

Pathways of Care Longitudinal Study: Outcomes of Children and Young People in Out-of-Home Care

Literature Review: Factors Influencing the Outcomes of Children and Young People in Out-of-Home Care



Pathways of Care Longitudinal Study

Research Report No. 6

Literature Review: Factors Influencing the Outcomes of
Children and Young People in Out-of-Home Care

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Published by

New South Wales Department of Family and Community Services (FACS)
Insights, Analysis and Research
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Ashfield NSW 2131
Phone + 61 2 9716 2222

June 2018

ISBN: 978-0-6482697-1-7

Recommended citation

Walsh, P., McHugh, M., Blunden, H. and Katz, I. (2018). Literature Review: Factors Influencing the Outcomes of Children and Young People in Out-of-Home Care. Pathways of Care Longitudinal Study: Outcomes of Children and Young People in Out-of-Home Care. Research Report Number 6. Sydney. NSW Department of Family and Community Services.

Disclaimer

FACS funds and leads the Pathways of Care Longitudinal Study. The findings and views reported in this publication are those of the authors and may not reflect those of FACS. The authors are grateful for the reviewers' comments in particular Dr Johanna Watson, Professor Judy Cashmore, Marina Paxman and Sharon Burke.

Pathways of Care Longitudinal Study Clearinghouse

All study publications including research reports, technical reports and bulletins can be found on the study webpage www.community.nsw.gov.au/pathways

Study design by NSW Department of Family and Community Services (Analysis and Research); Australian Institute of Family Studies; Professor Judy Cashmore, University of Sydney; Professor Paul Delfabbro, University of Adelaide; Professor Ilan Katz, University of NSW; Dr Fred Wulczyn, Chapin Hall Center for Children University of Chicago.

Study data collection by I-view Social Research.

Advisors Expert advice and support has been provided by the CREATE Foundation; Aboriginal Child, Family and Community Care State Secretariat (AbSec); Connecting Carers; and the out-of-home care program areas and stakeholders.

Acknowledgements We wish to extend our thanks to all the children, young people and caregivers who participated in interviews; childcare teachers, school teachers and caseworkers who participated in on-line survey interviews; and the data custodians in the relevant NSW and Commonwealth government departments. Ms Billy Black is a young person who grew up in care and designed the study artwork.

Ethics approval by The University of NSW Human Research Ethics Committee (approval number HC10335 & HC16542); Aboriginal Health and Medical Research Council of NSW Ethics Committee (approval number 766/10); NSW Department of Education and Communities State Education Research Approval Process (SERAP, approval number 2012250); NSW Population & Health Services Research Ethics Committee (Ref: HREC/14/CIPHS/74 Cancer Institute NSW: 2014/12/570).



Preface

The Pathways of Care Longitudinal Study (POCLS) is funded and managed by the New South Wales Department of Family and Community Services (FACS). It is the first large-scale prospective longitudinal study of children and young people in out-of-home care (OOHC) in Australia. Information on safety, permanency and wellbeing is being collected from various sources. The child developmental domains of interest are physical health, socio-emotional wellbeing and cognitive/learning ability.

The overall aim of this study is to collect detailed information about the life course development of children who enter OOHC for the first time and the factors that influence their development. The POCLS objectives are to:

- describe the characteristics, child protection history, development and wellbeing of children and young people at the time they enter OOHC for the first time
- describe the services, interventions and pathways for children and young people in OOHC, post restoration, post adoption and on leaving care at 18 years
- describe children's and young people's experiences while growing up in OOHC, post restoration, post adoption and on leaving care at 18 years
- understand the factors that influence the outcomes for children and young people who grow up in OOHC, are restored home, are adopted or leave care at 18 years
- inform policy and practice to strengthen the OOHC service system in NSW to improve the outcomes for children and young people in OOHC.

The POCLS is the first study to link data on children's child protection backgrounds, OOHC placements, health, education and offending held by multiple government agencies; and match it to first hand accounts from children, caregivers, caseworkers and teachers. The POCLS database will allow researchers to track children's trajectories and experiences from birth.

The population cohort is a census of all children and young people who entered OOHC for the first time in NSW between May 2010 and October 2011 (18 months) (n=4,126). A subset of those children and young people who went on to receive final Children's Court care and protection orders by April 2013 (2,828) were eligible to participate in the study. For more information about the study please visit the study webpage <https://www.facs.nsw.gov.au/resources/research/pathways-of-care>.

Contents

Preface.....	v
Contents.....	1
1 Executive Summary.....	4
1.1 Child characteristics.....	5
1.2 Placement characteristics.....	9
1.3 Conclusion.....	13
2 Introduction.....	16
2.1 Purpose.....	16
2.2 Background.....	16
2.3 Framework.....	18
3 Literature Review Methodology.....	20
3.1 Limitations.....	20
4 Child Characteristics that Effect Out-of-Home Care Outcomes.....	22
4.1 Child characteristics.....	22
4.1.1 Age at entry into OOHC.....	22
4.1.2 Age and time in OOHC.....	22
4.1.3 Age and placement stability.....	23
4.1.4 Age and mental health outcomes.....	24
4.1.5 Age and care extending into young adulthood.....	24
4.2 Gender.....	25
4.2.1 Gender and nature of maltreatment/abuse.....	25
4.2.2 Gender and placement outcomes.....	25
4.3 Culturally and Linguistically Diverse and refugee children.....	26
4.3.1 Ethnicity and placement.....	26
4.3.2 Culturally matched carers.....	27
4.3.3 Specific issues affecting refugee families.....	27
4.4 Indigenous children.....	28
4.4.1 Indigeneity, length and stability of placement.....	29
4.4.2 Culturally appropriate placements and cultural support plans.....	29
4.4.3 Indigenous children’s health needs.....	30
4.5 Children with disabilities.....	31
4.6 Siblings.....	33
4.7 Birth family characteristics.....	34
4.7.1 Single parenthood.....	35

4.7.2	A large number of children in the family.....	35
4.7.3	Poverty	36
4.7.4	Inadequate housing	37
4.7.5	Mental illness.....	37
4.7.6	Substance abuse.....	38
4.7.7	Domestic violence	38
4.7.8	Social exclusion.....	39
4.7.9	Parents with their own experience of abuse and neglect.....	39
4.7.10	Birth parent characteristics and reunification	41
4.8	Child protection history.....	42
4.8.1	Type of maltreatment and developmental outcomes	42
4.8.2	Poly-victimisation.....	45
4.9	Neighbourhood characteristics.....	46
4.9.1	Neighbourhoods and maltreatment	46
4.10	Emotional and behavioural problems and temperament	48
4.10.1	Age and emotional and behavioural problems.....	48
4.11	Resilience and protective factors	51
5	Placement Characteristics	53
5.1	Placement type and outcomes	53
5.1.1	Placement stability.....	55
5.1.2	Sense of safety, security and happiness	58
5.1.3	Family reunification.....	59
5.2	Adoption.....	61
5.2.1	Age and adoption	61
5.2.2	Open adoption	62
5.2.3	Adoption versus foster or kinship care.....	63
5.3	Carer characteristics	64
5.3.1	Foster carer attributes.....	64
5.3.2	Kinship carers' attributes	69
5.4	Casework, Services and interventions	72
5.4.1	Services and placement type.....	72
5.4.2	Caseworker support to child/young person.....	72
5.4.3	Casework and caseworker training.....	74
5.4.4	Caseworker caseloads	76
5.4.5	Education.....	77
5.4.6	Health care	79

5.4.7	Therapeutic approaches	80
5.4.8	Contact with birth family.....	84
5.4.9	Sibling groups and contact	86
6	Conclusion	88
7	References	91
	Appendix: Literature Review Methodology and Sources	119

List of Tables

Table 5.1:	Characteristics of government and non-government sector respondents	75
Table 5.2:	Level of caseload by care type	77

List of Figures

Figure 3.1:	Conceptual overview of factors influencing outcomes in OOHC	21
Figure 5.1	Qualifications of residential care workers	76

1 Executive Summary

The purpose of this literature review is to examine the factors that influence outcomes for children and young people in out-of-home care (OOHC). It aims to summarise research findings on which factors predict positive or negative outcomes and thereby inform policies and practices in order to increase the chances of positive outcomes for children and young people¹ in OOHC.

Overall, research in Australia and internationally clearly indicates that outcomes for children who have experienced OOHC because of abuse and neglect are in general poorer than for those children who have never been maltreated and placed into OOHC (see Clausen, Landsverk, Ganger, Chadwick & Litrownik, 1998; Tarren-Sweeney & Hazell, 2006; Meltzer, Gatward, Corbin, Goodman & Ford, 2003; Gypen, Vanderfaeillie, De Maeyer, Belenger & Van Holen, 2017).

This applies over a wide range of indicators including: mental health, substance abuse and eating disorders (Friedman et al., 2011 cited in Coyd & Walter, 2016) and other personality disorders (Guest, 2012; Rutter & Quinton, 1984); lower emotional and mental wellbeing generally (Broad, 2004; Buchanan, 1999; Clough, 1982; Cocker & Scott, 2006); involvement in the criminal justice system (McFarlane, 2008; CLAN, 2008; Narey, 2007; Robson, 2008); lower educational attainment (Connelly, Forrest, Furnivall, Siebert, Smith & Seagaves, 2008; Jackson & Sachdev, 2001; Townsend, 2012); higher housing instability and homelessness (Dixon, 2008; Robson, 2008); and higher rates of chronic health conditions and morbidity (Kendall-Tackett, 2002; Fernandez, Blunden, McNamara, Kovacs & Cornefert, 2016).

This report explores pathways into and through care for children and young people. It examines research literature on seven key domains known to influence outcomes:

Child characteristics that affect developmental outcomes for children in out-of-home care:

- Exposure to abuse/trauma
- Birth family characteristics
- Pre-placement history
- Neighbourhood and community characteristics
- Placement characteristics that affect developmental outcomes for children in out-of-home care:
 - Stability of placement
 - Carer characteristics
 - Services and interventions

¹ For simplicity, the term 'children' will generally be used.

1.1 Child characteristics

Age

Most research indicates that age, particularly the age a child enters OOHC, may be a factor in some outcomes. However, some studies do not show that age at entry influences developmental outcomes.

- Some researchers have found that the older the child on entering OOHC the greater the risk of placement breakdown (Berridge & Cleaver, 1987; Fratter, Rowe, Sapsford & Thoburn, 1991; Rowe, Hundleby & Garnett, 1989; Rushton, Mayes, Dance & Quinton, 2003).
- Being older at time of entry into care has been posited as a predictor of poorer outcomes compared with those of children who entered care at a younger age, especially infants. The younger the age of entry into care, the less likelihood of mental health difficulties (Tarren-Sweeney, 2008) and behavioural issues (Dozier, 2005).
- Pritchett, Gillberg and Minnis (2013) found mixed results in studies on the impact of placement age on outcomes but concluded that, overall, children placed younger tended to do better in care.

Other findings related to age generally include:

- Outcomes such as behavioural and mental disorders manifest at higher rates in older children and adolescents in care (Armsden, Pecora, Payne & Szatkiewicz, 2000; Dubowitz, Zuravin, Starr, Feigelman & Harrington, 1993; Heflinger, Simpkins & Combs-Orme, 2000).
- Younger children/infants are more likely to be adopted (Akin, 2011).
- Extending the time in care to an older age, for some young people, may alleviate some of the poorer outcomes (Kerman, Wildfire & Barth, 2002; McDowall, 2016).

Gender

Gender has some influence on the type of maltreatment suffered. Gender is not predictive of being placed in OOHC as male and female children are almost equally likely to be placed in OOHC in Australia (AIHW, 2016a). Further, gender is a weak factor in predicting or influencing outcomes while children are in care. However, some studies show that young women tend to do better than young men in a range of domains after leaving care (Cashmore & Paxman, 2006).

Emotional and behavioural problems and temperament

In relation to the emotional and behavioural problems of a child on entry into care, research indicates that:

- A significant proportion of children in care experience complex psychological and behavioural problems (Osborn & Bromfield, 2007).
- Early behaviour problems have been found to predict subsequent poor outcomes, such as delinquency, substance use and inappropriate sexual behaviour among children in OOHC (Taussig, 2002).
- Placement breakdown has also been shown to predict child behavioural problems (Newton, Litrownik & Landsverk, 2000; Rubin, O'Reilly, Luan & Localio, 2007) and therefore behaviour problems can be both a cause and a consequence of placement disruption (Newton et al., 2000).

Culturally and Linguistically Diverse and refugee children

There are few Australian studies on Culturally and Linguistically Diverse (CALD) and refugee children in OOHC.

- The prevalence of child abuse and neglect is not known amongst CALD and refugee communities in Australia (Kaur, 2012).
- CALD and refugee families face a number of unique risk factors and challenges (Kaur, 2012).
- US studies have shown that cultural background/ethnicity can influence placement into care and exit from care (Akin, 2011; Barth, 1997).
- There is no conclusive evidence that children and young people in culturally matched care have fewer social and emotional problems compared with those not in culturally matched care (Burke & Paxman, 2008; Huntsman, 2014).
- Children from inter-racial backgrounds who were in OOHC displayed cultural identity confusion and self-esteem issues (Kaur, 2012).
- Notifications of abuse were most commonly associated with physical abuse, neglect and domestic violence (Lewig, Arney & Salveron, 2010).

