8

Evidence to Action Note

Developmental Outcomes: Children and Young People who have Experienced Out-of-Home Care

Key messages

This note gives an overview of children and young people's physical health, socio-emotional wellbeing and cognitive/learning ability in the Pathways of Care Longitudinal Study (POCLS) since entering Out-of-Home Care (OOHC) for the first time between May 2010 and October 2011. It also provides information on child, carer and placement factors that are associated with development. It is intended to be a resource for policy makers and senior practitioners.

Over time (after approximately 5-6 years in OOHC), children and young people are less likely to be in the normal range[1] for total behaviour problems using standardised measures, indicating they need appropriate assessments, may need monitoring and professional support for socio-emotional wellbeing. Children and young people show little change on verbal ability and improvement in non-verbal ability over time. Fine and gross motor skill development was measured in children up to 6 years of age and they were more likely to be in the normal range over time.

The POCLS findings support the existing literature that:

- Age at entry into care is associated with normal socio-emotional and verbal development over time with children and young people that enter care at a younger age more likely to be in the normal range than older children.
- Placement stability is associated with normal socio-emotional, non-verbal ability, gross and fine motor skill development over time. Children and young people with higher levels of placement stability are more likely to be in the normal range for socio-emotional, non-verbal ability, gross and fine motor skill development over time than those with lower stability.

1 The language used in this note reflects the language/categories used in the standardised measures.

- Compared to children and young people in foster care, those in relative/kinship care were more likely to have normal socio-emotional and verbal development.

Approximately 7-8 years after entering OOHC, caregivers reported that the vast majority of children were in good physical health (97.0%) and the majority scored in the normal range for socio-emotional wellbeing as measured by total behaviour problems (65.1%). Caregiver report and direct measures with the children and young people found the majority were in the normal range of cognitive development with over 80% in the normal or above normal ranges for verbal ability and around 80% in the normal or above normal ranges for non-verbal/logical reasoning ability.

Analysis of the longitudinal POCLS data is ongoing. Key risk and protective factors that impact development over time will continue to be identified and the longer-term outcomes determined with further waves of data collection.

How does maltreatment affect child development?

Australian and international research indicates outcomes for children and young people (hereafter referred to as children) who have experienced maltreatment and have been placed in OOHC are poorer than for those children who have never been maltreated and placed in OOHC (Gypen et al.et al. 2017). This applies over a wide range of indicators including: lower emotional and mental wellbeing, lower educational attainment, involvement in the criminal justice system, higher housing instability and homelessness; and higher rates of chronic health conditions and morbidity (Walsh et al. 2018).

Exposure to adverse and traumatic events in childhood may result in developmental differences in key areas of cognitive and social functioning (McLean 2016). Early life adversity and maltreatment impacts children's development and increases a child's vulnerability to adverse mental health outcomes (MacLean et al. 2019). Children born to parents with more stressors during pregnancy and who experience more adverse experiences in the early years of their life, are at greater risk of long-term poor health and wellbeing across their lifetime. What happens in the first 2000 days of life has been shown to have an impact on health and wellbeing throughout a child's life (NSW Ministry of Health, 2019).

The POCLS contains information collected directly from children and caregivers[2] and links this with administrative data to allow policy makers, caseworkers and researchers to understand how children in OOHC are developing over time. This information allows us to identify the risk factors that lead to poorer outcomes as well as the protective factors that mitigate these risks.

2 The term caregivers includes birth parents, foster carers, relative/kin carers, guardians, adoptive parents and residential care workers. The term carer is used in this note for foster and relative/kin caregivers and reflects findings that were conducted with this subgroup.

The findings in this Evidence to Action Note on developmental outcomes over time are based on analyses of the POCLS data (NSW Department of Communities and Justice, 2019, Wells et al. 2020). The NSW DCJ presentation utilised the first four waves of data covering about seven years from when the children first entered OOHC and found that the majority of children in the POCLS were developing normally (NSW Department of Communities and Justice, 2019). Using the first three waves of data, Wells et al. undertook analysis to look at placement stability and a number of other child, carer and placement factors that may impact developmental outcomes over time (Wells et al. 2020).[3]

This Evidence to Action Note describes how this new evidence can inform OOHC policy and practice to improve the developmental outcomes of children who experienced maltreatment. This should be read in conjunction with the Aboriginal Children and Young People in Out-of-Home Care in NSW: Developmental Outcomes. Evidence to Action Note Number 9.

How is child development measured in the POCLS?

One of the key aims of the POCLS is to collect data on child development for a cohort of all children who entered OOHC for the first time between May 2010 and October 2011 and examine the factors that are associated with developmental outcomes. A number of standardised developmental and psychosocial wellbeing measures were used in the POCLS caregiver and/or child interviews.[4]

3 The report examines the impact of a range of factors on different developmental domains using the first three waves of data. The samples vary due to available data for each child outcome; n=1,138 for socio-emotional wellbeing, n=3,009 for verbal ability, n=2,962 for non-verbal ability, n=1,444 for fine motor skills and n=1,615 for gross motor skills. For more detail on each model please refer to Wells et al. 2020.

4 The measures are standardised meaning they can be used to show how a cohort of children compare with peers in the general population and also how individuals are developing. It is important to take cultural considerations into account when using standardised measures with children from minority cultures. The standardised measures used in the POCLS were selected in 2010 at which time measures of child development had not been tested for validity with Aboriginal children in Australia. For Aboriginal people in urban settings, non-verbal performance based tests that are less reliant on language skills such as the Matrix Reasoning have been found to be comparable to existing Australian norms (Westerman and Wettinger, 1997). The Child Behaviour Checklist (CBCL) has been tested in a range of diverse cultures but clinical cut-offs may not be uniform across all cultures (Crijnen et al. 1997). The Australian Early Development Census (AEDC) has been adapted for use with Aboriginal children but this occurred after POCLS children had been assessed. The measures may not be sensitive to the influence cultural norms may have on reporting child behaviours and parents' problem ratings. This should be considered when interpreting the data.

Socio-emotional development

- Caregiver and/or teacher reports of children's behaviour were measured using the Brief Infant Toddler Social Emotional Assessment (BITSEA) and the Child Behaviour Checklist (CBCL) covering an age span of 9 months to 17 years. Three different subscale scores were measured for socio-emotional development: internalising, externalising and total problems behaviour scores. The internalising measure captures emotional problems such as anxiety, mood disturbance and somatic complaints and the externalising measure captures problems including rule breaking and aggressive behaviours. Based on the scores, children's behaviours were categorised into 'normal', 'borderline' or 'clinical' range.[5] Children's scores in the borderline range indicate a need for ongoing monitoring and support while those in the clinical range indicate a need for assessment and professional support.

