'superior' and 63% 'high'). 18.5% reported feeling very confident and 77.8% confident to use learning in future. There was no difference in satisfaction based on participants' education level.	
Keeping Foster and Kin Parents Supported	G1 facilitators (trained and supervised by intervention developers) and G2	Context N/A	*Direct evidence* [17] Study design:

and Trained (KEEP) [16] USA	facilitators (trained by G1 facilitators) assessed for adherence with the Facilitator Adherence Rating (FAR), which is completed by the supervising consultant after each KEEP session. It is 14-item scale that rates content, process and structure of the group. Items are assessed with a 1 (not at all) to 5 (very much) score. Video recording sessions from G1 (n=155) and G2 (n=136) groups were coded.	Implementation *Fidelity:* No significant difference between G1 and G2 FAR scores (MD = 0.36, 90% CI=−2.62 to 3.33), with groups demonstrating equal intervention fidelity. Acceptability N/A	RCT Outcome measure: short-term outcomes (6-month follow up): • Total number of child problem behaviours Evidence: Uncertain effects *Indirect evidence* [18] Study design: RCT Outcome measure: Short-term outcomes (post-test): • Externalizing problems • Total problems • Internalizing problems • Anxiety / depression Evidence: Uncertain effects
Keeping Foster and Kin Parents Supported and Trained (KEEP) Chamberlain et al. (2008) (Chamberlain et al., 2008)	Completion rates for all participants measured for each session. Facilitators were video recorded and feedback provided.	Context The intervention was implemented in San Diego County, with a large Latin American, Spanish-speaking population. Authors discussed the challenge in adapting the research protocol to different regional agencies, who each differ in 'organization, financial structure, training procedures, and community contextual issues. Implementation *Recruitment/retention:* 429 of 1,129 identified eligible parents declined to take part (38%): Reasons given for declining to participate included too busy, too much work, or too many children (50%); not interested (43%); family health problems (2%); and concerns about participating in research (5%). 81% of the recruited foster parents completed 12 or more of the group sessions (max = 16), and 75% of the foster parents completed 14 or more group sessions (14+). Acceptability *Delivery agents:* Local Child Welfare agency expressed interest in continuing the programme and integrating it into their services and had applied for further funding to extend the programme locally.	
Keeping Foster and Kin Parents Supported and Trained (KEEP) [19]	After each group session, facilitators rated the degree of engagement by participants in the group	Context N/A Implementation	

USA	session using six Likert-scale items (1 =not at all - 5 =very much).	*Fidelity:* Significant upward trajectory for participants' "process-oriented engagement" over the course of the intervention (i.e., intervention engagement judged to have increased with each session). Acceptability N/A	
Life Story [20] USA	Interviews with children after the intervention. Carers completed an open-ended questionnaire after the intervention. Clinicians completed an open-ended questionnaire after the intervention. Evaluation also draws upon field notes completed by community clinicians.	Context Rural setting where access to mental health services is limited, especially for trauma symptoms. Travel times a barrier to accessing remote services. Implementation *Recruitment/retention:* 26 children referred, with 23 children (from 16 families) and their caretakers agreeing to take part. 7 children (4 intervention, 3 control) dropped out before end of study as moved area. 15 children (from 12 families) completed the study. Research team felt it was important that the intervention was delivered in children's homes / community, to address issue of travel time in rural communities. Acceptability *Children and young people:* Generally positive. Valued working with local person (e.g. community clinicians) they were already familiar with. Valued the relationship with clinician, although some children had anxiety about sharing details about past trauma. *Parent and carers:* Welcomed children having an extra person to have a relationship with. Valued having a person that they could speak to about the foster child's development. Wanted the intervention to last longer. *Delivery agents:* Discussed participants being an emotional and clinically complex group. Study team stated it was emotionally difficult for the clinicians, which was exacerbated by them knowing the child/family. Feeling of helplessness	*Direct evidence (Haight et al., 2010)* Study design: RCT Outcome measure Long-term outcomes (12-month follow up): • Total problems • Internalizing behaviour • Externalizing behaviour • PTSD / Disassociation Evidence: No evidence of effect