Indigenous children

Indigenous children in OOHC are over-represented across all age groups compared with non-Indigenous children.

- At 30 June 2016, the rate of Indigenous children in OOHC in Australia was nearly 10 times the rate for non-Indigenous children (AIHW, 2017).
- Some of the factors associated with this include: the legacy of past policies of forced removal, intergenerational effects of previous separations from family and culture, lower socio-economic status (SES), and drug and alcohol abuse and family violence (AIHW, 2017).
- Indigenous children typically spend five times longer in care than non-Indigenous children (Fernandez, 1999).

- Indigenous children in OOHC experienced more placements, and had more disruptions during their time in care, than non-Indigenous children (McDowall, 2013).
- It is not known if or how cultural support plans being in place affect outcomes.
- There is a need for research that compares child outcomes for those who are placed in accordance with the Aboriginal Child Placement Principle (ACPP) and those who are placed in non-Indigenous placements (Bromfield & Osborn, 2007a).

Children with disabilities

UK, US and Australian research noted a high percentage of children with disabilities in care systems. Despite their high representation, they appeared to have had minimal attention paid to them in studies evaluating outcomes.

- Little is known about outcomes for children with disabilities in care (McConkey, Nixon, Donaghy & Mulhern, 2004).
- Many studies did not find an effect of health or disability; however, where an effect was found, it was more likely to be negative, with health problems or disabilities being related to poorer outcomes for children in care (Pritchett et al., 2013).
- Children with disabilities remained in care longer, were more likely to be placed in foster care (Farmer, 2009), and faced particular barriers to achieving permanency and stability (Baker, 2011).

Siblings

There has been limited research in Australia on both the prevalence and outcomes for sibling groups placed in care, whether placed separately or together. The limited research indicates that wellbeing is improved if siblings are placed together.

- Research on sibling groups in care highlights the importance of keeping siblings together for children's health, wellbeing and placement stability (Akin, 2011; Albert & King, 2008; O'Neill, 2002; Waid, 2014; Waldeman & Wheal, 1999).
- Little is known about the complex and dynamic nature of sibling relationships in OOHC settings, especially in relation to wellbeing outcomes (Waid, 2014).

Birth family characteristics

Birth family characteristics that are risk factors for the child being placed in OOHC include:

- Family poverty/low socio-economic status
- Higher number of children

- Single parenthood
- Parental mental disorder
- Parental substance abuse
- Domestic violence in the home
- Parental history of trauma

Pre-placement history

Pre-placement factors such as exposure to maltreatment (including emotional, physical, sexual abuse and neglect) affecting outcomes include:

- Parental exposure to maltreatment (more likely to maltreat their own children)
- Family poverty/low socio-economic status.

Children who have experienced maltreatment exhibit negative developmental outcomes in later childhood (Johnson-Reid, Kohl & Drake, 2012) and are more likely to experience negative outcomes in adulthood across a range of domains (Fernandez et al., 2016). However, resilience factors such as intelligence, parental/carer attachment, external interests, coping skills, peer relations and temperament may have a mitigating or protective effect (Finkelhor, Ormrod & Turner, 2007).

Neighbourhood characteristics

Neighbourhood effects may have an influence in creating conditions conducive to maltreatment and poly-victimisation.

- There were consistent associations between neighbourhood maltreatment rates and neighbourhood characteristics, particularly structural characteristics (Coulton, Korbin & Su, 1999: 1132). The most consistent findings involved associations between rates of child maltreatment and socio-economic status and resources of the neighbourhood of the birth family² including poverty rate, income level, unemployment rate, and residential instability.
- Other neighbourhood characteristics (e.g. safety and neighbourhood belonging) are shown to be strongly connected to development outcomes for all children and as predictors for entry rates into OOHC.
- High levels of neighbourhood social disorder (e.g. heavy neighbourhood traffic, drug sales and crime) were related to more frequent physical abuse,

² Research has not yet shown whether the neighbourhood where the child is in OOHC makes a difference, but the Pathways of Care Longitudinal Study (POCLS) will address this issue.

while higher levels of collective efficacy were related to less frequent physical abuse.

- However, there is no research which directly links neighbourhood characteristics of either birth families or carers to children's outcomes in OOHC.

1.2 Placement characteristics

Type of placement

At 30 June 2017, most children on care and protection orders in Australia were placed with relative/kinship carers (38%). Just under a third (32%) were in foster care, 11% in third-party parental care arrangements³, 7% with their parents, 5% in residential care and around 7% in 'other/unknown' situations (AIHW, 2017).

In general, research has found that placement type (foster or kinship) is not predictive of outcomes across key domains (Foster, 2009).

- A study comparing attachment behaviour between infants and their foster and kinship carers reported similar percentages (67% and 68%) of secure attachment in both types of care (Cole, 2006).
- However, adoption is correlated with more positive outcomes, as indicated below.

Placement stability

- Placement stability is both a cause and a consequence of social, behavioural, emotional and cognitive outcomes for children in OOHC. Stability is very important in a child's life in care (Bromfield, Higgins, Higgins & Richardson, 1997; Jones, 2010; Lamont, 2011; O'Neill, Forbes, Tregeagle, Cox & Humphreys, 2010; Pecora, 2010; Wulczyn, 2010) and is associated with perceived emotional security (Cashmore & Paxman, 2006).
- Many studies have demonstrated the beneficial effects of being in care, with many children and young people perceiving their placements as providing increased safety and stability (Commission for Children and Young People and Child Guardian, 2013).

³ This includes where a third-party parental responsibility order is in place, transferring all duties, powers, responsibilities and authority to which parents are entitled by law to a nominated person(s) whom the court considers appropriate. The nominated person may be an individual such as a relative or an officer of the state or territory department (AIHW, 2017).

- Some research has found that kinship care provides greater stability because there is less risk of placement disruption in kinship care placements (Chamberlain, Price, Reid, Landsverk, Fisher & Stoolmiller, 2006).
- Placement breakdown may be associated with the age of the child and factors related to the child's exposure to maltreatment and concomitant social and behavioural issues.
- Adopted children generally experience fewer placement breakdowns; however, the difference between adoption and foster care reduced where placement for adoption occurred at an older age (Quinton & Selwyn, 2009).
- In addition, placement movements may occur due to 'fewer residential care options for children with severe behavioural or conduct problems' (Delfabbro, Hirte, Rogers, & Wilson, 2010: 29).
- A meta-analysis of disruptions in foster care by Oosterman, Schuengel, Wim Slot, Bullens & Doreleijers (2007) found that the quality of foster caregiving and other foster care related aspects, rather than placement type, protected against placement breakdown. This is consistent with other research which indicates that carer attributes (e.g. warm, responsive parenting style, good parenting skills and effective discipline practices) and meaningful relationships with caseworkers are more important in overall improved child wellbeing (CCYPCG, 2013) rather than the type of placement.

Contact and reunification with birth family

- Maintaining contact with the birth family can be beneficial. In an overview of the literature on contact between children and birth parents, Taplin (2005) suggests there are a number of positive outcomes for children in relation to family contact. However, Barber and Gilbertson found that the evidence on which the belief that contact is generally beneficial to the child appears 'weak or mixed' (Barber & Gilbertson, 2001).
- Maintaining contact with siblings was beneficial for children in care. Carers took the main responsibility in helping children maintain contact with family members, with caseworkers significantly less involved. Twenty per cent of the caseworkers 'reported high levels of difficulty in trying to organise sibling contact' (McDowall, 2015: 60).
- Reunification with the birth family was slower (or less likely) for younger children, children in kinship care and for families where poverty and substance abuse were factors (Delfabbro, Fernandez, McCormick, & Kettler, 2013). This was consistent with other international findings on family reunification.

Adoption

- Studies indicate that children placed for adoption tend to do better than those in other forms of care, due to the child tending to be younger at entry into

adoptive care, having less exposure to maltreatment/trauma than older children, fewer behavioural problems, a greater likelihood of the adoptive parent(s) forming attachment with the child, and greater level of stability provided by adoptive care.

- It is likely that selection bias accounts for much of the difference in outcomes between adoption and other types of care.
- The likelihood of adoption decreases with age.
- In a review of adoption literature, Huntsman (2014) found children adopted earlier were less likely to feel insecure or to have behavioural problems.
- Late removal reduced the chances of long-term achievement of a stable adoptive home (Rees & Selwyn, 2009).
- Smith, Howard, Garnier and Ryan (2006) found that the risk of adoption disruption increased with age at adoption, going up 6% for each year.
- There is no definitive research which links openness in adoption to child outcomes.

Carer characteristics

The attributes of a carer (such as low income, health status, stress and age) may impact on the outcomes of children in OOHC. Generally, kinship carers provide longer placements for children but receive less support and training than foster carers.

- Foster carers are more likely to be better educated and less socio-economically disadvantaged than kinship carers.
- Kinship carers, compared with foster carers, are less likely to receive support (including allocated caseworkers, case plans, annual review, training and services) and monitoring, to ensure children's and carers' needs are met (McHugh, 2013).
- Continued stressful experiences are strongly associated with a foster parent's decision to discontinue fostering and placement breakdown (Quinton, Selwyn, Rushton & Dance, 1999). Factors that may impact negatively on effective kinship care include economic disadvantage, stress, health issues and parenting skills. Ameliorating carer stress is critical in supporting carers. Ongoing support for carers was crucial to prevent burn out and loss of carers (Department of Human Services (DHS) Victoria, 1998; Higgins, Bromfield & Richardson, 2005; McHugh, McNab, Smyth, Siminiski & Saunders, 2004).
- As mentioned above, the type of care (kinship or foster) made little difference to the outcome (Farmer, 2009).

- Carers that gave high parental support and had the ability to maintain effective limit settings with children in their care offered more stable placements (Crum, 2010).
- Some Indigenous carers are not comfortable in accessing mainstream carer training sessions (McHugh & valentine, 2010). Development of culturally appropriate training and tools can assist in supporting Indigenous carers.

Services and interventions

Children who enter care with a history of abuse and neglect require a number of age-specific services including health services (particularly mental health services), optical, dental, educational, therapeutic services (e.g. counselling, speech, and physiotherapy) and recreational activities. In addition, placement-specific services including casework, case planning and management are also required.

- A NSW study of OOHC caseworkers found that 86.0% of all respondents whose work related to OOHC had a degree level qualification, with a lower proportion for respondents from the non-government sector (74.5%).
- Caseload was highest for children in General Foster Care (12.8 cases) and lower for children requiring Intensive Residential Care (6 cases) (NSW Auditor-General, 2015).
- The provision of casework to children is a critical component of OOHC in all Australian jurisdictions, with positive child/carer/worker relationships critical for placement stability and carer retention (Gilbertson & Barber, 2003; McHugh et al., 2004; Triseliotis, Borland & Hill, 1999).
- The majority (87%) of all children and young people in OOHC have an individualised case plan that details their health, education and other needs (AIHW, 2016b).
- There is substantial evidence that educational outcomes for children and young people in care are not as good as their peers (AIHW, 2015b: 1; CREATE Foundation, 2006; McDowall, 2011; Osborn & Bromfield, 2007). Placement disruption coincided with school changes. Indigenous children were found to have a higher number of school changes (McDowall, 2013).
- Support from foster families and their involvement with the child in the educational context predicted positive academic outcomes for youth in care (Cheung, Lwin & Jenkins, 2012).
- Indigenous children were found to have a heightened risk of mental health difficulties (Sawyer, Carbone, Searle & Robinson, 2007) and research indicated that Indigenous children and young people compared with their non-Indigenous counterparts have not fared as well at gaining access to health assessments, clinical services and interventions (Nous Group, 2014).

- Children and young people who present with complex problems including significant history of abuse (as victims, perpetrators or both), serious mental health issues, 'challenging' behaviours, intellectual and/or learning disabilities, history of school suspension/expulsion and difficult familial relationships may benefit from therapeutic approaches (including psychologists/clinical support and involvement of carers, and in residential settings).

1.3 Conclusion

This review of the literature on the factors that influence the outcomes for children in OOHC has identified a range of factors that have been demonstrated empirically to affect outcomes, as well as factors that research indicates have little effect on outcomes. There are also influences where research findings are inconclusive or where insufficient research has been conducted to confirm an effect.

What is known is that children in care, compared with children not in care, experience more serious physical, mental and emotional health problems. Many studies conducted in various countries have found that, in general, outcomes for children placed in OOHC are worse than for children never placed in OOHC, and that children in OOHC exhibit higher levels of behavioural and social problems (Clausen et al., 1998; Tarren-Sweeney & Hazell, 2006; Meltzer et al., 2003; Gypen et al., 2017). It is likely that these findings are due at least in part to selection effects—children with higher levels of emotional, social and behavioural difficulties being more likely to be placed in care and to remain in care once they are placed.

Fairhurst, David and Corrales (2016, p.2) state that explanations for 'generally poor outcomes tend to coalesce around two interrelated factors; the long-term impact of early childhood abuse, neglect and maltreatment; and the lack of support available to young people as they exit the OOHC system'.

Factors that are known to affect outcomes

In terms of child characteristics, research indicates that outcomes are affected by children's pre-care experiences and their demographic and personal characteristics. In particular, poorer outcomes are associated with exposure to maltreatment and trauma, especially longer exposure. Another key predictor of poorer outcomes is being placed in care at an older age. These are associated with poorer outcomes overall, including behavioural and emotional problems, diagnosed mental disorders, and placement breakdowns. Conversely, placement in infancy, particularly before 12 months, is associated with secure attachment with carers and better outcomes. Likewise, adoption at a young age is also associated with better outcomes.

