Kinship care: A scoping study for a pilot randomised control trial (RCT) of whether Kinship Connected improves children and young people's mental health outcomes

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Delivery Organisations	Ecorys, Kinship Connected, University of Exeter
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Principal Investigator	Prof Mark Kelson
Protocol Author(s)	Prof Mark Kelson, James Whitley, Diarmid Campbell-Jack, Kate O'Brien, Dr Paul McGrath.
Feasibility Study Participants	Kinship carers: 16 Kinship staff: 8
Pilot Evaluation Participants	The study to be scoped will be targeted at Kinship carer dyads (carer and child).
Number of Pilot Sites	Kinship carers from 5 local authorities will be invited
Protocol Date	28/6/22
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Summary

This document outlines the feasibility evaluation for an intervention exploring the Kinship Connected intervention.

Kinship care is where a person connected to a child, usually a family member, looks after them full-time as their parents cannot. Kinship carers and the children they care for have unique vulnerabilities which are frequently underserved by the current system. There is evidence that additional support can achieve good outcomes for children cared for in this way. Kinship Connected is a project that provides one-to-one support for kinship carers for at least six months and develops and maintains kinship carer's support networks via community based peer support groups. Kinship Connected is currently running in 17 local authorities (LAs). An additional five LAs plan to roll it out. This study is a feasibility study to address under what conditions a pilot RCT of the Kinship Connected intervention is feasible.

Answering this research question requires initial work with Kinship to refine, test, and finalise, a Theory of Change via a set of consultations. The final Theory of Change will inform the design and development of a potential pilot study, if one is deemed feasible.

The work will be completed by February 2023. Key milestones are to have our research tools (topic guides for focus groups) developed by June 2022, to have completed our focus groups by the end of October 2022, to have a draft proposal document and protocol template by the end of November, and the final report by the end of December.

We will produce a report in plain English in order to feed back to the study participants. A report will be produced for What Works for Children's Social Care. Finally, the work will be presented in academic forums including a national level conference.

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Background and Problem Statement

Kinship care is where a person connected to a child, usually a family member, looks after the child full-time as their parents cannot. Kinship carers and the children they care for have unique vulnerabilities which are frequently underserved by the current system. These vulnerabilities include: kinship carers typically being older, in poor health and in poverty, in deprived households, having more changeable circumstances than others caring for children. Meanwhile the children in kinship care often have behavioural and emotional issues, have experienced trauma, abuse or neglect. Finally, there are often tensions with managing parental contact with the child in kinship care. There is evidence that additional support can achieve good outcomes for children cared for in this way (Schofield and Beek 2005, Crittenden 2012, Bifulco and Thomas 2013, McSherry, Fargas Malet et al. 2013, Hunt 2020). Kinship Connected is a project that provides one-to-one support for kinship carers for at least six months and develops and maintains kinship carer's support networks via community based peer support groups. Kinship Connected is currently running in 17 local authorities (LAs). An additional five LAs plan to roll it out.

While the intervention is currently delivered in certain settings we do not know about barriers and facilitators to potential recruitment, what the key outcomes should be, how data collection is best managed, and acceptability of randomisation in this setting.

Our problem statement and objective to be addressed is: Is it possible to run a pilot RCT of the Kinship Connected intervention and what are the key design features of such a pilot?

Intervention and Theory of Change

Kinship Connected is designed to impact on children's mental health and wellbeing by ensuring kinship carers have the capacity to meet their kinship children's complex needs. We have already developed a descriptive Theory of Change that explains how the intervention is expected to work (Appendix 1). This Theory of Change is based on recent developmental work by Kinship to understand the pathways by which outcomes on the project can be achieved, and is underpinned by a solid theoretical understanding of the client group. This understanding builds on a significant body of research showing that supporting parents and kinship carers improves the outcomes for the children for whom they are caring (Schofield & Beek 2005, Crittenden 2012, Bifulco & Thomas 2013, McSherry 2016, Hunt 2020).

An initial task will be to refine, finalise and test the Theory of Change, in consultation with key Kinship staff and including PPI via focus groups and in consultation with the Kinship Carer Advisory Group. The Theory of Change will provide a conceptual framework to guide the feasibility study and any future pilot and/or fully-powered RCT.

As this stage solely involves feasibility for a pilot (rather than the actual pilot itself), a key result will be helping finalise the details of the intervention across TIDieR categories as a basis for any subsequent pilot.