		and felt they needed more training in forming therapeutic plans and professional supervision. Found delivering intervention in home setting to have benefits (insight into family life, child being in their own comfort area) but also challenges (made it harder to maintain professional boundaries with emotionally vulnerable children, challenges in confidentiality). May be torn between reporting child protection issues and maintaining relationship with child. Found time constraints of intervention difficult. Reflected on children's need for something more permanent and consistent.	
Herts and Minds: Mentalisation-Based Therapy [21] UK	Recruitment log of families and children referred to intervention. Skill level in delivering MBT assessed with MBT-Fostering- Adherence and Competence during and after intervention Scale (MBT-F-ACS) and focus groups with clinicians. Treatment attendance log and semi-structured interviews / focus groups with foster carers, social workers and targeted team clinicians.	Context N/A Implementation *Recruitment/retention:* Of the 47 eligible families, 36 were randomised (11 declined participation). Study team noted difficulties in recruitment because of the reliance on referrals to CAHMS mental health team and despite efforts to address it, the consent process was complex (consent required from both birth parent, foster carer, child and LA professional). There were no dropouts among recruited families. Attendance at intervention sessions was high (90% attendance), though the team had to extend the programme over a longer time-frame than anticipated (up to 24 weeks rather than the initial 12) to accommodate re-scheduled appointments. Authors note that children who had placement disruptions were still able to continue attending where the new foster carer felt appropriate. *Fidelity:* Using the MBT-F-ACS tool, all 13 intervention sessions were judged by researchers to be adherent to the MBT approach. However, 6 out of 11 of the control group sessions also met the standard for MBT adherence – suggesting that usual practice has	*Direct evidence (Midgley et al., 2019)* Study design: RCT Outcome measure: Short-term outcomes (post-intervention, 3 months; 6-month follow up): • Total problems (child reported) • Total problems (carer reported) • Internalizing problems (child reported) • Internalizing problems (carer reported) • Externalizing problems (child reported) • Externalizing problems (carer reported) Evidence: Uncertain effects

		many of the same elements as the intervention. This was corroborated by interviews with facilitators who felt that the program was broadly consistent with their normal practice. Acceptability *Parents and carers:* Foster carers generally reported very positive experience of the programme, and rated delivery agents well. Appreciated allowing children to play while talking during the sessions. Two carers were less positive, being concerned about the delays in receiving the intervention. One also felt criticised in their parenting approach by the facilitator. *Delivery agents:* Enthusiastic about the mentalisation aspect of the intervention, and felt that 'developing joint curiosity' and 'coming up with joint solutions' were distinct aspects of the intervention compared to the usual care they would administer.	
Mindfulness [22] USA	Focus groups conducted with the intervention group at week nine of ten weekly sessions. Foster carers and caseworkers interviewed for feedback on the programme at approximately 4-months following final sessions.	Context N/A Implementation *Recruitment/retention*: Intervention advertised as an opportunity for youth to meet with their peers and have a social meal, etc. The intervention not explicitly advertised as a mindfulness programme, as they felt that foster children would be put off. They also offered $25 for completing each set of intervention outcome measures, and a further $50 for intervention group if they attended all sessions. Of 45 youths recruited, attendance was 100% at first wave of data collection and 84% at second wave, which was explained by illness. Acceptability *Children and young people:* Key reflections from children in foster care: 1) incentives were a motivating factor for participation; 2) youth enjoyed being in a group with others similar to	*Direct evidence* [22] Study design RCT Outcome measure: Short-term outcomes (post-intervention, 3 months): • Trait anxiety • State anxiety Evidence: No evidence of effect

		themselves; 3) youth demonstrated gains in social skills (short and long-term); and 4) youth showed changes in responses to stress, positive and negative.	
Multi-dimensional Treatment Foster Care (MTFC) [23] USA	Implementation success measured by the 'Stages of Implementation Completion' (SIC) that assessed: intervention completion; speed of implementation; and quality of implementation. Evaluation compared two implementation strategies. Independent County Implementation (IND): standard MTFC implementation training package. Community Development Team (CDT): Standard package and support by two consultants.	Context Study conducted during a major economic recession, which potentially reduced some counties' willingness to take due to budgetary restrictions. Implementation *Fidelity:* Total of 9 of the 26 CDT counties started up MTFC during the study window compared to 8 out of 25 IND counties. The 9 CDT counties placed 2.5 times more children on average than 8 IND counties. 5 counties out of the 51 were evaluated to have achieved implementation competency, 4 in the CDT group and 1 in the IND group. Acceptability N/A	*Indirect evidence* [24] Study design: RCT Outcome evaluation: Long-term outcomes (12-month follow-up): • Child global functioning • Child MH symptoms and social/physical functioning Evidence: No evidence of effects *Indirect evidence* [25] Study design: RCT Outcome evaluation: Long-term outcomes (12-month follow-up): • Children's Global Assessment Scale • Nation Outcome Scales for Children and Adolescents Evidence: No evidence of effect *Indirect evidence* [26] Study design: RCT Outcome evaluation: Short-term outcomes (post-intervention): • Internalizing problems • Externalizing problems • Total problems Evidence: No evidence of effects