Research indicates a strong correlation between number of placements and poorer outcomes. Placement breakdown is in turn associated with behavioural problems, stemming from previous experiences. A higher number of placements in childhood is correlated with poorer outcomes in adulthood (Fernandez et al., 2016). Lack of secure attachment, and weak feelings of safety and security are associated with

placement breakdown. However, as indicated below, these effects can be mitigated by provision of quality OOHC and achievement of stability.

Demographic features are also known predictors of not only entry into OOHC, but also outcomes. Aboriginal children are at higher risk of poor outcomes than non-Aboriginal children. Children from lower socio-economic areas are also at higher risk of poorer outcomes. Less is known about cultural factors and culturally matched placements as mitigating factors.

In regard to placement characteristics, research indicates that children's outcomes are affected by the quality of care, as well as other factors which children experience while they are in care. The quality of caregiving and other care related aspects, rather than placement type, protect against placement breakdown (Oosterman et al., 2007). This is consistent with other research which indicates that carer attributes (e.g. warm, responsive parenting style, good parenting skills and effective discipline practices) and meaningful relationships with caseworkers are important in overall improved child wellbeing (Commission for Children and Young People and Child Guardian, 2013). The evidence indicates that placement instability may be prevented by interventions, including more in-depth assessment and screening for known risk factors and appropriate placement support.

Research has indicated that services received, including training for carers, wraparound type support, and other interventions, do have effects on outcomes. Extended support (into young adulthood) reduces the level of poorer outcomes as young people have more support moving into independence (Campo & Commerford, 2016; McDowall, 2016).

Factors that are known to have little impact on wellbeing

Factors that seem to have little or only weak impact on outcomes are also indicated in research.

In relation to child characteristics, gender has little bearing on outcomes while in OOHC. However, after leaving care some studies show that young women tend to do better than young men in a range of domains (Cashmore & Paxman, 2006).

With regard to placement characteristics, the type of care has not been shown to affect outcomes – it does not matter whether the carer is a foster or kinship carer. Children adopted, especially as infants, tend to have significantly better outcomes than those in foster or kinship care (Vinnerljung & Hjern, 2011). However selection issues are likely to be important in these findings.

Factors where the effect is unknown

For many of the factors which may affect outcomes in OOHC there is limited research in Australia or internationally, or the research is inconclusive.

For example, it is not clear that placement in OOHC, versus non-removal, improves outcomes. Some research has found that placement in OOHC (where it is determined this is necessary) may improve outcomes (compared with no intervention) (Verso Consulting, 2011). However, other studies indicate that for

children on the margin of placement (that is in situations where not all investigators would agree they were in such danger that removal was necessary) tend to have better outcomes if left at home, especially older children (Doyle, 2007).

Studies on the effect of disability on outcomes are inconclusive. Some found that disability creates difficulties in placements; however, other studies found that once placement is achieved, outcomes are similar between children with disability and other children in OOHC who do not have a disability.

There are a small number of studies on CALD background and outcomes. This is limited by the lack of collected data on the cultural background of children in care, particularly in Australia. With regard to culturally matched placements, studies were inconclusive as to whether this affected overall outcomes although some reported improved self-esteem and feelings of connection.

It is not really known whether placement with siblings affects outcomes. Most research indicates that siblings desire contact, but it is not clear if other factors are stronger in predicting outcomes (e.g. quality of care from caregivers).

Contact with birth families is not strongly associated with outcomes, although frequency of visits is associated with reunification. What is likely is that the impact of birth family contact is highly context specific, being beneficial for some children and detrimental for other children.

More research is required to examine the effects of the Aboriginal placement principle and cultural plans on children. It is unclear what effect, if any, placement with non-culturally matched carers can have on cognitive, emotional and behavioural outcomes. Importantly, however, children placed in kinship care with culturally similar carers report improved connections with their culture.

Research also indicates that kinship carers may get less support than foster carers, have lower incomes and suffer more stress than foster carers.

Overall, the research evidence indicates that the quality of care received by children is the strongest predictor of outcomes over time, given the level of difficulties they have on entry into OOHC. Research also shows that children's trajectories through the care system are determined by interactions between the different risk and protective factors over the course of their placement. It is these interactions, rather than the factors themselves, which are likely to have the greatest impact on children's wellbeing over time. The research evidence is accumulating rapidly and it is likely that new research including the POCLS and studies using data linkage will fill many of the gaps in the evidence base, particularly in the Australian context.

2 Introduction

2.1 Purpose

The purpose of this literature review is to examine the factors that influence the outcomes for children and young people in out-of-home care (OOHC). It aims to summarise research findings on which factors predict positive or negative outcomes, and thereby inform policies and practices in order to increase the chances of positive outcomes for children and young people⁴ in OOHC.

2.2 Background

Overall, research in Australia and internationally clearly indicates that outcomes for children who have experienced OOHC as a result of abuse and neglect are in general poorer than for those children who have never been placed into OOHC (see Clausen, et al., 1998; Tarren-Sweeney & Hazell, 2006; Meltzer et al., 2003; Gypen et al., 2017).

This applies over a wide range of indicators including: mental health, substance abuse and eating disorders (Friedman et al., 2011 cited in Coyd & Walter, 2016) and other personality disorders (Guest, 2012; Rutter & Quinton, 1984); lower emotional and mental wellbeing generally (Broad, 2004; Buchanan, 1999; Clough, 1982; Cocker & Scott, 2006); involvement in the criminal justice system (McFarlane, 2008; CLAN, 2008; Narey, 2007; Robson, 2008); lower educational attainment (Connelly, Forrest, Furnivall, Siebert, Smith & Seagaves, 2008; Jackson & Sachdev, 2001; Townsend, 2012); higher housing instability and homelessness (Dixon, 2008; Robson, 2008); and higher rates of chronic health conditions and morbidity (Kendall-Tackett, 2002; Fernandez et al., 2016).

Studies have suggested that young people in care present a higher level of emotional and behavioural problems than those in the general population (Clausen et al., 1998; Gypen et al., 2017; Meltzer et al., 2003; Tarren-Sweeney & Hazell, 2006 cited in Fernandez et al., 2016). Despite these consistent findings, it is still not clear whether these differences are due to the negative effects of OOHC on children or whether they are due to selection effects; i.e. that children with more difficulties are more likely to be placed into care. No study has compared children in OOHC with directly comparable children who have not been placed into care.

While differences in outcomes between children who have never been in OOHC and those who have are significant, there are also significantly different outcomes for

⁴ For simplicity, the term 'children' will generally be used.

children who have been placed in OOHC based on factors such as age at entry to care, trauma experienced prior to entry to care, and the quality of care received once in care.

There is a plethora of literature on the effects on children of separation and of being placed in OOHC. Children separated from parents and placed in OOHC exhibit signs of poor attachment, mistrust and defensive detachment (Gerdes, Hoza, Arnold, Pelham, Swanson, Wigal & Jensen, 2007; Gunnar, 2001 cited in Fernandez et al., 2016).

There is significant evidence that experiencing OOHC has negative effects over the life course of adult care leavers (Fernandez et al., 2016). Experience of a higher number of placements has been correlated with perceptions that the care experience was 'mainly negative' according to Duncalf (2010: 15).

On the other hand, research has also indicated a number of factors which facilitate positive outcomes for children in OOHC. Some of these factors relate to the child's characteristics such as temperament and intelligence, but others relate to factors in the placement itself. Stability of placement, quality education and the presence of a mentor who cares about the child have been shown to be protective factors (Gypen et al., 2017).

The review is structured around the different factors (divided into child characteristics and placement characteristics) that affect outcomes. Given this evidence on outcomes, this review details the factors that may affect the likelihood of, and impact on, these outcomes. The factors are divided into two types: child characteristics and circumstances, i.e. the birth family's characteristics, the exposure of the child to maltreatment, and neighbourhood effects. In addition, child attributes such as age, behavioural issues and temperament (often influenced by exposure to maltreatment and/or neglect) are considered. The second set of factors relate to the placement characteristics and are factors that governments and other organisations may reasonably be expected to have some control over. These factors include: selection of carers, training and support, stability of placement, and provision of support services.

The rationale is that many factors affect a range of different outcomes. In addition, sometimes it is difficult to discern between a risk factor or cause and an 'outcome'. For example, the relationship with a carer may be a factor in the educational achievement of the child. However, it may also be an outcome (of authorities carefully selecting the right carers/placement for the child). Another example is placement disruption. This may be an outcome due to the presence of behavioural problems in a child or young person. However, it may also be a factor underlying negative outcomes in other domains, e.g. disruption can lead to change of schools and interruption of education and can result in behavioural or emotional difficulties. Thus any 'outcome' for the child can also be a causative factor for other outcomes in the child's trajectory through the care system. In general, it is the interaction between these factors that are most important in the wellbeing of children over the course of their trajectory through OOHC.

In short, there is a multitude of factors that affect outcomes, and some are more subject to intervention than others. The review of the literature gives an overview and some idea of what interventions are likely to be the most effective and contribute to more positive outcomes.

2.3 Framework

Firstly, it is noted that some factors can be broadly categorised as child characteristics and others can be categorised as placement characteristics. Some factors are more or less subject to control and intervention than others (where OOHC providers can exert some control). There are three key outcome domains including:

- Health and physical development
- Social and emotional functioning
- Cognitive and learning development⁵.

Courtney (1993) points out that there are several factors that influence outcomes that are unrelated to the quality or type of care provided (i.e. pre-existing factors). These include child characteristics such as the age of the child on entry into care, and level of exposure to abuse/trauma.

Courtney (1993) identified three general areas over which OOHC service providers might be expected to have some degree of control. This framework has been further developed by Barber and Delfabbro (2004) and includes the following:

- 1) the *structural characteristics* of the services provided: this refers primarily to the quality of placements provided and includes variables such as the physical and social environment of the placement, ratio of children to carers and qualifications of the carers;
- 2) *case processes* which refers to the quality of assistance provided by caseworkers, frequency of contact between children and caseworkers, quality of support and services provided;
- 3) *case outcomes* which refers to three elements:

⁵ These outcome domains are consistent with those being measured by the Australian Government's Longitudinal Study of Australian Children (*Growing up in Australia*) (see Zubrick, Rogers, Nicholson, Sanson & Strazdins, 2015). This may enable comparisons between children in OOHC in NSW with a representative sample of general Australian children.

- a) case status refers to the legal status of the placement, the type of order that applies, reunification with family and type of placement (for example, foster care versus kinship care);
- b) client outcome refers predominantly to the psychosocial wellbeing of the child, how the child's development has been influenced by the experience of being in care;
- c) child satisfaction refers to the extent to which OOHC has met the child's own goals, expectations and needs.

3 Literature Review Methodology

Wherever possible, Australian literature was included. Use was made of academic databases (Social Abstracts) and Family and Society Studies Worldwide, as well as the National Child Protection Clearinghouse (Australia), published reports from specialist research institutes, government reports and other web-based literature⁶.

The literature review was revised in 2016-2018 by the Social Policy Research Centre. It now includes articles published in the period 2010-2017 related to factors influencing outcomes for children and young people in OOHC.

Further details on the methodology, including search terms and sources, is provided in Appendix A.