Cognitive development

- For verbal ability, caregiver reports were collected for children under 3 years of age using the Communication and Symbolic Behaviour Scales Infant and Toddler Checklist (CSBS) and the Macarthur-Bates Communication Development Inventories III (MCDI-III). A direct measure of language skills was administered for children aged 3-17 years using the Peabody Picture Vocabulary Test (PPVT-IV).
- For non-verbal ability, caregiver report was collected for children aged less than 6 years using the Ages and Stages Questionnaire (ASQ). A direct measure of logical reasoning (e.g. problem solving) was administered for children aged 6-16 years using the Matrix Reasoning Test from the Wechsler Intelligence Scale for Children IV (MR WISC-IV).

Physical development and health

- Caregiver report using the ASQ was administered for children aged 9 to 66 months to assess gross motor skills and fine motor skills.
- The child's current physical health was also rated by the caregiver using a six point rating scale from 1 being 'excellent' health to 6 indicating 'very poor' health. This is a general question about the child's physical health. Information on health issues diagnosed by a general practitioner and lasting six months or longer was also collected but not reported here (see Australian Institute of Family Studies, 2015). More in-depth analysis on children's health and disabilities are underway and will be published in 2021.

It is important to note that the POCLS collects data from children who entered OOHC for the first time at any age during an 18 month period (May 2010-October 2011). At Wave 4 (approximately 7-8 years after entering OOHC for the first time), around half (53.3%) of the children who participated were aged 6-8 years at the time of interview. Some of these children may have remained in OOHC, some may have exited OOHC to restoration, guardianship or adoption, and some may have re-entered care.

5 The language used in this note reflects the language/categories used in the measures (e.g. normal range, total problems).

It is also important to note that the findings on factors associated with development reflect analysis conducted with three waves of data. The results presented suggest a range of factors that are significantly associated with 'normal' development. Over time, using the additional POCLS data collections we can confirm the robustness of these associations.

Summary of key findings

Analysis of the key child development domains of socio-emotional wellbeing, cognitive ability and physical development and health shows that at Wave 4 over half of the children were in the normal range. There were notable proportions of children who require monitoring or additional supports.

Over time children are less likely to be in the normal range for total behaviour problems indicating a need for ongoing monitoring assessments and professional support for socio-emotional wellbeing and to support caregivers with managing challenging behaviours. Children show little change on verbal ability and improvement in non-verbal ability over time. There is also improvement in fine and gross motor skill development.

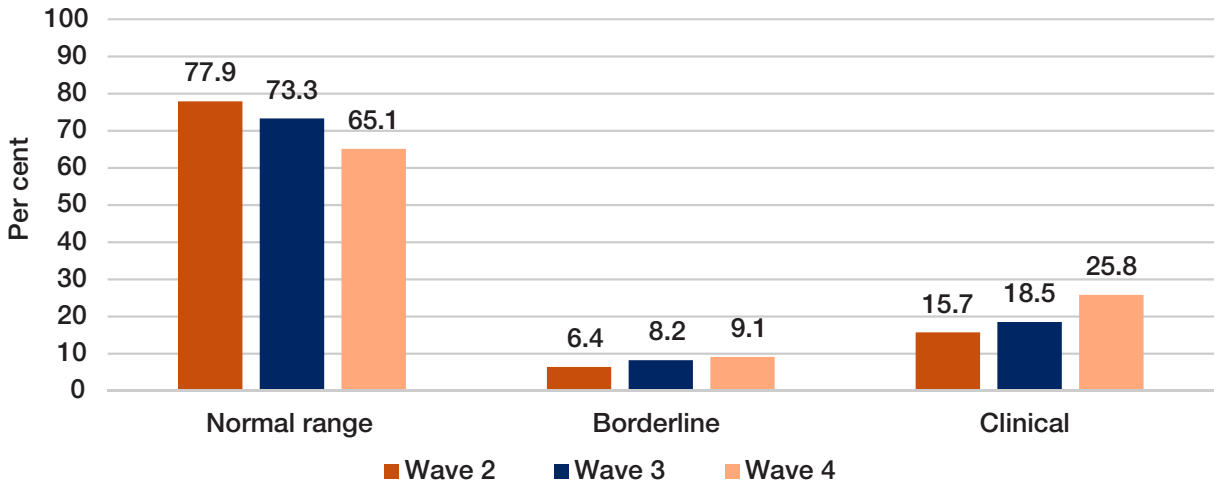
Child, caregiver and placement factors are associated with development over a five year period (Waves 1-3) and these vary by developmental domain.[6] The findings presented below do not suggest causality but highlight that there are a range of child, carer and placement characteristics that can be considered when developing policies and practices to support normal socio-emotional development, verbal ability, non-verbal ability and physical development.

Socio-emotional development

About two thirds (65.1%) of the children were in the normal range at Wave 4 for total problem behaviours with the remaining third (34.9%) needing ongoing monitoring or intensive support. There has been an increase in the proportion of children that may need support for behaviour problems over time (Figure 1). A quarter of children (25.8%) were in the clinical range for total behaviour problems at Wave 4, a significant increase from the 18.5% in Wave 3.

6 See Footnote 5 page 7 for the range of factors that were included in the analysis.

Figure 1: Total behaviour problems by CBCL score category from Wave 2 (approximately 3-4 years after entering OOHC) to Wave 4 (approximately 7-8 years after entering OOHC)