Parent Management Training (PMT) [27] USA	Delivery of sessions calculated. Delivery agents rating of carers understanding of intervention.	Context N/A Implementation *Recruitment/retention:* Eleven carers participated, with one dropping out. Carers received an average of 6 sessions, with 4 receiving none as they did not have time or did not think they needed the intervention. *Fidelity:* Carers had an understanding rated as 1.67 on a scale of 0-2. Acceptability N/A	*Direct evidence* [28, 29] Study design: RCT Outcome evaluation: Short-term and long-term outcomes (post-intervention; 12-month follow up): • Total problems (carer reported) • Total problems (teacher reported) • Internalizing problems (carer reported) • Internalizing problems (teacher reported) • Externalizing problems (carer reported) • Externalizing problems (teacher reported) Evidence: Uncertain effects *Indirect evidence* [30, 31] Study design: RCT Outcome evaluation: Short-term outcomes (6 months follow-up; 12 months follow-up): • Total problems • Total (impaired) functioning Evidence: Evidence of effect
Parent-Management Training Oregon (PMTO) [29] Netherlands	Fidelity of PMTO therapists measured during their certification process through video-recording of sessions. Adherence to the PMTO protocol was independently evaluated on 1-9 Likert-scale using the FIMP rating manual (1–3 needs work, 4–6 acceptable, 7–9 good work). Therapists must achieve an average score of over 6 to be eligible to practice.	Context Usual care in Northern Europe is more comprehensive than in USA where the intervention was developed. Implementation *Fidelity:* The higher the fidelity score of the therapist, the more parenting stress increased between baseline and follow-up (effect sizes were 0.28, 0.23, and 0.28 respectively). The higher the fidelity score, the more parenting behaviours, responsiveness, explaining and autonomy granting improved between baseline and follow-up (effect sizes were 0.23, 0.26, and 0.32 respectively). Acceptability N/A	

Parent-Child Interaction Therapy (PCIT) [32] USA	Foster carers self-reported measures were collected at baseline, 8 weeks (time 2) and 14 weeks (time 3). Attrition was measured by the number of carers completing follow-up assessments (time 2 and 3). Fidelity was measured by the number of consultation phone calls that carers completed.	Context N/A Implementation: *Recruitment/retention:* African American parents were more likely to drop out. *Fidelity:* 33.7% (n=28) of treatment foster carers failed to complete at least 4 follow-up phone calls with therapist. Correlation between not completing phone calls and not completing follow-up assessments, but unclear if causal. Acceptability N/A	*Indirect evidence*: [33, 34] Study design: RCT Outcome measure: Short-term outcomes (8 week; 14-week follow-up): • Total problems • Total (impaired) functioning • Internalizing problems • Externalizing problems Evidence: Uncertain effects.
Solution-Focused Parenting Group (SFPG) [35] Canada	Group facilitators monitored foster carer (n=9) adherence to training by assessing: percentage of sessions attended; and percentage of written homework assignments returned to each group. Interviews conducted with carers before and after the intervention.	Context Pre-existing contextual issues which made it difficult to deliver the intervention. Carers found young people's behaviour to be disruptive and demanding. They had restrictions on the role by external organisations, struggled to maintain a sense of family, had issues in accepting the foster child into their home, felt isolated, had too much responsibility, and had a lack of perceived competence. Implementation *Fidelity:* Carers attended 85% of the six sessions and completed 86% of the ten homework tasks. Pre-intervention factors continued which compromised intervention delivery, with notable issues being: role restriction; young people's disruptive behaviours; maintaining objectivity and no changes in the carer-youth relationship. Acceptability *Parents and carers:* Carers experienced a development in their parenting skills. Recommendations to improve the intervention were: modify goal-directed approach as it focused more on discussion than skill development; longer sessions; limit carers' talk time; space sessions over two weeks; more role	*Direct evidence* [35] Study design: QED Outcome evaluation: Short-term outcomes (4-month follow up): • Total problems Evidence: No evidence of effect