3.1 Limitations

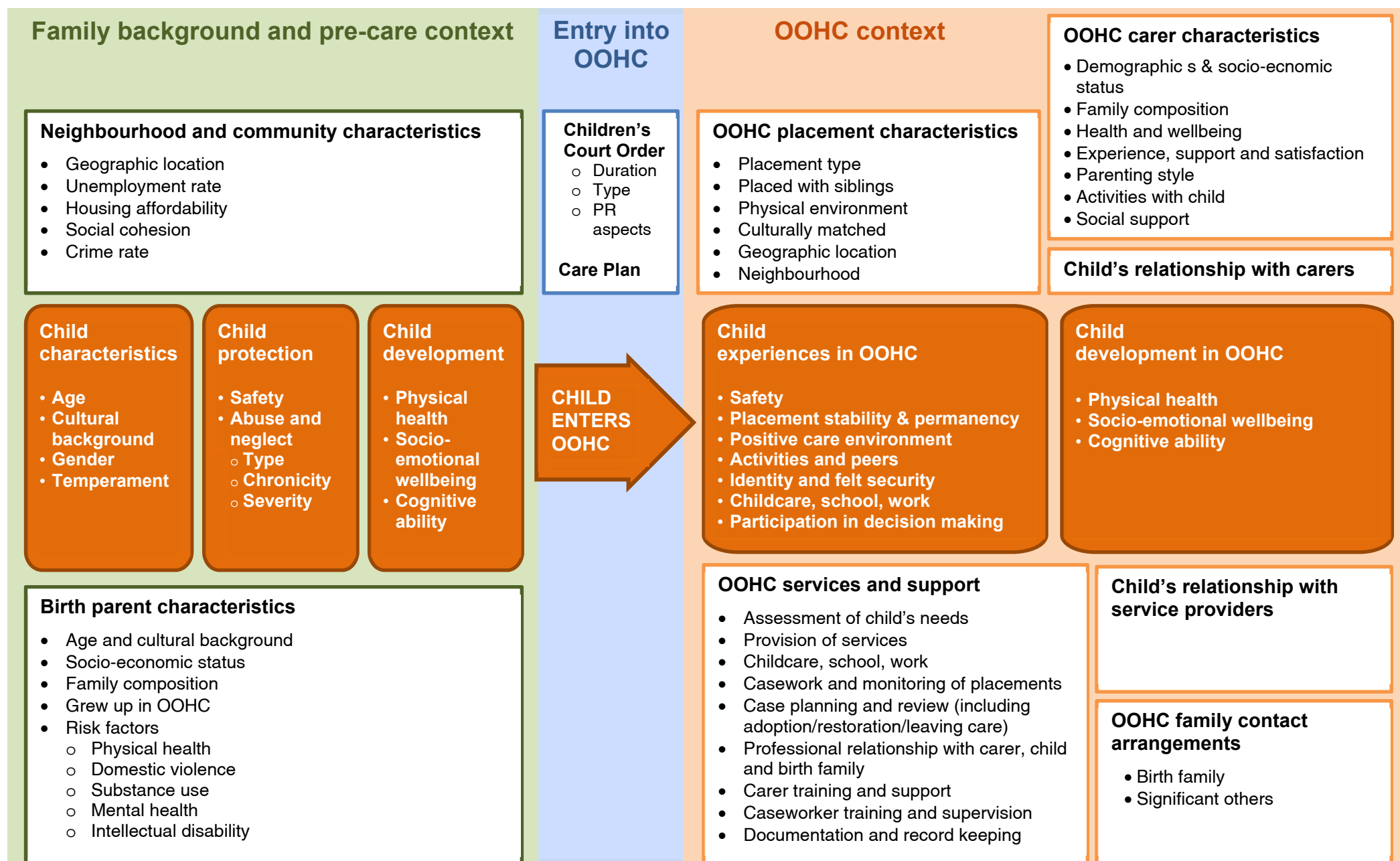
Studies differ in their choice of independent variables as well as statistical and sampling approaches. Sample sizes vary widely from smaller scale studies to those that draw upon large data sets such as those of the *National Survey of Child and Adolescent Wellbeing* (NSCAW) (US Department of Health and Human Services, 2005) in the US. Wherever possible, studies using large sample sizes have been included.

It is also important to note that some research studies on factors related to outcomes focus on children in specific age groups.

Although this report is based on a comprehensive examination of the peer reviewed literature, it is not a systematic review.

⁶ The previous version of this report (Walsh, 2006) noted that due to the extensive international and Australian literature available, the purpose of the review was to identify recent studies, reports and publications. Much of the available evidence comes from studies in the UK and US, and to a lesser extent European countries, and may not be directly applicable to the Australian context.

Figure 3.1: Conceptual overview of factors influencing outcomes in OOHC



4 Child Characteristics that Effect Out-of-Home Care Outcomes

This section discusses the child characteristics that are present before the child enters OOHC, including the age of the child, characteristics of the child (such as disability or other physiological condition), birth family characteristics and experiences of maltreatment/abuse. These are characteristics which can influence outcomes in OOHC and later in life.

4.1 Child characteristics

4.1.1 Age at entry into OOHC

This section examines the relationship between a child's age at placement in care and outcomes such as time in OOHC, placement stability/breakdown, mental health and adoption. In Australia, almost one third (32%) of children in OOHC are aged 5–9 years, and almost one third (31%) are aged 10–14 years. Children in residential care are older than children in home-based care – 82% of children in residential care or family group homes are aged 10 or older (median age is 14) (AIHW, 2017).

Being older at time of entry into care has been posited as a predictor of poorer outcomes compared with those children who entered care at a younger age, especially as infants. Specifically, in three US studies, outcomes such as behavioural and mental disorders manifested at higher rates in children and adolescents placed into care at a later age (Armsden et al., 2000; Dubowitz et al., 1993; Heflinger et al., 2000). Pritchett and colleagues in a 2013 Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA)-compliant review of English-language journals found mixed results in studies on the effects of placement age on outcomes but concluded that overall, children placed later in life are more likely to have lower wellbeing than children placed at a younger age. This, it is surmised, is due to older children having been exposed to longer periods of neglect, maltreatment and abuse prior to entering OOHC. However, it could also be a selection effect; older children with behavioural or emotional difficulties may be more likely to be placed into care than those who do not have these issues, whereas infants may not be old enough to manifest these problems.

4.1.2 Age and time in OOHC

The age of a child is an important predictor of OOHC length of stay and placement outcomes in the US and the UK (Barth, 1997; Rushton et al., 2003; Simmel, Brooks, Barth & Hinshaw, 2001). Although infants are clearly differentiated from older children in terms of time spent in OOHC, the sub-population of infants is itself heterogeneous with respect to length of stay.

Children under the age of 1 at admission tend to stay much longer in care than older children – although this can be affected by factors such as the type of placement, the child's race and ethnicity, and other factors according to several US studies (Barth, 1997; Courtney, 1995; Kemp & Bodonyi, 2000; Needell, 1996; Wells & Guo, 1999; Wulczyn, Hislop & Goerge, 2001). Wulczyn, Hislop and Harden (2002) examined the relationship between age and the risk of placement into care, the likelihood a child would leave placement and the likelihood a child would return to care having been discharged. Their study showed that infants under the age of 1 year are the most likely to be placed in care, particularly if they are from urban areas. Children under the age of 4 months at the time of placement remained in care longer than other children.

4.1.3 Age and placement stability

In a recent meta-analysis of English-language research of the literature by Pritchett and colleagues (2013) concerning the contribution of child characteristics to care outcomes, the researchers found that of the 74 studies that met the review criteria, approximately 15% showed no effect of age on placement outcome. Of those that did show an effect, three quarters of the papers reported more positive results for children who were placed in care at a younger age. The authors concluded that children who come into care earlier have more positive placement outcomes than those coming into care at an older age (Pritchett et al., 2013).

UK researchers have found that the older the child at placement, the greater the risk of placement breakdown (Berridge & Cleaver, 1987; Fratter et al., 1991; Rowe et al., 1989; Rushton et al., 2003). Similarly, Rowe and colleagues found that over a third of placements for children over 11 years broke down over a period of 13 to 23 months. While findings vary slightly, it seems that until the age of 15, the older a child is, the more likely he or she is to suffer a placement breakdown (Sinclair & Wilson, 2003). This is particularly the case for adolescents with mental health or conduct disorders, as found by Australian, Swedish and UK studies (Barber, Delfabbro & Cooper, 2001; Barber & Delfabbro, 2004; Salinas, Vinnerljung & Westermarck, 2004; Sinclair, Wilson, Taylor, Pithouse & Sellick, 2004).

A UK study of adolescents (11-17 years) ($n=68$) entering foster care used two outcome measures in determining how the young people fared in relation to the stability of the placement 12 months after being placed. The measures were: a) placement disruption or continuation, and, b) quality of placement for the young person. The study found a high rate of placement disruption (40%). While 10% had a planned ending, 13% continued with many difficulties, and 37% continued well. The study highlighted difficulties faced by carers of older children and the strategies that may be required when fostering adolescents (Lipscombe, Farmer & Moyers, 2003).

Age is also associated with the likelihood of re-entry to care (following restoration to birth family). In general, older children (those aged between 6 and 17 years) have been shown to have higher re-entry rates in US studies (Courtney, 1995; Wulczyn, 1991).

4.1.4 Age and mental health outcomes

Several studies have reported that older age on entry to care is associated with poorer mental health outcomes (Armsden et al., 2000; Dubowitz et al., 1993; Heflinger et al., 2000).

This finding was partially supported in the *Children in Care Study* (CICS) in Australian research by Tarren-Sweeney and Hazell (2005, 2006), and Tarren-Sweeney (2007) who examined the mental health of children and young people ($n=347$) in OOH in NSW. Children in the study were reported as having exceptionally poor mental health and socialisation 'both in absolute terms, and relative to normative and in-care samples' (Tarren-Sweeney, 2008: 7). Tarren-Sweeney found that 53% of girls and 57% of boys had at least one Child Behavior Checklist (CBCL) scale score in the clinical range' (2008: 7). However, further analysis showed that the poorer mental health of older children in care was largely attributable to the length of exposure to maltreatment prior to removal.

Key findings from the work of Tarren-Sweeney in relation to infants compared with older children was that there was a 'strong, linear relationship between age at entry into care and the mental health of children who entered care beyond age 7 months ($n=204$), with younger entry being protective' (2008: 11). Children who entered care between the age of 7 and 30 months had a moderate risk of mental health and attachment problems; those who entered after 30 months had a much higher risk. This is consistent with the findings from a US study by Dozier (2005) who found that infants placed before approximately 12 months of age adapt to caregivers relatively quickly (within a few weeks). In contrast, infants over 12 months old were described as having avoidant or resistant behaviours up to two months after the placement, and caregiver attachment was less pronounced. While age was a predictor, Dozier found that the type of (home-based) care does not appear to affect attachment between carers and infants (Dozier, 2005).

4.1.5 Age and care extending into young adulthood

Outcomes for young people leaving care can include poor mental health, delinquency, substance abuse, unintended pregnancies, reduced employment and educational achievement, homelessness and premature death according to US and Australian research (Dube, Anda, Felitti, Chapman, Williamson & Giles, 2001; Taylor, Moore, Pezzullo, Tucci, Goddard & De Bortoli, 2008). US and Australian research has found that extending the time in care to an older age, for some young people, may alleviate these poor outcomes (Kerman et al., 2002; McDowall, 2016). Therefore, continuity of care into young adulthood has been suggested as a way of reducing the likelihood of poorer outcomes by supporting young adults throughout the transition period as they become independent.

Placement stability beyond the age of 18 has been found to improve outcomes for young adults. A US study of youth ($n=87$) who remained in extended foster care into young adulthood (past their 19th birthday) had significantly better outcomes than the group who left at age 18 or before (Kerman et al., 2002). The group who remained in care received extra support by way of a stable continuing placement, educational aid, health care and case management. Measures used to assess outcomes for young people included

personal wellbeing, self-sufficiency and overall adult status. At time of interview (average age=22), three quarters (75%) of the group were found to be 'essentially self-sufficient in terms of income, housing and employment' (Kerman et al., 2002: 337). The authors argue that 'extending support services into young adulthood is crucial to launching healthy self-sufficient young adults from the child welfare system' (Kerman et al., 2002: 321). These findings are similar to those in an Australian study suggesting that extending the age of leaving care may be necessary to ensure better outcomes (McDowall, 2016). This is further confirmed in research by Campo and Commerford (2016) that suggests the leaving care transition needs to be individual (i.e. based on the young person's needs), flexible, gradual and well planned and that support should continue until the young person reaches 25 years of age.

To conclude, research has found that the earlier children are placed into OOHC, the better their outcomes are likely to be. This is likely due to older children having more exposure to abuse and/or neglect in their birth families, but other explanations are also possible. Extending the support given to age 25, for some young people, may alleviate some of the poorer outcomes associated with having been in care (Campo & Commerford, 2016; Kerman et al., 2002; McDowall, 2016).

4.2 Gender

Gender is not predictive of being placed in OOHC as male and female children are almost equally likely to be placed in OOHC in Australia (AIHW, 2016a). Further, gender is a weak factor in predicting or influencing outcomes while children are in care. However, some studies show (Cashmore & Paxman, 2006) that young women tend to do better than young men in a range of domains *after* leaving care.

4.2.1 Gender and nature of maltreatment/abuse

There were differences related to gender for substantiated reports of child abuse. In all jurisdictions of Australia, girls are more likely to be the subjects of substantiations of notifications of sexual abuse than boys (15% and 9%, respectively); girls were slightly less likely than boys to be the subjects of substantiated notifications of physical abuse. Boys had only slightly higher proportions of substantiations for neglect, physical and emotional abuse (AIHW, 2017).

4.2.2 Gender and placement outcomes

The majority of papers Pritchett and colleagues (2013) reviewed investigated gender and outcomes. Over 70% of these studies found no effect of gender on placement outcomes (for example, gender did not predict successful reunification or multiple placements). Where an effect had been found, the results varied, with approximately two thirds of the studies finding more positive outcomes for girls in care (Rosenthal, Schmidt & Conner, 1988; Snowden, Leon & Sieracki, 2008) while the remaining third indicated more positive results for boys in care (Farmer, Southerland, Mustillo & Burns, 2009; Fernandez, 1999). A US review by Akin (2011) found that in a small number of studies girls were more likely to be reunified with the birth family. A review of the adoption literature found gender was

not significantly related to adoption outcomes (Huntsman, 2014). Overall, gender does not seem to have any significant effect on children's outcomes (Pritchett et al., 2013). However, after young people leave care, some studies show that young women tend to do better than young men in a range of domains (Cashmore & Paxman, 2006).

To conclude, while gender has some influence on the type of maltreatment suffered, gender has little to no association with outcomes of children while in care, but may affect outcomes post-care, with young women tending to do better in a range of life domains than young men.

4.3 Culturally and Linguistically Diverse and refugee children

In the Australian context, there is little research and no national data on outcomes related to the cultural background of non-Indigenous children in care. Outcomes for Indigenous children, on the other hand, have been more widely researched and are discussed in a separate section.

This section of the report is heavily reliant on a small number of studies. As noted by Huntsman (2014) who examined a wide range of research findings on children's cultural or ethnic background and adoption outcomes, 'great caution needs to be exercised in considering whether findings from other countries are relevant to the situation here in Australia' (Huntsman, 2014: 19).