Research questions

The purpose of the study is to determine on what basis it would be advisable to proceed to a pilot RCT design that is acceptable to participants (namely local authorities, Kinship staff, families and children), feasible to deliver, and to address what the key design components of that study are. Further detail on each of these is provided below.

a) Acceptability

Our focus groups with key stakeholders will explore the willingness of potential participants, local authorities and Kinship staff to take part in a pilot RCT. These will address how acceptable our proposed approach is to these groups. We already have good evidence that the kinship carers' intervention is acceptable to participants. We will focus on the acceptability of randomisation.
RQ1: Is randomisation acceptable to participants in this setting?

b) Feasibility

We will explore practical and methodological barriers to the successful delivery of a pilot RCT

RQ2: What are the key barriers and facilitators to potential participants in taking part in this study?
RQ3: What are the key barriers and facilitators for the study's success more widely

c) Key components

Key design questions which will be finalised in the feasibility study include:
- What the inclusion and exclusion criteria should be
- What the comparator group should be (usual care or standardised best-practice care)
- What incentives might be used to maximise recruitment and retention
- Where control participants should be recruited from (local authorities where Kinship Connected runs or not)
- What the primary and secondary outcomes should be and their best mode of collection
- The type of randomisation (e.g. individual/clustered and simple/stratified)
- What the progression criteria (to a fully-powered trial) should be.

RQ4: What are the key design components of a proposed pilot study protocol?

Outcomes

Research question	Indicator	Method
Evidence of acceptability	Qualitative assessment of acceptability to participants, local authorities and Kinship staff	Qualitative analysis of our focus group sessions will inform this assessment
Evidence of feasibility	The identification of practical or methodological barriers to the successful delivery of a pilot RCT	Qualitative analysis of our focus groups will inform this indicator.
Key study components	The identification of: ● inclusion and exclusion criteria ● a suitable comparator group (usual care or standardised best-practice care) ● what incentives might be used to maximise recruitment and retention ● where control participants should be recruited from (local authorities where Kinship Connected runs or not) ● what the primary and secondary outcomes should be ● what type of randomisation (e.g. individual/clustered and simple/stratified) ● what the progression criteria (to a fully-powered trial) should be.	Qualitative synthesis of the focus groups in consultation with the Kinship advisory group and the study team.

Methods

Sample selection and recruitment

Focus groups will be conducted with up to 16 kinship carers over two sessions. These carers will be drawn from five local authority areas where Kinship has a contract to deliver services. Kinship works with all kinship carers regardless of their legal status, so it is expected that the focus groups will feature carers with a mix of formal (e.g. special guardians, kinship foster carers) and informal arrangements. Kinship will select as representative a mix of carers as possible, based on their legal status, gender, age, situation etc., depending on carers' availabilities. There are other mechanisms for participation for kinship carers who are not available (e.g. Kinship Carer Advisory Group, remote feedback on research tools, etc.). Four members of Kinship staff will participate in focus groups also.

Kinship staff have experience working with kinship carers and will be on hand to ensure that the focus groups are appropriately pitched and inclusive.

Kinship carers will be invited to attend the focus groups, depending on their current situation and how comfortable they feel contributing. Kinship will invite a range of carers from across their programmes and services by email (if they have an email address – by telephone if not) and then follow up by telephone. Kinship will invite more carers than needed as there is likely to be some drop-out due to the complex nature of kinship carers' lives. We will have to reschedule if there is very low attendance Carers will all be fully briefed by the project workers who are supporting them. Our Content Designer will ensure readability of any materials that we send to carers and Kinship staff and a kinship carer will also provide feedback on the materials. All carers will need to give consent to participate in the focus groups. The Ecorys Ethics Committee have reviewed this study and confirmed that recording verbal consent of participants is sufficient.

Data Collection

The primary method of data collection will be through focus groups. There will be five separate focus groups (see below) (two 8-person kinship carer focus groups and two 4-person Kinship staff focus groups). These focus groups will include Ecorys staff, Kinship staff, local authority staff and kinship carers.

Following the inception meeting, research tools will be developed for the focus groups. They will be shared with Kinship, PPI representatives and WWCSC following drafting. Resource has also been allocated to secure approval for the research tools from the Ecorys internal ethics committee. Our Theory of Change will allow the feasibility study to assess the outcomes of interest.