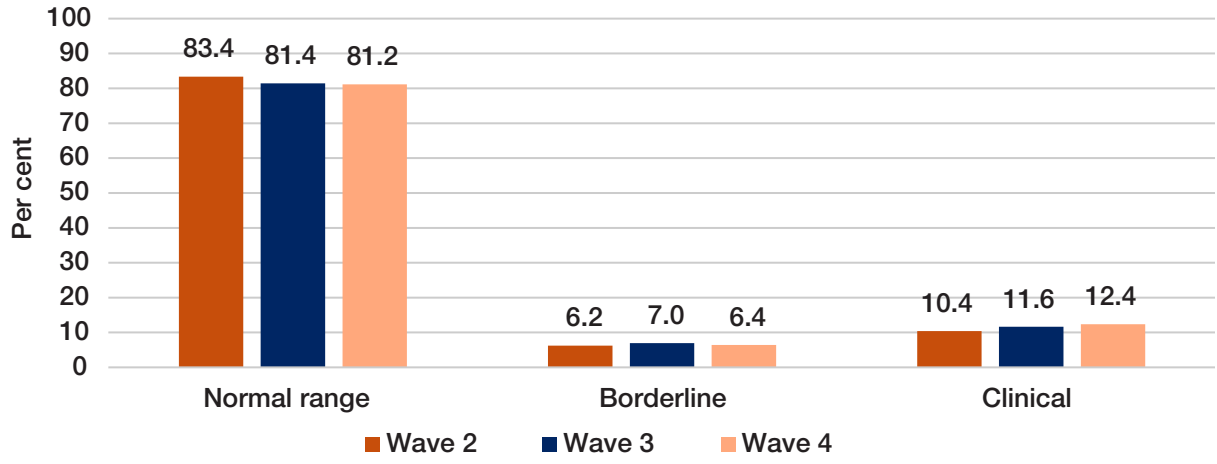


Source: NSW Department of Communities and Justice, 2019.

Children who participated in CBCL in all waves from Wave 2 to 4, n=791. Falling into the normal range indicates the child is developing at the normal rate, 'borderline' indicates the need for monitoring and support, and 'clinical' indicates that the child may need intensive support.

Overall, the majority of the POCLS children were in the normal range for internalising behaviours (such as anxiety and depression). This was constant across the three waves (83.4% at Wave 2, 81.4% at Wave 3 and 81.2% at Wave 4). About 1 in 10 children require intensive support as indicated by the proportion in the clinical range at each wave (Figure 2).

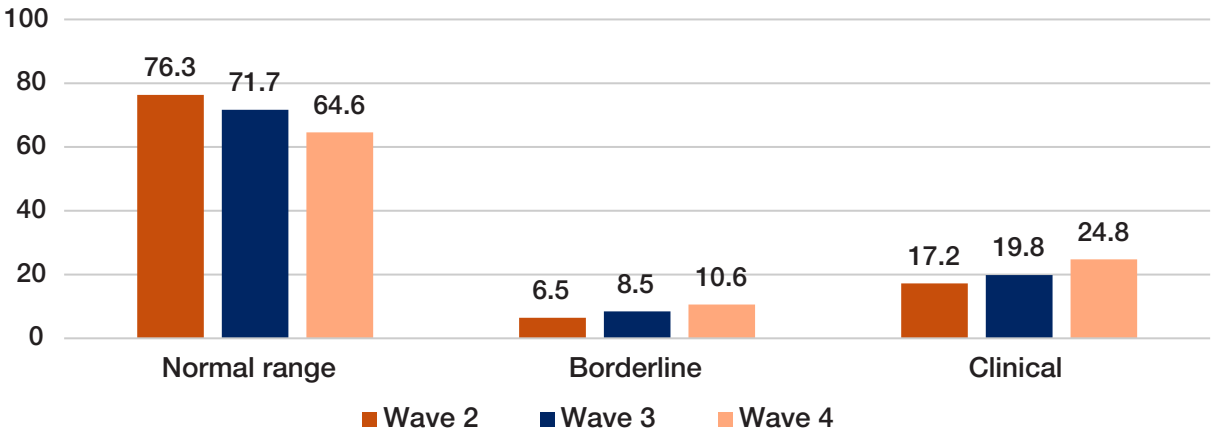
Figure 2: Internalising behaviour problems by category from Wave 2 (approximately 3-4 years after entering OOHC) to Wave 4 (approximately 7-8 years after entering OOHC)



Source: NSW Department of Communities and Justice, 2019. Children who participated in CBCL in all waves from Wave 2 to 4, n=791. Falling into the normal range indicates the child is developing at the normal rate, 'borderline' indicates the need for monitoring and support, and 'clinical' indicates that the child may need intensive support.

There was an increase in the proportion of children who may require intensive support to address externalising behaviours (such as rule breaking or aggression) over time, with a significant increase from 19.8% at Wave 3 to 24.8% at Wave 4 (Figure 3).

Figure 3: Externalising behaviour problems by category Wave 2 (approximately 3-4 years after entering OOHC) to Wave 4 (approximately 7-8 years after entering OOHC)



Source: NSW Department of Communities and Justice, 2019. Children who participated in CBCL in all waves from Wave 2 to 4, n=791. Falling into the normal range indicates the child is developing at the normal rate, 'borderline' indicates the need for monitoring and support, and 'clinical' indicates that the child may need intensive support.

What factors are associated with socio-emotional development over time?

After controlling for a number of factors[7], children who entered OOHC at an older age were less likely to be in the normal range for socio-emotional development as measured by total behaviour problems than children who entered care at a younger age[8]. Children who had a Risk of Significant Harm (ROSH) report for psychological harm prior to

7 Controlling for a number of factors allows the examination of the association of the factor of interest with the outcome, independent of the other factors in the analysis. The factors examined included; Child factors: age at entry (in years), gender (male/female), cultural background (Aboriginality, CALD, Other Australian), DCJ District (15 DCJ districts categorised into seven larger groups), number of ROSH reports prior to entering care (substantiated and unsubstantiated), binary variables (Y/N) for type of ROSH reports prior to entering care (including physical abuse, sexual abuse, neglect, psychological abuse, psychological harm, domestic violence, carer serious mental health, carer emotional state, carer drug alcohol abuse, carer other issue, risk behaviour of the child/young person and prenatal issues). Placement factors: placement stability – number of placements per 1,000 care days between waves, predominant placement type - foster care, relative/kinship care (with Aboriginal carer), relative kinship care (non-Aboriginal carer), residential care, or other (supported accommodation, independent living or other).Carer factors: age, income, cultural background, education, carer satisfaction (a binary variable (Y/N) was created for each question including; being able to reach the caseworkers when needed, assistance from caseworkers, your working relationship with other agencies related to study child (early childhood education, counsellors, etc.), having enough information about study child and opportunities to meet other foster or kinship families, carer psychological distress was assessed using the K10 with scores categorised as low, moderate, high or very high, Social cohesion and Trust Scales were converted to an index measuring the perceived safety and unity of a neighbourhood, with higher values indicating less cohesion (Wells et al. 2020).

8 All results reported on factors associated with development outcomes are statistically significant. It is important to note that these findings reflect analysis conducted with three waves of data. The results presented suggest a range of factors that are significantly associated with normal development. Over time, using the additional POCLS data we can confirm the robustness of the associations.

entering OOHC the first time were less likely to be in the normal range than children who had not had this type of ROSH report.