4.3.1 Ethnicity and placement

Cultural factors may affect children's experiences in foster care. Anderson and Linares (2012) studied 106 ethnic minority children aged 7-15 in New York City in the US, using tools measuring depression symptoms, loneliness and conduct problems. They concluded that ethnic compatibility of biological and foster families may facilitate the child's positive ethnic identity while cultural dissimilarity may be a risk factor in child conduct problems. However, the study only examined the child's and carer's perceptions after initial placement, and the authors noted that further research was necessary.

Overseas studies from the US have found that race and ethnicity are significant determinants of the type and quality of services received and type of care placements. Sheppard and Benjamin-Coleman (2001) examined the association between race and type of service placement for black and white youth ($n=2,803$) aged 10 to 19 years who had serious emotional and behavioural disturbances and had received mental health services between 1993 and 1996. After controlling for socio-demographic variables (race, gender, age, and rural/urban population) and presenting problems (cognitive/neurobehavioral problems, abuse, delinquency, health disabilities, substance abuse and emotional disturbances), they found that African-American youth were over-represented in the care system relative to their representation in the population. Although African-American youth had fewer presenting problems including significantly less substance abuse and fewer emotional issues compared with their white peers, they were three times more likely to be placed in a detention centre but were less likely to receive mental health hospital treatment than white youth.

In the UK, while Quinton and Selwyn (2009) found that minority ethnic children were over-represented in the care system, over-representation is greatest for children of mixed ethnicity. In contrast, they found that children of Asian background (Pakistani, Bangladeshi) were under-represented. For example, in one local authority 23% of children in the general population were of Pakistani heritage, whereas they formed only 6% of the care population. Further, they found that there were no overall differences between white and minority ethnic children in their experiences of maltreatment. However, they did find differences in the probability of adoption between white and black and Asian children. Fifty per cent of white children were adopted within 10 months of the recommendation, compared with 12, 16 and 19 months for the mixed ethnicity, Asian and black children (Quinton & Selwyn, 2009).

Akin (2011) also noted that in US research, race and ethnicity are frequently cited as significant predictors of exit from foster care, with most studies in the review finding African-American children were less likely to reunify than white and Latino children.

4.3.2 Culturally matched carers

There is very little research in Australia in relation to whether outcomes for children in culturally matched OOHHC placements differ compared with children placed with non-matched (i.e. different culture) carers for CALD children. Australian research suggests that although some benefits of cultural matching have been observed, there is no conclusive evidence that children and young people in culturally matched care have fewer social and emotional problems compared with those not in culturally matched care (Burke & Paxman, 2008; Huntsman, 2014).

On the other hand, UK and US studies note that placement with culturally/ethnically similar foster families helps children draw on their culture, language, ethnic affiliation and religious faith as supportive and protective factors (Kurtz, 2002; Waniganayake, Hadley, Johnson, McMahon, Karatasas & Mortimer, 2017; Urquiza, Wu & Borrego, 1999). Children placed within culturally/ethnically similar families, or families specially trained and assessed to provide culturally competent care, were found to have the following benefits:

- better communication and less misinterpretation due to language and cultural barriers;
- a positive sense of self and ethnic identity;
- familiarity with food, language and customs;
- increased stability of placement; and
- reduced need for caseworker intervention due to cultural and linguistic issues (Lutheran Immigration and Refugee Service, 2003).

4.3.3 Specific issues affecting refugee families

Kaur's (2012) study seeks to remedy the lack of research in this area and focuses on child protection issues in relation to CALD communities in Australia. This scoping study of CALD and refugee children in OOHHC in 19 Community Services Organisations (CSO) in Victoria found that of the sample surveyed ($n=2,053$), approximately 13% were CALD ($n=250$) or refugee ($n=30$) children. The author reported:

- 'CALD and refugee families face a number of unique risk factors and challenges which may lead to their involvement with the Australian child protection system.'
- 'Children from inter-racial backgrounds who were in OOHC displayed cultural identity confusion and self-esteem issues.'
- There was a need 'for frontline child protection caseworkers to develop cross cultural competence' (Kaur, 2012: 6).

Kaur also identified gaps in knowledge, including the prevalence of child abuse and neglect among both CALD and refugee communities in Australia (2012).

Another Australian study by Lewig and others (2010) investigated the reasons why recently arrived families from refugee backgrounds were presenting to the child protection system. The study found that notifications of abuse were most commonly associated with physical abuse, neglect and domestic violence. For these families, the problems were ongoing, resulting in a history of child protection notifications (Lewig et al., 2010).

In summary, this is an under-researched area in Australia. While CALD and refugee families face a number of unique risk factors and challenges, the prevalence of child abuse and neglect is not known amongst neither CALD nor refugee communities in Australia (Kaur, 2012). US studies have shown that cultural background/ethnicity can influence placement into care and exit from care (Akin, 2011; Barth, 1997); however, these are not as relevant to the Australian context. There is no conclusive evidence that children and young people in culturally matched care have fewer social and emotional problems compared with those not in culturally matched care (Burke & Paxman, 2008; Huntsman, 2014).

4.4 Indigenous children

In Australia, Indigenous children in OOHC are over-represented across all age groups, with the rate of Indigenous children in OOHC at almost 10 times the rate for non-Indigenous children. Reasons for the high over-representation of Indigenous children in the OOHC system are varied and complex:

The legacy of past policies of forced removal, intergenerational effects of previous separations from family and culture, lower SES (socio-economic status), and perceptions arising from cultural differences in child-rearing practices are all underlying causes for their over-representation in child protection services. Drug and alcohol abuse and family violence may also be contributing factors (AIHW, 2017: 27).

Neglect (36%) and emotional abuse (39%) were the most common types of substantiated abuse for Indigenous children, compared with 20% and 47% respectively for non-Indigenous children (AIHW, 2017).

Reviews by the Australian Institute of Family Studies (AIFS) (Bromfield & Osborn, 2007b; McDonald, Higgins, valentine & Lamont, 2011) found limited research related to OOHC for Indigenous children and young people.

4.4.1 Indigeneity, length and stability of placement

Indigenous children typically spend five times longer in care than non-Indigenous children (Fernandez, 1999). Those that enter care due to temporary parental incapacity (such as parental incarceration) are less likely to return home in the first few months of care (Barber & Delfabbro 2004: 149). In their study of reunification in Australia, Fernandez and Delfabbro (2010) found that Indigenous children are likely to spend longer in care. They note that given Aboriginal families:

... generally experience significantly higher rates of social disadvantage, higher rates of domestic violence and substance abuse than non-Aboriginal families... they are likely to face greater difficulties in being able to challenge court orders because of the geographical remoteness of some communities, language barriers and the complex and adversarial nature of court processes that require dedicated legal representation to understand and contest (Fernandez & Delfabbro, 2010: 128).

McDowall (2013) found Indigenous children in OOHC experienced more placements and had more disruptions during their time in care than non-Indigenous children. Indigenous children were less likely to understand why they were in care and primary school-aged children were more likely to have changed schools more than four times compared with children from other cultures (McDowall, 2013). See Eastman, Katz, McHugh (forthcoming) for further discussion on Indigenous children in OOHC⁷.

4.4.2 Culturally appropriate placements and cultural support plans

The implementation of the Aboriginal Child Placement Principle (ACPP)⁸ has impacted on the maintenance of family and community connections for Indigenous children. One of the unintended consequences of the ACPP is that Indigenous children may have to be placed with relatives who live a considerable distance away from a child's birth parents.

⁷ Throughout this review of the literature on outcomes, reference is made to another literature review on services for children in OOHC, conducted for the POCLS. Both reviews cover similar aspects of OOHC and, as a consequence, are reliant on similar literature. This study is referred to as Eastman, Katz & McHugh (forthcoming).

⁸ The Aboriginal Child Placement Principle outlines a preference for the placement of Aboriginal and Torres Strait Islander children with other Aboriginal and Torres Strait Islander people when they are placed outside their family. The Principle has the following order of preference for the placement of Indigenous children: with the child's extended family; within the child's Indigenous community; with other Indigenous people (Lock, 1997).

This may occur because there is no appropriate carer family in the child's community, or where community violence and alcohol abuse limit the availability of placements for children in or near their family and community (McHugh et al., 2004).

Being connected to their culture is important for Indigenous children (Arney, Iannos, Chong, McDougall & Parkinson, 2015). A national study with Indigenous ($n=309$) and non-Indigenous ($n=704$) children and young people in OOHC found that only one third (31%) of Indigenous children felt 'quite connected' and 30% reported 'little connection' to their culture. Only 10% ($n=32$) knew of their cultural support plan and of this group, half (50%) had been involved in the development of the plan (McDowall, 2013). It is not known if or how cultural support plans affect outcomes, or whether distance from kin are also a factor.

4.4.3 Indigenous children's health needs

In relation to the health needs of Indigenous children in OOHC, Raman, Reynolds and Khan's (2011) analysis of Indigenous children's health records ($n=100$) in south-western Sydney found Indigenous children had a similar range of identified health needs as other children in care. They concluded that the health needs of school-aged children were impacting on their ability to learn.

An evaluation of the *NSW OOHC Health Pathway Program* found Indigenous children, compared with non-Indigenous children, did not fare as well in relation to health assessments, clinical services and interventions. The report suggested this may be due to difficulties in ensuring that caseworkers and carers take children and young people to appointments for services and interventions (Nous Group, 2014).

In brief, the limited research in this area demonstrates that it is vitally important that research on outcomes for Indigenous children address issues that reflect the principles that guide welfare provision for Indigenous children. For instance, there is a need for research that compares child outcomes for those who are placed in accordance with the ACPP and those who are placed in non-Indigenous placements (Bromfield & Osborn, 2007a).

To summarise, indigenous children in OOHC are over-represented across all age groups compared with non-Indigenous children. At 30 June 2016, the rate of Indigenous children in OOHC in Australia was nearly 10 times the rate for non-Indigenous children (AIHW, 2017). Some of the factors associated with this include: the legacy of past policies of forced removal, intergenerational effects of previous separations from family and culture, lower socioeconomic status (SES), and drug and alcohol abuse and family violence (AIHW, 2017). Indigenous children experienced more placements and had more disruptions during their time in care than non-Indigenous children (McDowall, 2013). It is not known if or how cultural support plans affect outcomes or whether outcomes for those who are placed in accordance with the Aboriginal Child Placement Principle (ACPP) with Indigenous carers and those who are placed non-Indigenous carers differ (Bromfield & Osborn, 2007a).

4.5 Children with disabilities

Findings from the Australian National Comparative Study indicate that 11.6% of children in OOHC have a physical disability and 28% were identified with an intellectual disability or with developmental delay (Osborn & Delfabbro, 2006b). There is limited Australian or international research on children with disabilities in OOHC and little is known about their outcomes (McConkey et al., 2004). Baker (2011), in an overview of data sources, estimated that children with disabilities in care in England constitute between 10% and 25% of the looked after population and 11% in Scotland (Baker, 2011). In an overview of the literature, the study found that children with disabilities remained in care longer but faced similar barriers to placement and permanency as children without disabilities. However, there was some evidence that local authorities had difficulty delivering best practice when it came to looked-after disabled children, including inappropriate placement provisions, and out of area placements. Baker (2011) noted that many looked-after children returned home soon after entering care, but the likelihood of return declined with time. Baker also found there were difficulties in finding adoptive families for some children with learning impairments. Long-term foster care appeared to offer permanency for many children with disabilities, but stability was found to be an issue, particularly as children approached adulthood (Baker, 2011). In a review of mainly US literature, Akin (2011) found children with disabilities were less likely to exit care (Akin, 2011).

According to the US National Survey of Child & Adolescent Wellbeing (NSCAW) study (US Department of Health and Human Services, 2005), foster children are almost four times more likely to have a disability than children who are not in foster care, regardless of their age. Almost one third⁹ (30%) of foster children under the age of 15 have a disability (Department of Health and Human Services, 2005). Given their over-representation in the US care population, Blakeslee, Del Quest, Powers, Powers, Greenan, Nelson, Lawrence and McHugh (2013) suggested that youth with intellectual, serious emotional and physical impairments may be under-represented in research and studies evaluating foster care outcomes.

One US study, using state administrative data, examined the experience of older youth with disabilities in foster care (n=1,313) (Hill, 2012). The study, focusing on placement stability, permanency planning and placement outcomes, found that older youth with disabilities were more likely to experience longer time in OOHC, and higher rates of placement instability than youth without disabilities (Hill, 2012).

Children and young people with disabilities may experience multiple problems while in care, such as placement instability, delayed reunification and increased likelihood of remaining in foster care. Developmental delay may compound other vulnerabilities

⁹ There is no internationally recognised operational definition of disability, and therefore the different prevalence rates of children with disability cited in these studies may well reflect different definitions rather than significantly different prevalence rates. Nevertheless, the overall conclusion that children with disabilities are over-represented is a robust finding across a number of studies.

(Silver, Dilorenzo, Zukoski, Ross, Amster & Schlegel, 1999) and may exhaust the resources of caregivers with limited experience, social support or finances (Leslie, Gordon, Ganger & Gist, 2002) which may affect placement stability (Takayama, Wolfe & Coulter, 1998). Further, children with developmental delays are more likely to stay in foster care (Malik, Lederman, Crowson & Osofsky, 2002). In a systematic literature review by Pritchett and colleagues (2013) examining the way child characteristics affected child outcomes from care, it was concluded that:

...although many studies did not find an effect of health or disability, it seems where there is an effect, it is more likely to be negative, with health problems or disabilities being related to poorer outcomes for children in care (Pritchett et al., 2013: 1335).