A focus group leader will be present at each focus group to monitor group dynamics and ensure that all participants are given opportunities to speak. However, we need to be conscious that kinship carers are made aware that whatever they tell us will not impact on the support they receive. We will explain at the start of each focus group that attendees' opinions are important and that the purpose of the study is to find out those opinions. As the study is focused on understanding the methodology for a pilot study as opposed to researching kinship experience, it is unlikely that any sensitive issues will be raised in discussion. However, as this cannot be ruled out, the possibility will be raised as part of gaining informed consent and focus group participants reminded on the day that they do not need to answer questions and can withdraw their consent at any time (see later section on ethics).

The proposed format for the focus groups is as follows (all focus groups are planned to be conducted virtually):

- A focus group comprising kinship carers will be conducted over a half day (e.g. morning), facilitated by Ecorys and Kinship staff. This will gain the views of carers on important participant facing questions such as acceptability of randomisation, what kind of information would need to be provided, format and regularity of data collection, as well as discussing more generally what barriers and facilitators to participation they see. This would ideally involve carers from across five local authorities.

- On the same day, in the afternoon we will convene Kinship staff and local authority staff (separately) to discuss logistical and practical barriers and facilitators to a proposed pilot study, as well as discussing and distilling what carers raised in the earlier session.
- The results of these sessions will be incorporated into a draft pilot study proposal plan by Ecorys and Professor Kelson. This proposal plan will outline from both patient and Kinship and local authority staff perspectives what involvement in a pilot study would look like.
- This draft pilot study proposal will be presented for discussion at a second day of focus groups with the same structure as the first (carers in the morning, staff in the afternoon). This will provide the opportunity for the proposal to be iteratively improved.
- Following this second day of focus groups, the draft proposal will be amended for presentation to the Kinship Care Advisory Group for further feedback, with this forming a fifth and final focus group.

In summary, pilot data will be captured through:

Data Collection Method	Sample Size	Collection Timeline
Focus groups	Up to 8 kinship carers in each of two focus groups	Sep-Oct 2022
Focus groups	8 Kinship and local authority staff	Sep-Oct 2022

Analysis

Being a feasibility study for a pilot RCT, there is a relatively small amount of data to analyse compared with larger studies, requiring relatively minimal data cleaning and allowing this data to be analysed in depth. We plan to complete an analysis grid table in spreadsheet software, which will map the findings from the focus groups against the questions in the topic guides. the research team and Kinship will meet to discuss the findings and context within which they sit. The topic guides will link back to the overarching research questions and check points relevant to the study. The Project Manager and particularly the Project Director will provide key quality assurance roles, conducting spot checks of data from the focus groups and the internal files used for analysis purposes. Given the nature of the focus groups, transcription and use of analysis software has not been costed into the budget for the study.

Ethics & Participation

The feasibility study will adhere to relevant ethical frameworks and industry guidelines, including the UK Framework for Health and Social Care Research, the ESRC's framework for research ethics, and Market Research Society and Social Research Association codes of conduct. These include specific

guidance on COVID-19 mitigation approaches and guidance on diversity and inclusion in research participation including guidance from the INCLUDE Ethnicity Framework, Centre for Ethnic Health Research and National Institute for Health Research (NIHR).

The feasibility study will test proposed pilot RCT design against ethical requirements and considerations. The feasibility study will seek ethical approval from the Ecorys Ethics Committee.

All participants will be asked to consent to the study and will have the right to withdraw at any stage.

Data protection

Our approach to risk management is included as part of our established project management standards, including the ISO 9001 Quality Management Standard and Cyber Essentials Plus certification. For the purpose of this project, Ecorys will be an Independent Data Controller and WWCSC shall not process nor have access to, or have any decision-making power over the purpose and means of processing personal data within this project (see Terms and Conditions of the grant, section 11.5.2).

We will provide WWCSC with any and all data protection documentation including, but not limited to, Data Protection Impact Assessments, Data Sharing Agreements, Data Privacy Notices before data collection, and liaise with WWCSC where we find any legislative non-compliance.

Personnel

The Project Director, **Diarmid Campbell-Jack**, will have overall responsibility for delivery of the contract and reviewing and monitoring the quality of work. Additional review and quality assurance will be performed by **Professor Mark Kelson**, Associate Professor of Statistics for Health at University of Exeter. **Kate O'Brien** is Kinship's Director of Business Development and Programmes and will be the study's named link person at Kinship. Kate will ensure access is maintained to project workers, local authority staff, families and children throughout the feasibility study. The research team also includes quantitative research specialists **Matthew Cutmore**, Associate Director at Ecorys, Research Managers **Panos Deoudes** and **Angus Elsby**, and Researcher **Rebecca Van Zanten**. **Jo Llewellyn** will be PPI Lead, working with **Natalie Baldry**, a Kinship trustee, kinship carer and co-applicant, to strengthen PPI and provide links with Kinship's Kinship Carer Advisory Group. Jo has considerable experience of stakeholder involvement in research, involving inputs into recruitment, data collection, analysis, research outputs and dissemination, and including Participatory Action Research and delivering an accredited course on this subject.