Placement factors were also associated with normal socio-emotional development. Children with fewer placements per days in care[9] were more likely to be in the normal range for socio-emotional development as measured by total behaviour problems.

A number of caregiver characteristics were found to be associated with a child's socio-emotional development - children who lived with:

- Older carers (>51 years) were more likely to be in the normal range compared to children who lived with younger carers (<40 years).
- Carers that reported to be satisfied with i) their working relationships with other agencies or ii) the amount of information they had about the child in their care, were more likely to be in the normal range compared to children who lived with carers who were not satisfied.
- A carer that reported low psychological distress were more likely to be in the normal range compared to children who lived with a carer that reported moderate to very high psychological distress.

In addition children at Wave 3 (i.e. approximately 5-6 years after entering OOHC) were less likely to be in the normal range compared to children in Wave 1.

These findings do not suggest causality. It highlights that there are a range of child, carer and placement characteristics that can be considered when developing policies and practices to support normal socio-emotional development. For example focussing on the needs of children who enter care at different ages, placement stability, ensuring carers are satisfied and providing appropriate support to younger carers and carers identified as stressed may be considered to support the child's socio-emotional development. A range of strategies are noted from page 15.

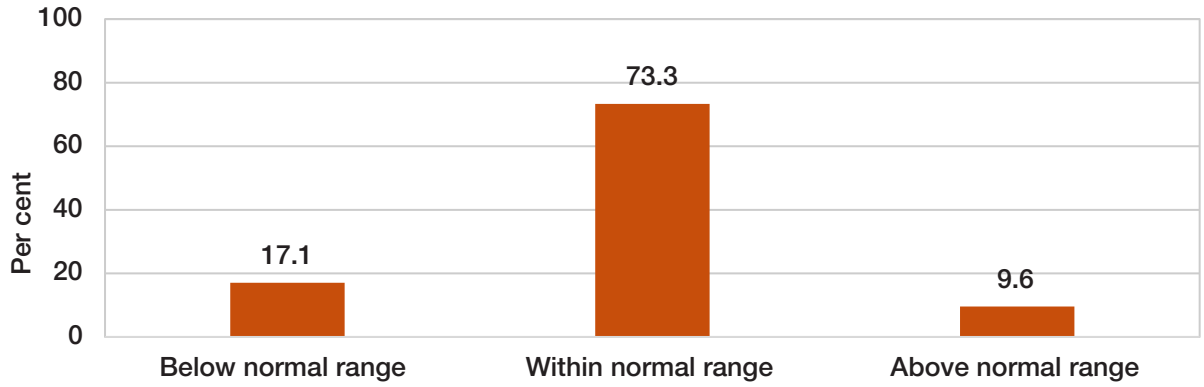
Cognitive development

Verbal ability

At Wave 4, over three quarters (82.9%) of children aged 3 years and older were in the normal or above normal range for verbal ability as measured by the PPVT. About 1 in 6 (17.1%) children are in the below normal range and require support (see Figure 4).

9 The analysis used a measure of placement stability that considered the number of placements changes and accounted for the length of time a child had been in OOHC.

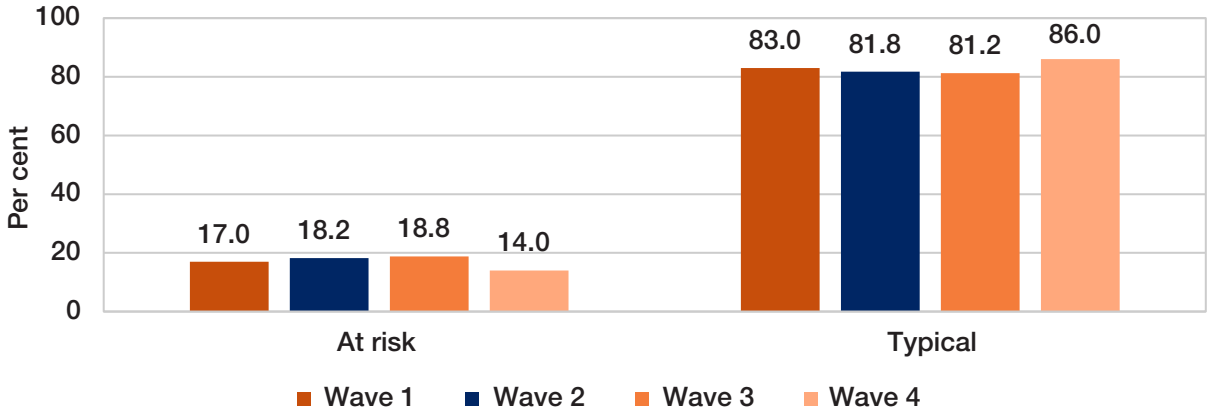
Figure 4: Verbal ability at Wave 4 – approximately 7-8 years after entering OOHC



Source: NSW Department of Communities and Justice, 2019. All participants in the PPVT in Wave 4, n=885

As can be seen in Figure 5, there was an increase in the proportion of children in the 'normal' range over time. The difference in the proportion of children at risk and requiring intensive support for verbal ability between Wave 3 and Wave 4 was significant.

Figure 5: Proportion of children in the normal range for verbal ability over a 7-8 year period since entering OOHC



Source: NSW Department of Communities and Justice, 2019.

Children who participated the verbal ability measures in all four waves, n = 565. Wave 1: 35% CSBS, 16% MCDI-III, 49% PPVT, Wave 2: 0% CSBS, 25% MCDI-III, 75% PPVT Wave 3: 100% PPVT, Wave 4: 100% PPVT. A binary variable 'typical' vs 'at risk' was created as different measures were used across age groups.

What factors are associated with verbal ability over time?

Analysis that examined a range of child, carer and placement factors on development over time (Wells et al. 2020), found some of the factors that were associated with normal socio-emotional development were also associated with normal verbal ability.[10]

10 It is important to note that these findings reflect analysis conducted with three waves of data. The results presented suggest a range of factors that are significantly associated with 'normal' development. Over time, using the additional POCLS data we can confirm the robustness of the associations.

This included children who:

- Entered OOHC at an older age were less likely to be in the normal range for verbal development than younger children.
- Lived with a carer that had very high psychological distress were less likely to be in the normal range for verbal development than children who lived with a carer with low distress.