However, of the 77 studies they reviewed, approximately one third did not report any significant effect of health/disability on placement (Pritchett et al., 2013). UK Department of Education data indicated greater placement stability for this group of children in foster care than for non-disabled children (Department of Education, 2013).

A systemic review of randomised control trial or quasi-experimental studies in English ($n=4$) by Australian researchers examined the effectiveness of current practices and interventions for children and young people in OOHC with challenging behaviours related to disabilities (Ziviani, Feeney, Cuskelly, Meredith & Hunt, 2012). Two of the four studies examined behaviourally-based foster parent training interventions and the other two focused more on individualised case management plans and foster parent training. Three of the four studies reported positive outcomes for children and young people as well as their caregivers/parents, whilst the fourth found no significant change. The researcher argues that:

In light of the complexity of providing services to CYP [children and young people] with behavioural issues and/or disability who are in OOHC, the costs associated with these services, and the risks if these are not effective, this review highlights the need for further research of the efficacy of support services for this group (Ziviani et al., 2012: 769).

Huntsman (2014) notes the limited research literature in relation to the adoption of children with 'special needs' (e.g. with a disability). Huntsman (2014) cites Haugaard and Moed (2000), who concluded:

- Most families adopting a child with developmental disabilities rate their experience as positive, with strong relationships reported between parents and children.
- Many of the characteristics that predict adoption outcomes in general predict the same outcomes in families adopting children with developmental disabilities.
- Post-adoption services are critical to family recruiting and to effective family functioning after adoption placement for children with disabilities (Huntsman, 2014: 43).

To summarise, UK, US and Australian researchers noted the high percentages of children with disabilities in care systems. Despite their high representation, they appeared to have had minimal attention paid to them in studies evaluating outcomes. Not

enough is known about outcomes for children with disabilities in care (McConkey et al., 2004). While many studies did not find an effect of health or disability, where an effect was found, it was more likely to be negative, with health problems or disabilities being related to poorer outcomes for children in care (Pritchett et al., 2013: 1335). Others found that children with disabilities remained in care longer, were more likely to be placed in foster care (Farmer, 2009), and faced particular barriers to achieving permanency and stability (Baker, 2011).

4.6 Siblings

The prevalence of sibling groups in OOHC in all jurisdictions in Australia is unknown. No official data is published on sibling placements (Wise, 2011).

Research conducted in the US, UK and Australia over the last two decades on sibling groups in care emphasises the importance (where appropriate) of keeping siblings together, in terms of their health, wellbeing and placement stability (Akin, 2011; Albert & King, 2008; O'Neill, 2002; Waid, 2014; Waldeman & Wheal, 1999). However, Waid's comprehensive review of literature on sibling placements concluded that 'the relationship between sibling co-placement, stability, and child and family wellbeing remains unclear' (2014: 294).

In terms of placement, there are factors which inhibit the placement of siblings as a group, including 'complex family relationships, willingness and ability of caregivers to take in sibling groups, sibling age difference and sibling conflict' (Waid, 2014: 286). Other factors preventing sibling placements include: the size of the sibling group; differences in the needs of the siblings; adequacy of placement resources and support; and agency rules regarding the maximum number of children who can be placed together in a foster home (Child Welfare Information Gateway, 2013).

Two US studies indicate that kinship carers are more likely to care for larger sibling groups compared with foster carers (Dubowitz, 1994; Geen, 2003) and this has been viewed as one advantage of kinship care. A recent UK study, however, found similar proportions of children were placed with siblings in kinship care and foster care (Farmer & Moyers, 2005).

In a review of records in the *National Study of Child and Adolescent Wellbeing* (NSCAW), Hegar and Rosenthal (2011) looked at three types of sibling placements: *Split* (child has no siblings in the home), *Splintered* (at least one sibling in the home) and *Together* (all siblings in the home). Sibling placement status was found to have no particular bearing on behavioural problems, based on reports from foster parents and children and young people. However, there were some differences reported by teachers in terms of academic performance with the *Together* group performing better than the other groups. For children in kinship homes, the *Splintered* and *Together* groups had less internalising and externalising behaviour than the *Split* group (again based on teacher reports).

In a review of research on sibling foster care, placement stability and wellbeing, Waid (2014) noted that little is known about the complex and dynamic nature of sibling relationships in OOHC settings, especially in relation to wellbeing outcomes. In

summarising various studies of siblings in care settings, Waid (2014) found it difficult to make clear inferences. Waid proposed using a multilevel conceptual model for advancing research and practice in relation to siblings in foster care:

Utilising a theoretically grounded conceptual framework of siblings in foster care, tested in controlled experimental trials, may help the field better understand the protective mechanisms and levers of change within sibling groups that promote placement stability, permanency and wellbeing outcomes for children in foster care (Waid, 2014: 294).

Tarren-Sweeney and Hazell's (2005) study in NSW, cited in Waid's review, explored the relationship between sibling placements, internalising behaviours, externalising behaviours and measures of socialisation. The authors found that separation from siblings did not affect the mental health and socialisation of boys, but girls who were separated from their siblings had poorer psychological health and socialisation than those living with at least one sibling (Waid, 2014). Another NSW study found children who had been placed with their siblings had higher rates of wellbeing (Fernandez & Lee, 2013).

To conclude, there has been limited research in Australia on both the prevalence and outcomes for sibling groups placed in care, whether placed separately or together. The limited research indicates that wellbeing is improved if siblings are placed together (Fernandez & Lee, 2013); however, Waid's review of studies of siblings in care found it difficult to make clear inferences (2014). Research on sibling groups in care highlights the importance of keeping siblings together for children's health, wellbeing and placement stability (Akin, 2011; Albert & King, 2008; O'Neill, 2002; Waid, 2014; Waldeman & Wheal, 1999).

4.7 Birth family characteristics

Studies have found a number of similarities in the family characteristics of children taken into care, including:

- Single parenthood
- Large numbers of children
- Poverty
- Inadequate housing
- Mental illness
- Substance abuse problems
- Domestic violence
- Social exclusion

- Parents with their own traumatic experience of abuse and neglect (Berger, 2005; Bromfield, Lamont, Parker & Horsfall, 2010; DHS, 2003; Rutter, 2000; Sinclair et al., 2004; Walsh, 2016)

Staer's 2016 study, based on Statistics Norway 2015 data, summarises the main reasons why families come to the attention of child welfare agencies: parental problems such as mental illness, substance abuse, violence, and inadequate parenting skills are the key reasons. These factors have also been isolated in many other studies conducted on large cohorts from the US, Australia, Denmark and Sweden.

4.7.1 Single parenthood

Single parenthood has been identified as a risk factor for children being taken into care in Bebbington and Miles's landmark 1989 study which analysed the backgrounds of 2,165 children from 108 local authorities in England and compared these with 5,407 children who had not entered care. The study used a regression analysis which indicated that having a single parent was the single greatest risk factor for care placement, increasing the odds ratio in the logistic regression model almost eight-fold, after adjustment for other factors including maternal age, receipt of welfare benefits, ethnicity, standard of housing, child's age and number of children. Using a similar regression analysis method, a Norwegian study by Staer (2016) found that living in a single-parent household at birth, rather than with both parents, increased the odds of entering the child welfare system before age 6 four-fold. A Swedish study using a similar statistical regression analysis also found that single-adult households had almost three-fold higher odds of children entering out-of-home care (Höglund-Davila & Landgren-Möller, 1991). A Swedish study by Franzén, Vinnerljung and Hjern (2008) examined risk of placement in out-of-home care for three age cohorts: birth to 6 years of age, 7 to 12 years of age, and 13 to 17 years of age using national citizen register data. They compared 14,839 children and youth who were placed in out-of-home care for the first time between 1992 and 2002 with 1,553,385 children and youth who had never entered care before 31 December 2002. They found for the youngest group, almost two out of three children who entered care had single mothers (63.5%). A Danish study of a birth cohort (1981-2003) found that the mother's characteristics were more important risk factors than the father's corresponding risk factors. They found single motherhood was the third most important risk factor for a child being taken into care (Ejrnæs, Ejrnæs & Frederiksen, 2011). Further, they found that children living with a single mother or living with a mother and a stepfather have much higher probability of entry into out-of-home care than children living with both biological parents. US research has also found this association; for example, Paxson and Waldfogel (1999, 2002) reported that US states with higher proportions of poor families and/or higher proportions of single working mothers have higher child maltreatment rates. Two US studies also found single parenthood to be a risk factor, even when single parent status resulted from divorce or widowhood (Katz, Hampton, Newberger, Bowles & Snyder, 1986; Lindsey, 1991).

4.7.2 A large number of children in the family

A large number of children in the family is also associated with greater likelihood of children being placed in out-of-home care and is also a predictor of abuse. Berger

(2005), using a regression analysis, found that families with more children tend to engage in more physical violence. He found that for each additional child, a family is 2.4 percentage points more likely to engage in abuse (Berger, 2005: 121). Staer (2016), in a Norwegian study based on a similar method, found that the number of children born of the mother was one factor that increased involvement with the child welfare system. Other studies corroborating this include Lee and George (1999) and Needell and Barth (1998).

4.7.3 Poverty

There is a plethora of research linking both family and neighbourhood poverty to both reported and unreported child abuse (and, more closely, to child neglect) rates in the US (Berger, 2005). As noted in numerous studies conducted in various countries, family poverty is a strong socio-economic indicator of involvement with child welfare systems (Akin, 2011; Akin, Bryson, McDonald & Walker, 2012; Berger, 2005; Bromfield & Higgins, 2005; Fluke, Chabot, Fallon, MacLaurin & Blackstock, 2010; Maguire-Jack & Showalter, 2016). Socio economic disadvantage and poverty represented ubiquitous stressors on families and have been identified as key risk factors for both family homelessness and child welfare involvement (Barth, Wildfire & Green, 2006; Shinn, Weitzman, Stojanovic, Knickman, Jiménez, Duchon & Krantz, 1998, cited in Fowler, Henry, Schoeny, Landsverk, Chavira & Taylor, 2013). Australian data indicates that 37% of families where children were the subject of abuse/neglect substantiations were from the lowest socio economic areas. Indigenous families were more likely to be from the lowest socio economic areas - 49% compared with 33% for non-Indigenous children (AIHW, 2016a). It is well established that families who have received or are currently receiving welfare are more likely to come in contact with the child welfare system (Berger, 2005; Franzén et al., 2008). Inadequate income is a key predictor and associated with parental stress. Franzén and colleagues (2008) found that 57% of children placed in care between birth and the age of 7 came from families that had received social assistance for three consecutive years. However, after adjusting for other factors, they found that low maternal income was only weakly (or not at all) related to placement; however, receiving statutory payments (such as sickness benefit or disability pension) for three years was. Staer too in a large cohort Norwegian study found a weak association between household income and involvement with child welfare authorities (Staer, 2016). In another large cohort study, Ejrnæs and colleagues (2011) found that the key predictor for children aged 0-6 being taken into care in Denmark, when controlled for all other factors, was the mother's receipt of a disability pension, an odds ratio of 14.2 meaning that those children had nearly 15-fold higher odds for being placed in out-of-home care than children whose mothers were employed. The second most important risk factor was for children whose mothers received social assistance. Both indicate low income; however, disability pension is also associated with mental health disorder, as well as other disabilities. In addition, it should be noted that Scandinavian statutory incomes are more generous than those in Anglo-capitalist countries such as the US, where poverty is more strongly associated with child abuse or neglect. In a US study, Berger (2005) found that families with incomes between 100% and 200% of poverty were significantly more likely to engage in physical abuse of their children, and that effects of low income were greater for single parents. This has been partly attributed to maternal stress.

4.7.4 Inadequate housing

Inadequate housing includes overcrowding and unsafe conditions, as well as homelessness. Various studies have illustrated the link between homelessness and likelihood of child placement in OOHC. Homeless families have demonstrated disproportionate levels of parent-child separations (Culhane, Webb, Grim, Metraux & Culhane, 2003). Bebbington and Miles in their landmark UK study found that children whose parents were tenures or living in overcrowded housing conditions had a higher rate of being in out-of-home care than children whose parents were not living in overcrowded dwellings (Bebbington & Miles, 1989). Fowler and colleagues, using data from the US's National Survey of Child and Adolescent Well-Being longitudinal survey of child welfare-involved families, found that inadequate housing contributed to risk for out-of-home placement in approximately 16% of intact families under investigation by child welfare agencies. Given this association and the rise in homelessness among families, they concluded that there was a need to identify early precariously housed families for inclusion into networks of housing services (Fowler et al., 2013). In a Canadian study, Afifi, Taillieu, Cheung, Katz, Tonmyr and Sareen (2015) used 2008 data from the Canadian Incidence Study of Reported Child Abuse and Neglect (CIS) to determine risk factors in child abuse and neglect cases. They looked at both overcrowded housing and unsafe housing as factors that could be associated with child abuse or neglect. They found that household overcrowding was associated with increased likelihood of child functional impairment, and among cases of neglect and emotional maltreatment. Unsafe housing was housing where guns or weapons were in the home; needles, legal, or illegal drugs were in the home; the home was a drug or narcotics laboratory, grow operation, or crack house; industrial solvents or chemicals were in the home; poisons, fire implements, or electrical hazards were in the home; or quality of the home presents a health risk to the child. They found that unsafe housing was reported in 30.9% of substantiated cases of neglect (Afifi et al., 2015). In Australia overcrowding is associated with increased interpersonal contact between residents, greater stress and the spread of infections (Bailie, Stevens, McDonald, Brewster & Guthidge, 2010). In relation to Aboriginal households in remote areas, Bailie and colleagues found overcrowding associated with poor housing conditions and other day-to-day stressors (lack of privacy, loss of control, high demand, noise, lack of sleep) was associated with raised levels of stress and poor mental health (physical and psychological withdrawal, aggression, depression). They found such housing conditions posed risks to health, 'with children and the elderly being the most vulnerable to these risks' (Bailie et al., 2010: 2).