Timeline

Anticipated key outputs and project dates are:

Dates	Activity
Sep 2022	Research tools for focus groups
Sep 2022	Outcomes of interest, measurement tools and study checkpoints for discussion at focus groups agreed
Sep-Oct 2022	Focus groups to be undertaken
30th Dec 2022	Final report and lay summary

Appendices

Appendix 1: Descriptive Theory of Change

Kinship Connected descriptive theory of change for:
'Kinship care: A scoping study for a pilot Randomised Control Trial (RCT) of whether Kinship Connected improves children and young people's mental health outcomes'

Background & recommendations from grant award process
As part of the project 'Kinship care: A scoping study for a pilot Randomised Control Trial (RCT) of whether Kinship Connected improves children and young people's mental health outcomes' delivered in partnership with Ecorys and funded by What Works Childrens Social Care (WWCSC), the existing theory of change (see Appendix A below) will be reviewed to ensure it meets the amended focus on outcomes for children and young people's mental health and will be tested via focus groups with kinship carers and in consultation with Kinship's Kinship Carer Advisory Group.

As part of the grant award process, WWCSC's grants Committee stated that "a descriptive theory of change would benefit the study. The Committee would have liked to see more detail on the actual intervention, in particular the activities of the visits or groups, the focus and number of visits per week etc. This lack of detail makes it hard to define what the future RCT would actually be testing, i.e. what are the key criteria that would determine success or failure of the intervention. Additionally, if improvement in child/ carer attachment security is to be considered an outcome, there would require to be clarity within the theory of change on how attachment styles and behaviours would be targeted as part of the service. Please ensure that you prioritise refining your theory of change."

Additional outcomes to consider including in the theory of change
The outcomes below are not currently part of the theory of change but could be considered as part of the scoping of the pilot RCT process.

INTERMEDIATE OUTCOMES
- Attachment: this is likely to be challenging to measure so appropriate measures would need to be considered and piloted before including this (see Appendix B).
- Education: this could be included as a perception from the kinship carer. Attaining data from schools or children themselves on this may be challenging.

ULTIMATE GOALS
- Cost savings for local authorities: this could be an outcome as a result of reduced reliance of kinship carers on statutory services. It would also be of interest to numerous key stakeholders in the sector. Consideration would need to be given as to how this is evidenced.

Overview of Kinship Connected
Kinship Connected is a three to six-month intensive programme focused on supporting kinship carers to develop a personalised, strengths-based action plan to address their immediate priorities and can better support the children in their care. This time-bound support is in keeping with our social action approach to empower kinship carers to go on to support other carers through peer support, to build community resilience and reduce dependency on statutory services.

Many kinship children have experienced significant early childhood trauma – 73% who left care on a Special Guardianship Order (SGO) had experienced abuse and neglect (DfE data for the year ending 31 March 2021) – so having a secure relationship with at least one adult, particularly a committed and supportive relative, is key to enabling them to thrive. Kinship Connected is heavily influenced by the Secure Base model (developed by Schofield and Beek), which is based on theories of attachment, trauma awareness, resilience and child placement research. This theoretical underpinning has developed a model of family support that helps kinship carers to provide children with a secure, stable and loving home and helps them build trusting relationships with the children in their care.