In addition,

- Non-Aboriginal children placed in relative/kinship care were more likely to be in the normal range for verbal development compared to children placed in foster care.
- Aboriginal children placed in relative/kinship care were less likely to be in the normal range for verbal development compared to children placed in foster care.
- Children who were placed in the combined district grouping[11] of Murrumbidgee, Far West and Western were less likely to be in the normal range for verbal development compared with children placed in Hunter New England and Central Coast districts.

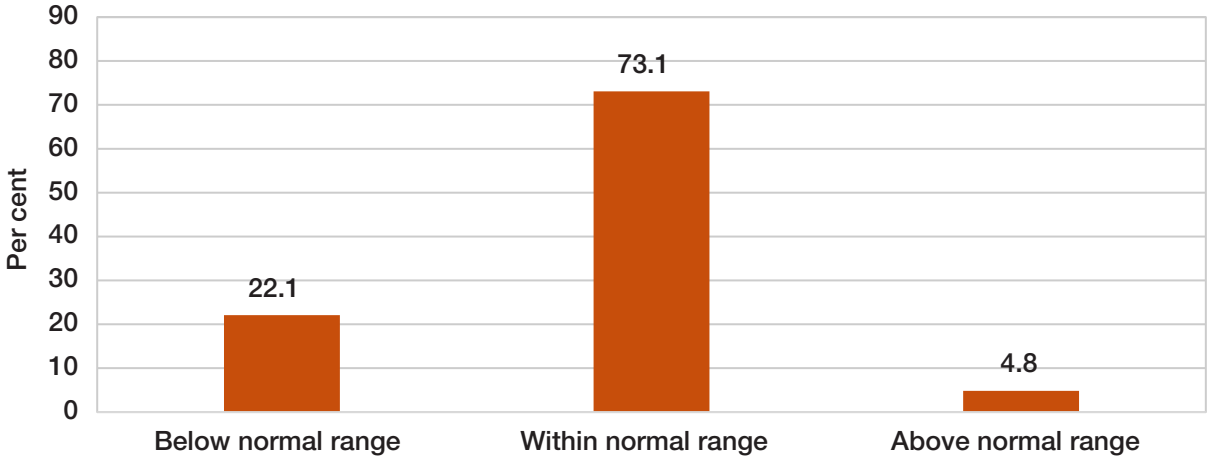
Again these findings do not suggest causality but highlight that there are a range of child, carer and placement characteristics that can be considered when developing policies and practices to support children's verbal development over time. For example, providing appropriate carer support may be considered such as identifying and supporting carers that are stressed. While it is acknowledged that relative/kinship is a preferred placement type for children, relative and kinship carers of Aboriginal children may need additional culturally appropriate support to help address the child's verbal developmental needs. Children may need early assessments, ongoing monitoring and culturally appropriate services. A range of strategies are noted from page 15.

Non-verbal ability

Most children (77.9%) were in the normal or above normal range for non-verbal ability as measured by the MR-WISC-IV at Wave 4 (Figure 6), although over 1 in 5 (22.1%) children require professional support.

11 District grouping incorporates a number of DCJ Districts. Due to small numbers in some districts, geographic categories were combined.

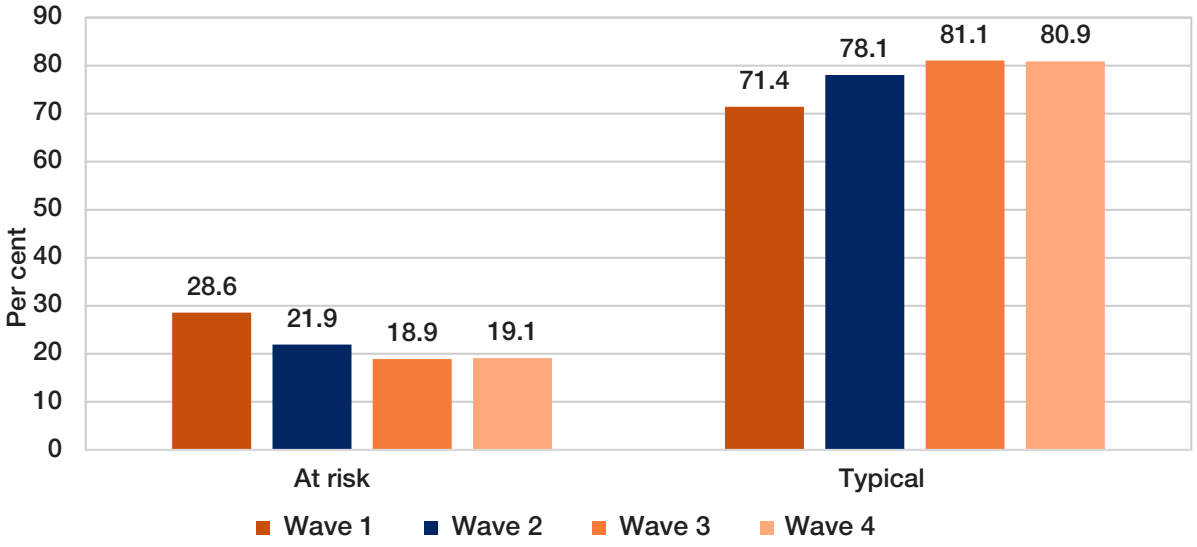
Figure 6: Non-verbal ability at Wave 4 – approximately 7-8 years after entering OOHC



Source: NSW Department of Communities and Justice, 2019. All children who completed the MR-WISC-IV in Wave 4, n=806

Figure 7 includes those children that completed the ASQ or the MR-WISC over Waves 1-4. There was a significant improvement between Wave 1 and Wave 2, but not between other subsequent waves.

Figure 7: Non-verbal ability over a 7-8 year period after entering OOHC



Source: NSW Department of Communities and Justice, 2019. Children who participated in non-verbal ability tests in all four waves, n=497; Wave 1: 72% ASQ, 28% MR-WISC, Wave 2: 66% ASQ, 34% MR-WISC, Wave 3: 54% ASQ, 48% MR-WISC, Wave 4: 100% MR-WISC. A binary variable 'typical' vs 'at risk' was created as different measures were used across age groups. Children were considered to be 'at risk' if they were below average on the WISC (more than 1 Standard Deviation) or were in the 'follow up or monitor' or 'refer' range on the ASQ (more than 1 Standard Deviations).

What factors are associated with non-verbal development over time?