4.7.5 Mental illness

Symptoms of untreated or inadequately treated mental illness may put children at risk for abuse and neglect; child abuse and neglect can be thought of as a consequence of parental mental illness (De Bellis, Broussard, Herring, Wexler, Moritz & Benitez, 2001). Mental illness can decrease parental caregiving capacity and reduce parental ability to care for their child or protect their child from harm. Several US studies link parental mental illness with higher risk to child safety in the home (De Bellis et al., 2001; Park, Solomon & Mandell, 2006; Westad & McConnell, 2012; Young, Boles & Otero, 2007). The Swedish study by Franzén and colleagues (2008) found that for children who were placed in out-of-home care between birth and their 7th birthday, over half (54%) had a

mother or a father who had been hospitalised for a suicide attempt, psychiatric disorder or addiction problem at least once between 1987 and 1992. De Bellis and colleagues' 2001 study attempted to determine the lifetime incidence of mental disorders in caregivers involved in maltreatment. They compared psychiatric diagnoses for 53 maltreating families to a group of 46 socio-demographically similar non-maltreating families. They found that 'mothers of maltreated children exhibited a significantly greater lifetime incidence of anxiety disorders (especially post-traumatic stress disorder), mood disorders, alcohol and/or substance abuse or dependence disorder, suicide attempts, and comorbidity of two or more psychiatric disorders, compared to control mothers' (De Bellis et al., 2001: 924).

4.7.6 Substance abuse

Substance abuse is also associated with child abuse, neglect and involvement of child welfare agencies. Miller, Fisher, Fetrow and Jordan (2006) in the US found that a wide range of research suggested that parental substance abuse is a predominant cause of children entering (and re-entering) out-of-home care. Estimates from US studies of the prevalence of chemical dependence among families in the child welfare system has been found to be between approximately 50% (Curtis & McCullough, 1993; Murphy, Jellinek, Quinn, Smith, Poitras & Goshko, 1991) up to 80% (Barth, 1994). Walsh, MacMillan and Jamieson, in a Canadian study (2003), examined a sample of 8,472 respondents to the Ontario Mental Health Supplement (OHSUP), a comprehensive population survey of mental health. They found that parental substance abuse was associated with a more than twofold increase in the risk of exposure to both childhood physical and sexual abuse – both indicative of grounds for removal. Roscoe, Lery and Chambers (2018) in a US study found that substance abuse was associated with increased risk of various maltreatment types and associated with an increased risk of involvement with the child welfare system. They also found that mental illness was a risk factor and associated with substance abuse. Berger (2005) found, in line with other studies, that maternal alcohol use was associated with child abuse; however, notes the limitations of studies that predated the 'crack' epidemic in the US.

4.7.7 Domestic violence

Domestic violence (DV) is a key predictor of child abuse, as the abuser often abuses not just their partner but children as well. As Berger notes there is a strong positive relationship between marital violence and physical child abuse (which often co-occur) (2005: 113). When children in families affected by DV become involved with the child welfare system, the children are at risk of being removed from their biological parents (i.e. family of origin) and placed in out-of-home care due to either direct abuse from a parent or fears that the children's safety will be in jeopardy if they remain in the home (Ogbonnaya & Guo, 2013). Edleson (1999), in a comprehensive review of existing research on the overlap between child maltreatment and male-to-female partner abuse, estimated that in 30% to 60% of families in which child maltreatment or domestic violence is present, the other is also present. Berger (2005), using a statistical regression analysis, found that the presence of domestic violence increases the likelihood of child abuse – while they found 'wife to husband' violence was not significant in any of their models, 'husband to wife' violence significantly predicted increased violence toward

children in all of the models. Ogbonnaya and Guo used propensity score analysis (PSA), a sample of 5,501 from a longitudinal US data set (NSCAW), to examine the relationship between caregivers' reports of DV and subsequent child placement outcomes. Using a Kaplan-Meier survival curve analysis, they found that by the end of the study period, approximately 15% of caregivers who reported DV had children in out-of-home placement as compared with 10% of caregivers who did not report DV, and that placement occurred at faster rates where DV was present (Ogbonnaya & Guo, 2013). They conclude that detecting DV might be useful in preventing poor child outcomes and promoting child wellbeing, and that 'caseworkers should be trained to conduct DV screening for all caregivers who are brought to the attention of CPS [Child Protection Services]' (2013: 208-210).

4.7.8 Social exclusion

While social exclusion is a somewhat nebulous term, social exclusion is associated with unemployment, lower educational achievement and few or weak community and social connections. Low educational achievements and secondary school dropout are well established risk factors for involvement with child welfare services (Staer, 2016) as well as being correlated with a higher risk of unemployment. Franzén and colleagues (2008) also found in their Swedish study that children whose mothers had a basic education had 2.7-fold higher odds for being placed in out-of-home care than children whose mothers had completed post secondary education. Ejrnæs and colleagues (2011) also found marked differences in the employment and education status of parents whose children had been placed in care to those whose children had not. Interestingly, social welfare settings (the generosity of social supports, and incomes affected child abuse and neglect and placements in OOH outcomes. Paxson and Waldfogel (1999, 2002) found a positive relationship between increased poverty rates and increased rates of substantiated child abuse and neglect, as well as a negative relationship between the generosity of state welfare benefits and state rates of child neglect and foster care placements. Such findings have relevancy to the Australian context given our relatively ungenerous statutory income support payments and association of child abuse and neglect with poverty (for example, living in low socio-economic status areas with child protection involvement (AIHW, 2016a). Scandinavian studies that found that being on a statutory income alone was not a strong predictor of involvement with the child welfare system – only a certain type of benefit (disability pension) was strongly predictive of child welfare involvement (Franzén et al., 2008). Disability pension is awarded to persons who experience mental illness and may have substance abuse issues. Ejrnæs and colleagues (2011) examined the influence of parental characteristics on the risk of being placed in out-of-home care and found that 'labour-market status, especially being on disability pension, increases the risk substantially and is the single most important risk factor. Furthermore, we document that low educational attainment, criminal record, and low income of the parents are all associated with higher risk of out-of-home care' (Ejrnæs et al., 2011: 24).

4.7.9 Parents with their own experience of abuse and neglect

Parents with their own experience of abuse and neglect are often assumed to be more likely to repeat such behaviours with their own children. However, evidence is mixed, with

some studies providing empirical support for the intergenerational transmission of child abuse (Berlin, Appleyard & Dodge, 2011; Dixon, Browne & Hamilton-Giachritsis, 2005; Egeland, Jacobvitz & Papatola, 1987; Hunter & Kilstrom, 1979; Pears & Capaldi, 2001; Thompson, 2006; Thornberry, 2009), while other researchers have found no evidence for transmission (Altemeier, O'Connor, Sherrod, Tucker & Vietze, 1986; Renner & Slack, 2006; Sidebotham, Golding & ALSPAC Study Team, 2001; Widom, 1989). Berger (2005), using a sample consisting of 2,760 families with children drawn from the US 1985 National Family Violence Survey, undertook a comprehensive study of factors present in households where physical violence towards children was present. Berger's survey asked respondents about the presence of parental physical violence in the respondent's family of origin (whether the respondent was hit more than 10 times by either parent as a teenager). Results suggested that, in both single-parent and two-parent families, a history of family violence affected children's probabilities of being abused (Berger, 2005). Widom (1989) and Widom, Czaja and DuMont (2015) undertook a longitudinal study of parents and their children in the US over a 30-year period. They found that about one-fifth of parents who had experienced some form of abuse growing up had been reported to CPS for child maltreatment roughly twice the rate of the control group. The data on sexual abuse and neglect indicated that children of people who had suffered either sexual abuse or neglect were around twice as likely to experience such abuse: CPS reports of sexual abuse were filed for 3.4% in the control group and 7.7% in the abused group; the figures for neglect were 9.5% in the control group and 18% in the abused group (Underwood, 2015). Widom and colleagues concluded that 'The strongest evidence for the intergenerational transmission of maltreatment indicates that offspring are at risk for neglect and sexual abuse.' (but not physical abuse) (2015: 1484). Widom and colleagues (2015) noted that these results suggested the need for expanded prevention services and parent support within low-income communities.

In terms of multiple factors being present, a review of home-based care in Victoria by the Department of Human Services (DHS) Victoria pointed to the escalation and co-occurrence of complex characteristics (noted above) of the parents of children and young people placed in care. The report found the OOH system was absorbing the effects of the crisis in the wider welfare system (DHS, 2003). Between a third to half of all parents whose children were in OOH had a psychiatric disability, alcohol or substance abuse problem, and over half (56%) of all families had experienced domestic violence. Most families experienced multiple problems and the prevalence of these was increasing:

- 65% of parents with domestic violence problems also had substance abuse problems (up from 56% in 1997);
- 62% with a psychiatric disability also had a substance abuse problem in 2001-02 (up from 50% in 1997); and
- 77% of parents with an alcohol problem also experienced domestic violence (up from 71% in 1997) (DHS, 2003).

In summary, birth family characteristics that were factors for the risk of the child being placed in OOH (in no particular order) included parental mental disorder; parental substance abuse; family poverty/low socio economic status; single parenthood; higher

number of children; inadequate housing; and parental history of abuse (particularly sexual abuse and neglect).

4.7.10 Birth parent characteristics and reunification

In a US study, Akin and colleagues (2012) examined long-term foster care for children with serious emotional disturbances and discussed the barriers to permanency. Case level data ($n=30$) was collected and coded for four categories of parent and family characteristics: (1) poverty and social support, (2) parental clinical needs (e.g. problems with mental health or alcohol/drug issues), (3) parenting, and (4) home and environmental stressors (e.g. domestic violence and legal system problems).

The study found parental history of trauma present in 80% of cases, and in 90% of cases, there was prior child welfare involvement with the family. Five risk factors were both highly prevalent and most critical to inhibiting permanency:

- (1) poverty-related issues (90%), (2) parent mental health problems (90%), (3) parent alcohol and drug problems (83%), (4) parent history of trauma (80%), and (5) parenting competency or attitude (97%) (Akin et al., 2012: 88).

It should be noted that the authors stated that the case record review and interview data used to describe parental risk factors of permanency were limited by the small sample size and the inherent weaknesses of using case documentation.

The study also found systems issues negatively impacting permanency outcomes, including a lack of dedicated parental services and a lack of transportation availability and access for parental contact visits (Akin et al., 2012). Parental substance abuse is a factor in preventing reunification. Parents preoccupied with getting and using drugs may mean parents place their own needs above those of their children (Barnard, 2007). Parents with a combination of substance abuse problems and other problems were less able to reunify; the presence of substance abuse also delayed reunification (Wulczyn, 2004). Miller and colleagues also found that parent characteristics previously linked with reunification failure is substance abuse history (Miller et al., 2006). Terling (1999) found that increased risk of re-entry into care was related to parental substance abuse. Frame, Berrick and Brodowski (2000) found that 27 out of 28 infants from a random sample that re-entered care within 4-6 years of being reunified had parents that reported a substance abuse problem. Miller and colleagues (2006) concluded that substance abuse appears to be a key variable in decisions involving reunification and re-entry.

A study by Gifford, Eldred, Vernerey and Sloan (2014) in the US looked at participation in a Family Drug Treatment Court Program and discussed outcomes for children ($n=566$) in foster care whose parents participated in a program. The study found that children of parents completing the program had shorter stays in care, were more likely to be reunified and less likely to be adopted than those whose parents were referred to the program but did not enrol, or who enrolled but did not complete (Gifford et al., 2014).

Similar positive findings were found in a UK study on the first Family Drug and Alcohol Court (FDAC) involved in care proceedings. A follow-up of cases ($n=240$) in the study

found that in the short term, FDAC mothers were more successful at stopping alcohol and/or drugs by the end of the care proceedings than mothers from the comparison group. This led to a higher rate of family reunification in FDAC families than in the comparison cases, with the evidence suggesting a long-term effect enabling FDAC mothers to maintain positive changes (Harwin, Alrouh, Ryan, McQuarrie, Golding, Broadhurst, Tunnard & Swift, 2016).

A study by Tasmania's Child Protection Service ($n=47$) examined birth parents' experiences with the system (Winton, 2013). Good relationships with workers were the main determinants for positive outcomes for birth parents. Parents reported that information and support which clarified their situation was invaluable in assisting them to negotiate the service system and dealing with court processes. Given the importance of parental contact and child reunification (Akin, 2011; Scott, O'Neill & Minge, 2005), it was of concern that the parents in this study did not have positive outcomes in relation to access/contact visits. Parents with children in OOHC noted difficulties in maintaining positive relationships with their children, including changes to access arrangements, cancellations of access visits, the cost of visits, the management and supervision of visits, and relationships with their children's carers. The report also noted that parents seeking reunification with their children:

...were bewildered by trying to meet an array of conditions imposed by Care and Protection Orders, which they described as 'jumping through hoops', and a lack of clarity about goals and timescales (Winton, 2013: 12).