Kinship Connected descriptive theory of change

	ACTIVITIES	INTERMEDIATE OUTCOMES	ULTIMATE GOALS
Stage 1: referral & registration	There are two referral routes – depending on which the local authority chooses as part of the contract set up. They can have one or both. Both routes come via an online portal, with confirmation emails (or text) to both the referral contact (if via the local authority) and the kinship carer with next steps: 1) self-referral from a kinship carer direct to Kinship 2) a referral of a kinship carer by a professional from a local authority. Within a week of referral, the project worker contacts the carer to: ● confirm all details, consent and register them onto the programme ● book in the initial assessment of needs of the kinship carer ● explain more about the programme ● explain about other support offered including the Kinship Advice Team ● answer any initial questions the carer may have ● set expectations of engagement from both sides ● start to build trust and establish a positive relationship with the kinship carer	Increased confidence to seek support when it is needed. Increased awareness amongst kinship carers of the support available. Increased awareness about kinship care in public services. Increased use/ take up of local and national services. Reduced feeling of isolation of kinship carers. Reduced loneliness of kinship carers.	Increased number of kinship carers feel confident in fulfilling their caring role. The kinship care community is more resilient and less reliant on public services. More children are able to grow up in well-supported kinship care placements. Fewer children grow up in the care system. Children whose parents are unable to care for them have the best possible outcomes.
Stage 2: assessment of needs	The project worker conducts a structured registration and assessment, using an adaption of the Signs of Safety model, to understand and start to plan three to five achievable goals for the		

	kinship carer. The project worker uses a strengths and solutions-based approach with kinship families that supports them to develop sustainable strategies incorporating both their personal strengths and the assets within their communities to enable them to provide a permanent home for their kinship children. The Warwick and Edinburgh Mental Wellbeing Scale (WEMWBS) is used as a baseline to measure the kinship carer's wellbeing and enable an open conversation. The focus is also on the current situation of the kinship child/ children through the eyes of the kinship carer. The assessment of needs normally takes place in the carer's home, or another private location where the carer feels comfortable. If this is not possible, it may also take place on the phone or video call. The place and length of registration is recorded as part of the structured process. Project workers work to build trust and establish a good relationship with the kinship carer, encouraging them to become more confident.	Kinship carers feel more able to manage family relationships. Kinship carers are more able to manage children's behaviour. Reduced financial concerns amongst kinship carers. Kinship carers have an increased sense of wellbeing. Improved mental health outcomes for kinship children.
Stage 3: support & mid-point review	Project workers, working in partnership with local authority teams and other multi-agency teams, work with kinship carers and their families in community settings where they feel most comfortable (home, school or other venues). Once goals have been articulated, project workers then continue to provide one-to-one support to kinship carers around any (and most likely a combination) of the following themes:	

	- Support to access specialist information and advice through the Kinship specialist advice service, such as for welfare and benefits advice. This financial support is essential in allowing them to feel more financially secure, which allows them to focus on meeting the needs of their children. - Support to access grants to address hardship (buy white goods, beds, laptops etc), to support children (including financial aid for therapy or community activities), or to provide short holiday breaks. - Access to preparatory workshops about what it means to be a kinship carer, including basic understanding of trauma and attachment theory. - Support to access virtual knowledge enhancing themed workshops with guest speakers on topics like managing children's behaviour, foetal alcohol syndrome, managing contact with birth family, county lines etc. These sessions help to develop kinship carers' awareness of key issues affecting their children, as well as how best to support them and how to seek additional support if necessary. - Advocacy and support at meetings which include multi-agency teams like schools, local authority social work and court. - Introduction to a local peer support group and online Facebook community to meet other kinship carers and share experiences. - Matching to Someone Like Me peer support telephone service, to access up to three phone calls with trained kinship carer volunteers.		

	● Support to access other relevant services, such as bereavement support. Not all kinship carers will require all this support. It is often those carers with higher needs that require more intense support. The support need is categorised by high, medium and low throughout the intervention to see distance travelled. After three months, a formal review takes place to ensure goals are on track, discuss progress, update goals if appropriate and to plan subsequent activity and support. If these goals have been achieved after three months, the project worker will complete a final review at this point. In the lead up to a six-month review, project workers will continue to support the kinship carer to achieve their goals. The aim is to empower the kinship carer to have more ownership and responsibility of these goals and reduce dependency on the project worker. This then helps to prepare the kinship carer for the transition in stage 4.		
Stage 4: intervention close	Kinship Connected activities last for three to six-months. During this time kinship carers receive intensive and structured support from a project worker with a clear transition plan from the outset. After a final review, depending on their needs, the kinship carer is supported to access further peer support and any other services (both from Kinship and local partners). Peer support is a vital aspect of Kinship Connected and kinship carers are introduced to other carers through local in-person and		