A number of child, placement and carer factors were found to be associated with below normal range non-verbal development (Wells et al. 2020).[12]

- Male children were less likely to be in the normal range compared to female children.
- Aboriginal children were less likely to be in the normal range than non-Aboriginal children.
- Children who had fewer placements per days in care were more likely to be in the normal range for non-verbal development.
- Children who had ROSH reports for carer drug and alcohol abuse prior to entering OOHC the first time were more likely to be in the normal range compared to those without carer drug and alcohol reports.[13]
- Carer education level was associated with normal logical reasoning development. Children who lived with a carer that had university education were more likely to be in the normal range compared to children who lived with a carer who completed high school only.

In addition, there were some differences found between Districts - children who were placed in the two district groups of Illawarra Shoalhaven & Southern NSW, and Sydney (South Eastern, Northern & Sydney) were more likely to be in the normal range compared to children placed in Hunter New England and Central Coast.

Over time, children were more likely to be in the normal range for non-verbal ability in Waves 2 and 3 than in Wave 1.

Again these findings do not suggest causality but highlight that there are a range of child, carer and placement characteristics that can be considered when developing policies and practices to support logical reasoning development. For example focussing on placement stability and providing additional support to children living with carers with only high school education may support a child's non-verbal development. See from page 15 for specific strategies.

Physical development and health

The vast majority (97.0%) of caregivers reported children of all ages to be in 'good' to 'excellent' health and this remained consistent over time (NSW Department of Communities and Justice, 2019). Less than 1 in 5 (17.2%) of caseworkers reported they had some concerns regarding the physical health or medical problems of children. A small proportion (4.0%) reported they had a lot of concern (Hopkins et al. 2019).

12 It is important to note that these findings reflect analysis conducted with 3 waves of data. The results presented suggest a range of factors that are significantly associated with 'normal' development. Over time, using the additional POCLS data we can confirm the robustness of the associations.

13 The positive association between a particular type of ROSH report on development should be interpreted with caution and **not** be considered as a protective factor (e.g. reported carer drug and alcohol abuse improves non-verbal skills). Instead, this may be explained by the absence of other types of ROSH reported issues which may have a greater negative influence on development. The anlaysis includes all ROSH prior to entering care (i.e. both substantiated and not substantiated). Further analysis to be conducted to confirm these findings.

What factors are associated with fine and gross motor skill development?

After controlling for a number of factors:

- Male children were less likely to be in the normal range for both fine and gross motor skill development compared to females.[14]
- Children who had fewer placements per days in care were more likely to be in the normal range for both fine and gross motor skill development.
- Children who had ROSH reports for carer drug and alcohol abuse prior to entering OOHC the first time were more likely to be in the normal range for both fine and gross motor skill development compared to those without those reports.[15] In addition, children who had ROSH reports involving domestic violence prior to entering OOHC the first time were more likely to be in the normal range for fine motor skill development compared to those without those reports.
- Carers' income and age were found to be associated with normal fine motor skill development. Children who lived with a carer that reported a high annual income were less likely to be in the normal range compared to those reporting a low income. Children who lived with an older carer (>61 years) were more likely to be in the normal range compared to children who lived with a younger carer.
- Children living in a socially cohesive neighborhood were more likely to be in the normal range for both fine and gross motor skill development.

Compared to children placed in Hunter New England and the Central Coast, children placed in district groups of:

- Murrumbidgee, Far West and Western NSW, and the Illawarra, Shoalhaven and Southern NSW districts were more likely to be in the normal range for fine motor skill development.
- Illawarra, Shoalhaven and Southern NSW, and Sydney (South Eastern, Northern Sydney) districts were more likely to be in the normal range for gross motor skill development.

Over time, children were more likely to be in the normal range for both fine and gross motor skill development in Wave 3 than in Wave 1.

Again these findings do not suggest causality but highlight that there are a range of child, carer and placement characteristics that can be considered when developing policies and practices to support physical development. See from page 15 for specific strategies.

14 It is important to note that these findings reflect analysis conducted with three waves of data. The results presented suggest a range of factors that are significantly associated with 'normal' development. Over time, using the additional POCLS data we can confirm the robustness of the associations.

15 The positive association between a particular type of ROSH report on development should be interpreted with caution and not be considered as a protective factor (e.g. reported carer drug and alcohol abuse improves motor skills). Instead, this may be explained by the absence of other types of ROSH reported issues which may have a greater negative influence on development. The analysis includes all ROSH prior to entering care (i.e. both substantiated and not substantiated).Further analysis to be conducted to confirm these findings.

Implications of the research to improve child outcomes

Strategies to support children's development

Care plans

Care plans emphasise the importance of engagement and building relationships with children and their families. High quality care planning requires adequate timeframes to allow for permanency planning and appropriate consultation with the child's extended family/kin. As age at entry into care is associated with normal socio-emotional and verbal development over time care plans should take into consideration that older age groups are more likely to need intensive support on entry to OOHC.

Strategies to engage family/kin of children in OOHC to assist in identifying relationships to foster lifelong connections and permanency are important (e.g. Family Group Conferencing and the Family Finding model). Finding family should have a wide scope and include but not be limited to: grandparents, aunts/uncles, older siblings, cousins and Aboriginal kinship structures and child rearing responsibilities beyond the immediate family group.

The Permanent Placement Principles should be followed. The Aboriginal and Torres Strait Islander Placement Principles should be followed when finding appropriate placements for Aboriginal children. See Evidence to Action Note Number 9 – Developmental Outcomes: Aboriginal Children and Young People in Out-of-Home Care.

Establishing placements

Caseworker support to both the child and caregivers[16] should include advice and strategies to support the child's needs in relation to safety, physical health and development, socio-emotional wellbeing and cognitive/learning ability. It is important to share information about the child's culture and history, including their trauma history, with caregivers from the beginning of a placement to ensure the caregiver can adequately care for the child.

Case plans

The POCLS evidence shows that a proportion of children developing in the normal range for health, socio-emotional wellbeing and cognitive/learning ability may change over time highlighting the importance of a case plan being a living document that should reflect the changing needs of children with reviews occurring at least annually. Case plans should:

16 The term caregivers includes birth parents, foster carers, relative/kin carers, guardians, adoptive parents and residential care workers. The term carer is used in this note for foster and relative/kin caregivers and reflects findings that were conducted with this subgroup.

- Be developed with key supports in the child's life and include the child (appropriate to their age and maturity)
- Be based on culturally appropriate assessments
- Support timely referrals to culturally appropriate services
- Support continuity with professional service providers
- Support ongoing personal relationships that children might have with peers and previous caregivers that may provide the benefits of relational stability
- Ensure a genuine connection to family, community, cultural identity and country is sustained and supported.