		play; and make the intervention ongoing or provide refresher sessions.	
TAKE CHARGE [36] USA	Coaches completed weekly log sheets documenting the activities they engaged in and the time spent with each participant.	Context N/A Implementation *Recruitment/retention:* Youth were invited to participate in three mentoring workshops and attended an average of 1.79 workshops. *Fidelity:* Fidelity for 79 coaching elements was 90.68%. Acceptability N/A	*Direct evidence* Study design: RCT Outcome measure: Long-term outcomes (12 + 18 month follow up): • Anxiety / depression • Somatic complaints • Anxiety / depression • Withdrawn / depressed Evidence: Evidence of effect
Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) and evidence-based engagement strategies [37] USA	Delivery agents self-assessed their own ability to deliver the engagement aspect of the intervention (e.g. the element of contacting and engaging participants in the engagement group with an initial home visit). This was assessed with a self-completed checklist: they successfully completed a phone call (according to a 4-point Likert scale with 4 being successful completion) and/or home visit (4 points); and how skillfully they felt they delivered each of the two components (rating from 1-4). A total score (max 16) was calculated by summing these elements. Children and foster carer's acceptability were assessed through a satisfaction with treatment questionnaire. Interviews were conducted with foster children and foster carers, but results not reported.	Context N/A Implementation *Recruitment/retention:* Difficulty in receiving referral from Child Welfare social workers due to wide and large caseload. There were 30 intervention sessions. For children in the standard intervention (n=22), 1 did not attend any sessions. 21 attended at least one session, 16 attended at least 4 sessions. For children in intervention with evidence-based enhancement (n=25), 1 did not attend any treatment sessions, 24 attended at least one session, 24 attended at least 4 sessions. A significantly higher percentage of youth in the engagement condition attended at least four sessions. Significantly more children completed the intervention in the engagement condition (80%) than standard condition (40.9%). *Fidelity:* Where data were available, adherence was high for both the telephone and first visit intervention (M = 3.7/4; M = 3.94/4). Delivery agents also self-rated reasonably high levels of skill in delivering phone calls and visits (M = 14.27/16; M = 13.87/16), corresponding with a rating of good to excellent.	*Direct evidence* Study design: RCT Outcome measure: Short-term outcomes (post intervention; 3-month follow-up): • Internalizing problems • Externalizing problems • Post-traumatic stress • Social and emotional functioning Evidence: No evidence of effect

		Acceptability *Children and young people:* No difference for foster children in satisfaction between TF-CBT or when integrated with evidence-based engagement strategies. *Parents and carers:* No difference for foster carers in satisfaction between TF-CBT when integrated with evidence-based engagement strategies.	
Trauma Systems Therapy (TST) [38]	Proxy fidelity score based on an 11-point scale (0 = carer not trained in TST,10 = carer trained in TST for 15 or more months).	Context N/A Implementation *Fidelity:* Children had increased exposure to the intervention over time. Acceptability N/A	*Direct evidence* Study design: QED Outcome measure: 3 years of administrative data: • Behavioural regulation • Emotional regulation • Children's functioning Evidence: Evidence of effect
Treatment Foster Care (TFC) [39] USA	Interviews with 23 professionals: 11 had significant practice and administrative experience in TFC; 7 were university-based researchers; and 5 were practitioners were knowledge about best practices in training and knowledge transfer.	Context N/A Implementation *Fidelity:* Key implementation barriers: carers having to balance their role as a caregiver with the expectation of being a professional; and struggle to collaborate effectively with their TFC social worker, largely due to different types of expertise. Suggestions to improve implementation: taking a strengths-based approach to support carers; improve carers knowledge how to navigate the system; allow the carer to be able to advocate for the child; increase carers' ability to identify when the child needs clinical help; and improve how they can work with their social worker. Acceptability N/A	*Indirect evidence* [24] Study design: RCT Outcome evaluation: Long-term outcomes (12-month follow-up): • Child global functioning • Child MH symptoms and social/physical functioning Evidence: No evidence of effect *Indirect evidence* [25] Study design: RCT Outcome evaluation: Long-term outcomes (12-month follow-up): • Children's Global Assessment Scale

			• Nation Outcome Scales for Children and Adolescents Evidence: No evidence of effect *Indirect evidence* [26] Study design: RCT Outcome evaluation: Short-term outcomes (post-intervention): • Internalizing problems • Externalizing problems • Total problems Evidence: No evidence of effects
Triple P for Foster Carers (TPFC) [40] Germany	Percentage of delivered session content assessed compared intended content (range: 0%–100%) using Protocol Adherence Checklists (PACs). Adherence Measure for Process Quality (AMPQ) assessed if session delivered with quality fidelity across 15 measures (1= not present – 4 fully present). Client Satisfaction Questionnaire (CSQ) assessed parental satisfaction with the intervention (1= not at all satisfied - 7= totally satisfied).	Context N/A Implementation *Recruitment/retention:* 25 of 44 participated in intervention, with non-participation due to distance to venue and lack of time. Two families dropped out. Of 23 remaining sessions, 64% participated in all eight sessions. *Fidelity:* Completeness of session delivery varied from 82% in session 1 to 82% in session 2. Process quality ratings varied between M = 47.6 in Session 1 and M = 53.8 in Session 8 indicating high quality. Acceptability *Parent and carers:* Carers were very satisfied with the intervention, with mean of 5.88.	*Direct evidence* Study design: RCT Outcome measure: Long-term outcomes (12 month follow up): • Child mental health symptoms and social/physical functioning • Child global functioning Evidence: No evidence of effects

2. References

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