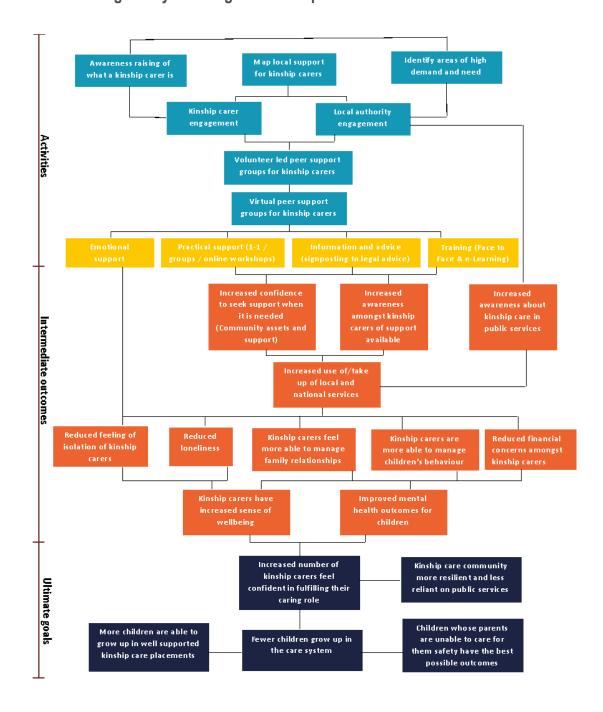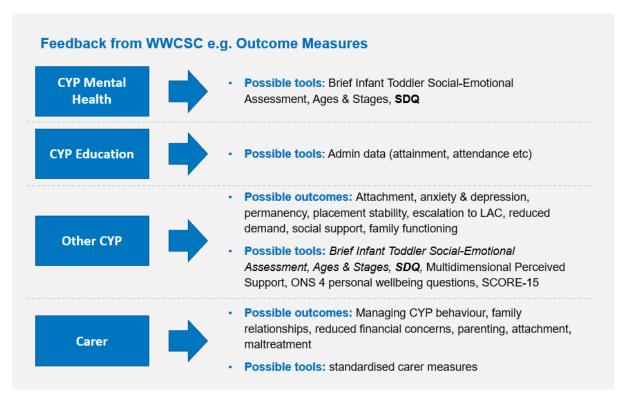|	virtual peer support groups, which become a sustainable and long-term support network for kinship carers that remains in place at the end of any one-to-one intervention period. Peer support is essential in building resilience, and many describe the impact of attending these as life changing. This increase in confidence translates into a happier carer who feels more equipped to provide the right support for the traumatised child in their care. Frequently kinship carers and their children form friendships in their local area as a result of attending peer support groups and family activities. Alongside the established peer support network these friendships remain in place, providing a local support network. These connections help the children realise they are not the only ones being raised by relatives, which helps to reduce stigma and isolation and increase confidence. Kinship carers also remain connected to Kinship's Kinship Community, which keeps kinship carers connected to the wider kinship care community and informed of key events and policy updates in relation to kinship care. Both of which help to reduce loneliness.		

APPENDIX A: Existing theory of change for Kinship Connected

APPENDIX B: Slides from inception meeting with Ecorys & WWCSC relating to outcome measures

Appendix 2: References

Bifulco, A. and Thomas, G. (2013) Understanding Adult Attachment in Family Relationships: Research, Assessment and Intervention. Oxen: Routledge.

Crittenden, P, M. (2012) Raising Parents: Attachment, Parenting and Child Safety. Oxon: Routledge.

Early Intervention Foundation (2020) Strengths and Difficulties Questionnaire (SDQ). Available here: https://www.eif.org.uk/files/resources/measure-report-child-sdq.pdf

Goodman, R. (2001) Psychometric properties of the strengths and difficulties questionnaire. J Am Acad Child Adolesc Psychiatry; 40(11):1337-45.

Hunt, J. (2020) Two Decades of UK Research on Kinship Care: An Overview. London: Family Rights Group.

McSherry, D., Malet, M. F. and Weatherall, K. (2016) 'Comparing Long Term Placements for Young Children in Care: Does Placement Type Really Matter?', Children and Youth Service Review, 69, 56-66.

Midgley, N., Besser, S.J., Fearon, P. et al (2019) The Herts and Minds study: feasibility of a randomised controlled trial of Mentalization-Based Treatment versus usual care to support the wellbeing of children in foster care. BMC Psychiatry 19, 215.

Schofield, G. and Beek, M. (2005) 'Providing a Secure Base: Parenting Children in Long Term Foster Care', Attachment and Human Development, 7(1), 3-26.

Youth In Mind (2020) Information for researchers and professionals about the Strengths & Difficulties Questionnaires: English (UK). Available here: https://www.sdqinfo.org/py/sdqinfo/b3.py?language=Englishqz(UK)