All children in OOHC should participate in the OOHC Health Pathway to receive timely physical and mental health assessments, interventions, monitoring and ongoing reviews of their health needs. Caregivers should be involved and plans regularly reviewed and updated.

All children in OOHC should participate in the Personalised Learning and Support Planning (PLaSP) process to identify and support the education needs of the child, as part of the OOHC Education Pathway. This collaborative process ensures that all children who enter OOHC have their developmental and educational needs identified, met, monitored and reviewed to help them reach their full learning potential. It includes the caseworker, carer, educators and all relevant stakeholders to identify and arrange appropriate support to address learning needs and goals, improve attendance and decrease suspensions.

All children should have access to quality childcare.

Strategies to support and train caregivers

Identify caregiver stress

The early identification of stress in carers or dissatisfaction with the amount of information they are given or their relationship with OOHC agencies, may have a positive impact on a child's development by prompting the provision of culturally appropriate services, support and monitoring.

Training and development

Culturally appropriate and trauma informed carer training tailored to the carers' needs should support the provision of physical and relational stability for the child. Evidence from POCLS suggests that placement stability is associated with normal socio-emotional, non-verbal, fine and gross developmental outcomes.

Trainers should consider carer characteristics (e.g. age and education) and placement type when designing, promoting and delivering training, given associations with development.

Casework support

Good casework practice includes:

- Consideration of the individual needs and perspectives of the caregiver, child and placement type given the association of carer, placement characteristics and age at entry to OOHC with normal development. For more guidance on casework practice see the resources below.
- Identification and monitoring of caregivers' needs and satisfaction with their caring role regarding support, training and access to services. Caregiver satisfaction with their working relationship with agencies is found to be associated with a child's normal socio-emotional development.
- Encouragement and support for both children and caregivers to be involved in the OOHC Health Pathway and the OOHC Education Pathway (PLaSP process).

Behaviour support plans to equip caregivers with strategies to promote appropriate behaviours, address the underlying reasons for concerning behaviours to keep the child safe and improve their wellbeing.

Strategies to develop casework skills and casework supervision

Consider whether adequate time and resources are allocated to early assessment, ongoing monitoring and review in casework practice supervision.

Support caseworkers' skill development through group supervision with consideration of capacity to support cultural permanency and cultural connections, monitoring OOHC health and education assessments, behaviour support plans, and carer satisfaction with information and support.

Assist caregivers to access available resources and supports.

Provide regular caseworker training and provision of key resources and materials. This would include training on the OOHC Health, Education Pathways and behaviour support plans. This provides opportunity to promote the importance of these assessments and processes to determine a child's needs earlier and provide the appropriate supports to meet individual needs.

Provide caseworker training on working effectively with caregivers including monitoring of carer satisfaction to identify early carer stress and the needs of the carer for child services and additional support.

Reporting of child outcome related data

Accurate identification and documentation of the child's cultural background (specifying the birth mother and father's cultural background) is required in DCJ datasets so appropriate services and supports can be provided.

Routine collection and reporting of child developmental outcomes is important. Information on the child's needs, the services they receive and their development should be collected consistently.

Routine data collection on the services children receive and their developmental outcomes will enable DCJ to support programs that improve the outcomes for children in OOHC through monitoring and evaluation.

DCJ administrative data could be improved by consistent recording of data on the reason for placement changes including if they are planned or unplanned.

Where to from here?

Policy and practice improvements underway

The new Casework Development Program[17] is underway with online training for new caseworkers that includes training on Finding Family.

The Permanency Support Program (PSP) provides tailored services to vulnerable children. DCJ has commissioned the Permanency Support Program Learning Hub to improve the knowledge and skills of practitioners.

DCJ is reviewing the Child Assessment Tool (CAT)[18]. The CAT helps determine the service type required and level of support to best meet the needs of a child under the Permanency Support Program (PSP).

Practice webinars and training resource development for the OOHC Health and Education Pathways are underway. This provides an opportunity to promote the importance of these assessments and processes to determine a child's needs earlier and provide the appropriate supports to meet that need. It is important to include ongoing monitoring and review of these plans as children's and carers needs change over time.

DCJ are trialling the implementation of the Quality Assurance Framework (QAF). The QAF provides regular information to caseworkers about each child in OOHC to support and inform their case planning. A Child Overview Form is produced quarterly and provides information on:

- ROSH reports received, the number of days in a placement and placement type
- NAPLAN results and school attendance
- Child safety, permanency, and multicultural identity
- Carer report of the child's wellbeing (Strengths and Difficulties Questionnaire - SDQ).

17 Aboriginal Outcomes, Child and Family reviewed the CDP program and provided advice on each module to ensure that the needs of Aboriginal children and their families are addressed in all aspects of casework.

18 Includes Aboriginal Impact Statement and in consultation with the Aboriginal Outcomes, Child and Family team

In response to the Family is Culture, Independent Review of Aboriginal Children and Young People in Out-of-Home Care (OOHC), DCJ has committed to work to build a child protection system that is more responsive to the needs of Aboriginal children, families and communities. The report highlighted the importance of a culturally capable service system that keeps children safe and connected to culture. The DCJ response includes:

- Providing evidence-based supports to help keep families together. Half of the places in the newest programs are available for Aboriginal families.
- Implementing the Aboriginal Case Management Policy developed with AbSec in consultation with local Aboriginal communities. The policy guides DCJ caseworkers to use: Aboriginal community-controlled mechanisms, Aboriginal family-led decision-making and Aboriginal advocates and facilitators.
- Redesigning training for new child protection caseworkers including a module on how to work better with Aboriginal families developed in partnership with Aboriginal stakeholders and peak organisations.
- Funding nine Aboriginal Child and Family Centres to provide quality culturally appropriate wrap-around services for Aboriginal children, families and communities.
- Supporting Aboriginal-led, evidence-informed programs that are embedded in local communities such as the Nabu Demonstration Project and ID Know Yourself which provides mentoring and intensive support to Aboriginal children and families.
- Welcoming a Deputy Children's Guardian for Aboriginal Children and Young People within the Office of the Children's Guardian to provide leadership within the sector to elevate the rights and wellbeing of Aboriginal children.
- Establishing an Aboriginal Knowledge Circle to provide independent advice to the Minister. This group will comprise of five independent and expert Aboriginal members who will work with DCJ and the Aboriginal community to ensure Aboriginal-led advice is at the heart of our response.
- Establishing an Aboriginal Outcomes Taskforce to drive improvements in services and supports for Aboriginal families, data collection and reporting, casework policy and practice, and interagency coordination.

Further research to improve evidence informed practice

To develop policies and practice to improve outcomes, it is important to determine the factors that influence outcomes for children and young people in the POCLS. The analysis presented here is a starting point. Further analysis of the POCLS data is needed to learn more about the characteristics of those children who improved over time and those who did not.

A number of projects are underway and outlined in the POCLS Objectives and Strategic Research Agenda (Department of Communities and Justice, 2020). Ongoing consultation with DCJ policy colleagues occurs to formulate policy relevant research questions that can be answered with the POCLS data asset.

Policy and practice guides and further reading

Early intervention services

- https://www.facs.nsw.gov.au/providers/children-families/early-intervention

Intensive Family Based Services

- https://www.facs.nsw.gov.au/providers/funded/programs/atsi/intensive-family-based-services-aboriginal
- NSW Framework for Therapeutic Care https://www.facs.nsw.gov.au/about/reforms/NSWPF/nsw-therapeutic-care
- Permanency Support Program https://www.facs.nsw.gov.au/families/permanency-support-program
- Permanency Support Learning Hub https://psplearninghub.com.au/
- Permanent Placement Principles https://www.facs.nsw.gov.au/families/permanency-support-program/paths

Care planning

- https://caseworkpractice.intranet.facs.nsw.gov.au/mandates/legal-options/care-plan.

Case planning

- https://caseworkpractice.intranet.facs.nsw.gov.au/mandates/case-planning/case-planning-in-oohc

Health Pathway

- https://www.facs.nsw.gov.au/providers/children-families/OOHC-Health-resources-and-tools

Education Pathway

- https://www.facs.nsw.gov.au/providers/children-families/oohc-education-resources-and-tools

Personalised Learning and Support Planning (PLaSP)

- https://www.facs.nsw.gov.au/providers/children-families/oohc-education-resources-and-tools/oohc-education-pathway-a-guide-for-caseworkers

Department of Communities and Justice Casework Practice Mandates

- https://caseworkpractice.intranet.facs.nsw.gov.au/mandates

Independent Review of Aboriginal Children and Young People in OOHC in NSW in the Family is Culture Review Report 2019.

- https://www.familyisculture.nsw.gov.au/

The Australian Institute of Family Studies (AIFS) have produced a series of practice guides for working with children who have experienced adversity.

- https://aifs.gov.au/cfca/publications/developmental-differences

Developmental differences in children who have experienced adversity: Emerging evidence and implications for practice. CFCA Practitioner Resource. Published by Australian Institute of Family Studies 2018.

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Wells, R. Asif, N., Breen, C. and Zhou, A. (2020). The influence of placement stability on developmental outcomes for children in out-of-home care. Pathways of Care Longitudinal Study: Outcomes of Children and Young People in Out-of-Home Care. Research Report Number 21. Sydney. NSW Department of Family and Community Services.

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Pathways of Care Longitudinal Study

The Pathways of Care Longitudinal Study (POCLS) is the first large-scale prospective longitudinal study of children and young people in out-of-home care (OOHC) in Australia. The study collects detailed information about the life course development of children who enter OOHC and the factors that influence their safety, permanency and wellbeing. The POCLS links data on children's child protection backgrounds, OOHC placements, health, education and offending held by multiple government agencies; and matches it to first-hand accounts from children, caregivers, caseworkers and teachers. The population cohort is a census of all children who entered OOHC for the first time in NSW over an 18-month period between May 2010 and October 2011 (n = 4,126). A subset of those children who went on to receive final Children's Court care and protection orders by 30 April 2013 (n = 2,828) were eligible to participate in the study. Information about the study and publications can be found on the POCLS webpage.

The POCLS acknowledges and honours Aboriginal people as our First Peoples of NSW and is committed to working with the Department of Communities and Justice (DCJ) Aboriginal Strategy Coordination & Evaluation team to ensure that Aboriginal children, young people, families and communities are supported and empowered to improve their life outcomes. The DCJ recognises the importance of Indigenous Data Sovereignty and Governance (IDS & IDG) in the design, collection, analysis, dissemination and management of all data related to Aboriginal Australians. The POCLS will continue to partner with Aboriginal Peoples and will apply the DCJ research governance principles once developed. Interpretation of the data should consider the factors associated with the over-representation of Aboriginal children in child protection and OOHC including the legacy of past policies of forced removal and the intergenerational effects of previous forced separations from family and culture. The implications for policy and practice should highlight strengths, develop Aboriginal-led solutions and ensure that better outcomes are achieved for Aboriginal people.

About this Evidence to Action note

The POCLS data asset will be used to improve how services and supports are designed and delivered in partnership with the policy and program areas to improve the outcomes for children and young people who experience OOHC, the support provided to caregivers and families, and the professional development of staff.

The Evidence to Action Note was prepared by the POCLS team at DCJ and report authors with input and endorsement from the POCLS Evidence to Action Working Group. This Note is intended to be a resource for policy makers and senior practitioners.

The findings in this evidence to action note are primarily based on:

- NSW Department of Communities and Justice (2019). Study overview and the wellbeing of children & young people in OOHC. Presentation by Merran Butler and Joanna Hopkins at the Australian Social Policy Conference University of NSW.
- Wells, R. Asif, N., Breen, C. and Zhou, A. (2020). The influence of placement stability on developmental outcomes for children in out-of-home care. Pathways of Care Longitudinal Study: Outcomes of Children and Young People in Out-of-Home Care. Research Report Number 21. Sydney. NSW Department of Family and Community Services.

This note should be read in conjunction with: NSW Department of Communities and Justice (2020). Developmental outcomes: Aboriginal children and young people who have experienced out-of-home care. Pathways of Care Longitudinal Study: Outcomes of Children and Young People in Out-of-Home Care. Evidence to Action Note Number 9. Sydney. NSW Department of Communities and Justice.

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Study design

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Ethics approvals

- University of NSW Human Ethics Committee (UNSW HREC) (Approval numbers HC 10335, HC 16542)
- Aboriginal Health and Medical Research Council (AH&MRC) of NSW Ethics Committee (Approval number 766/10)
- NSW Population and Health Services Research Ethics Committee (Approval number HREC/14/CIPHS/74 Cancer Institute NSW 2014/12/570).

POCLS webpage

NSW GOVERNMENT

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