Due to the complexity of the birth family characteristics, the study found that no single service (or program) was available to address their needs in a holistic fashion (e.g. offered mental health services, alcohol/drug services, housing services, and family support services) (Winton, 2013).

In summary, there were a variety of factors that prevented reunification including parental substance abuse, mental illness and lack of contact visits.

4.8 Child protection history

Children entering care may have experienced more than one form of maltreatment and the degree of maltreatment/abuse experienced is likely to affect outcomes.

4.8.1 Type of maltreatment and developmental outcomes

In Australia, emotional abuse (45%) is reported as the primary type of substantiated child abuse or neglect followed by neglect (25%), physical abuse (18%) and sexual abuse (12%) (AIHW, 2017). AIHW (2017) reports that emotional abuse and neglect were the most likely types to co-occur, with average co-occurrences of 33% and 28%, respectively.

The Chronic Maltreatment Study by Bromfield and Higgins (2005) investigated the course, characteristics and predictors of chronic and isolated maltreatment in a statutory

child protection sample ($n=100$) of Australian children aged 0-4 years. In the 65% of cases where maltreatment was chronic, the study found various correlated variables:

- a) family size – the more children in the family, the greater the likelihood of maltreatment;
- b) severity – the higher the assessed risk at the initial investigation, the greater the likelihood of children experiencing chronic maltreatment; and
- c) living in areas of highest poverty.

For chronic cases there were on average 3-4 notifications. Neglect (39%) ($n=95$) and physical abuse (26%) ($n=65$) were the most frequently experienced types of maltreatment. The study also found that children experiencing more than one incident of maltreatment may also experience multiple types of abuse within a single event (Bromfield & Higgins, 2005). They concluded that the 'case study analysis showed that families in which children experienced any maltreatment (chronic or isolated) typically experienced multiple interlinked problems, including poverty and exclusion' (2005: 44). Further research on chronic child maltreatment conducted by Bromfield, Gillingham and Higgins (2007), based on the report from the Victorian Child Death Review Committee on the deaths of children known to child protection services, found that children subject to multiple notifications of chronic neglect often failed to reach the threshold for statutory intervention. Bromfield and colleagues (2007) argued that there was an urgent need for child protection assessments to be adapted to enable caseworkers to identify and respond in a timely way to cases of chronic child maltreatment. Failure to intervene (by removing a child into OOHC) where multiple notifications of neglect were received was associated with child death outcomes.

In relation to cumulative harm, Bromfield and colleagues (2007: 35) stated that 'the way in which cumulative harm impacts on children can be understood in terms of neurobiology (i.e. brain development) and trauma theory'. In a literature review, McAloon (2016) noted that neurophysiological development is particularly important in relation to the attachment of the carer/parent to the child and the impaired attachment of some children entering care has 'significant implications for future cognitive, motor, social, emotional and behavioural development' (McAloon, 2016: 10). Likewise, in a large study of Australian adults who had been primarily in institutional care and experienced disrupted attachments, Fernandez and colleagues (2016) found significant adverse outcomes in various domains over their life course. For those who had experienced abuse:

[this] compounds the trauma already suffered leading to an extreme lack of trust, impaired ability to form relationships, and vulnerabilities to self-harm and drug and alcohol abuse (Friedman, Marshal, Guadamuz, Wei, Wong, Saewyc & Stall, 2011) (Fernandez et al., 2016).

The experience of chronic maltreatment can affect the child's neurological development resulting in, for example, behavioural problems, developmental delays, and/or anxiety. In a review of the literature, Huntsman (2014) notes that while there are links between early maltreatment and changes to the brain and neurobiological systems which can have

enduring consequences, 'children vary in the extent to which they prove resilient to such adversity' (Huntsman, 2014: 15).

The outcomes of cumulative harm and repeated maltreatment reports have also been examined in the US. One study followed a group of children ($n=3,521$) aged 1.5 to 11 years of age at sampling with child maltreatment reports from 1993-1994 to 2009 (Jonson-Reid et al., 2012). The study examined how child chronic maltreatment was related to negative developmental outcomes in later childhood and early adulthood. An analysis of administrative and treatment records indicated substance abuse, mental health treatment, brain injury, sexually transmitted disease, suicide attempts, violent delinquency before the age of 18, and in adulthood, child maltreatment perpetration, mental health treatment, or substance abuse.

The study found a relationship between the number of maltreatment reports for a child and the higher likelihood of negative developmental outcomes in both childhood and adulthood (Johnson-Reid et al., 2012). Of interest was the finding that adult perpetration of child maltreatment was most strongly associated with a history of childhood maltreatment.

US studies indicate that different forms of maltreatment, or a combination of maltreatment types, appear to be associated with a variety of adverse outcomes. For example, neglect is associated with a range of developmental difficulties including cognitive, language and academic delays, poor peer relations and internalising and externalising behavioural problems (Bolger & Patterson, 2001; Crittenden, 1998). Similarly, physical abuse has been linked to cognitive delays, aggressive behaviour, peer difficulties, post-traumatic stress disorder and other externalising and internalising behaviour problems (Crittenden, 1998; Kaufman & Henrich, 2000).

An Australian review of the literature found high levels of exposure to abuse, neglect and domestic violence in birth families is consistently related to adoption disruptions (Huntsman, 2014).

A German study investigated the outcomes for children ($n=358$) (average age 10-11 years) with a known history of abuse and neglect who had experienced a combination of maltreatment types (Witt, Munzer, Granser, Fegert, Goldback & Plener, 2016). About a third (33.5%) were in an out-of-home placement. The study found exposure to multiple forms of maltreatment were associated with poor outcomes for a significant number of children, including mental disorders (54%). Other outcomes included post-traumatic stress disorder and affective disorders (e.g. depression). Many children had more than one disorder/diagnosis and Witt and colleagues (2016) found that 'MTM [multiple types of maltreatment] has a greater impact on psychopathology than do single types of maltreatment' (2016: 8). Although Witt and colleagues' study did not only focus on children in OOHC, the findings are applicable.

After controlling for other adverse outcomes, Johnson-Reid and colleagues found in a US study that children with three or more reports were at twice the risk of later alleged child abuse or neglect, compared with those with less than two reports. The researchers suggest the response to a maltreatment event should be 'early detection and increased

service provision [that addresses] behavioural and developmental needs within a reported population' (Johnson-Reid et al., 2012: 844). The researchers concluded:

There is also a need for a better understanding of how the timing and quality of intervention may help alter negative trajectories associated with experiencing abuse and neglect. Finally, chronic maltreatment generally includes a preponderance of neglect allegations. Although research on neglect is growing, it remains an area of significant weakness in the prevention and intervention literature (Johnson-Reid et al., 2012: 844).

A US study of children ($n=16,707$) known to child protection services (CPS) aimed to identify predictors of child maltreatment re-reporting among initial neglect subtypes. Five neglect subtypes were identified in the sample:

- 1) medical neglect (13.9% of all children);
- 2) lack of supervision (7.5%);
- 3) failure to provide with possibly additional neglect (25.4%);
- 4) lack of supervision with possibly additional neglect (49.7%); and
- 5) neglect with abuse (3.5%) (Jiyoung, Bae & Fuller, 2015).

Data analysis also found common predictors in substantiated reports:

That substantiation of the initial report and service receipt were common predictors of re-reporting across all neglect subtypes; being black, child age, parental relationship, and number of children increased the risk of re-reporting for certain neglect subtypes. Regardless of the neglect subtype, cases with substantiation and service receipt required more effective interventions to reduce the risk of re-reporting (Jiyoung et al., 2015: 190).

4.8.2 Poly-victimisation

Complicating the issue of child maltreatment is that it is correlated with other forms of victimisation, that is, there is a likelihood of poly-victimisation. Finkelhor and colleagues (2007) explored the implications of poly-victimisation exposure to abuse/neglect plus other forms of victimisation (e.g. domestic violence, property crimes, assault, sexual assault, theft, burglary, warfare, civil disturbances and bullying). Based on the findings from a large US study of children ($n=2,030$), the researchers found poly-victims were more likely than non-poly victims to be male and older. They were more likely to live in large cities and had considerably higher rates of other adverse life events. Further, 'the high poly-victims... were more likely to be black, come from lower socio-economic status, and reside in one-parent households' (Finkelhor et al., 2007: 16). They found that poly-victimisation was a strong predictor of trauma symptoms with some poly-victims suffering from high clinical levels of anxiety and depression (Finkelhor et al., 2007). Finkelhor and colleagues' research suggested a correlation between poly-victimisation and neighbourhood and community characteristics.

A Spanish study on poly-victimisation by Segura, Pereda, Guilera & Abad (2016) with adolescents aged 12-17 years ($n=127$) in residential care found those with more victimisation experiences had higher levels of anxiety/depression symptoms and were more likely to exhibit severe rule-breaking behaviour. Sexual victimisation significantly predicted withdrawn, depressed and aggressive behaviour; electronic victimisation predicted attention problems. The study highlights the importance of assessing the range of victimisation experiences among adolescents in care, since poly-victimisation is predictive of psychological problems.

4.9 Neighbourhood characteristics

There is increasing recognition in Australia and elsewhere that neighbourhood effects have an impact on child development in a number of areas (Edwards, 2005; 2006; Edwards & Bromfield, 2009). Neighbourhood type (e.g. disadvantaged) and other neighbourhood characteristics (e.g. safety and neighbourhood belonging) are strongly associated with development outcomes for all children and are predictive of entry rates into OOHC.

Edwards (2005), drawing on a national sample from the Longitudinal Study of Australian Children (LSAC), found that four to five-year-old children living in the most disadvantaged neighbourhoods had lower social/emotional and learning outcomes than those in more affluent areas.

In a further study using the same sample, Edwards and Bromfield (2009) found that children's hyperactivity, conduct problems, emotional symptoms and peer problems were influenced by neighbourhood socio-economic status, neighbourhood safety and a sense of neighbourhood belonging. Neighbourhood safety and neighbourhood belonging mediated the effects of neighbourhood socio-economic status on hyperactivity, emotional symptoms, conduct problems and peer problems. The effects of neighbourhood safety on these outcomes were, in turn, mediated by neighbourhood belonging.

A US study by Lery (2009) found that foster care entry rates were significantly higher in neighbourhoods with relatively high levels of disadvantage. The key variables indicating neighbourhood disadvantage in the analytical models used in the study were residential instability, impoverishment (including poverty) and childcare burden (ratio of children 0-12 years/adults >21 years). In addition, rates of entry in local areas were influenced by social conditions in both local and neighbouring areas, meaning that children were at higher risk for placement not only when they lived in disadvantaged neighbourhoods, but also when they lived *near* disadvantaged neighbourhoods.

4.9.1 Neighbourhoods and maltreatment

From a child welfare perspective, Coulton and colleagues (1999) in a US study noted that the concentration of child maltreatment in certain neighbourhoods is well established. However, it is less clear what processes can explain these patterns. In seeking to gain an understanding of how neighbourhoods influence child maltreatment, they posited a number of possible pathways. The first pathway is a *behavioural influences* pathway

where neighbourhood structure (defined as level of neighbourhood disadvantage, neighbourhood demographics and neighbourhood stability) is linked to a set of neighbourhood processes including collective efficacy, social organisation and community resources and deficits. These in turn influence various social stressors and support that affect transactions between parents and their children and, therefore, contribute to child maltreatment. Their review of the literature found that there were consistent associations between neighbourhood maltreatment rates and neighbourhood characteristics, particularly structural characteristics (Coulton et al., 1999). The most consistent findings involved associations between rates of child maltreatment and socio-economic status and resources of the neighbourhood of the birth family¹⁰ (including poverty rate, income level, unemployment rate and residential instability).

A US study examining the relationship between neighbourhood social cohesion and child abuse and neglect focused on the potentially supportive component of neighbourhoods (Maguire-Jack & Showalter, 2016). Study data was from a survey with parents ($n=1,326$) relating to support within their neighbourhood and risk of child maltreatment. The authors found that neighbourhood cohesion was associated with:

lower levels of basic needs neglect [e.g. leaving a child unattended, providing adequate food, and taking the child to the doctor when s/he is sick but not neglect due to caregiver mental health or substance abuse concerns. There were no significant associations between neighbourhood social cohesion and corporal punishment or severe assault (Maguire-Jack & Showalter, 2016: 34).

The authors found that 'residents who perceive their communities to be cohesive have lower levels of neglect' in their communities (Maguire-Jack & Showalter, 2016: 34).

Based on a large sample of parents ($n=3,023$), Freisthler and Maguire-Jack's (2015) US study examined the influence of neighbourhood structural characteristics (e.g. disadvantage) and social processes (e.g. interactions between residents) on child physical abuse. Neighbourhoods with high proportions of Asian/Pacific Islander families were positively correlated with frequency of physical abuse. Boys and older children were physically abused more frequently than girls and younger children. In addition, high levels of neighbourhood social disorder (e.g. heavy neighbourhood traffic, drug sales and crime) were related to more frequent physical abuse, while higher levels of collective efficacy were related to less frequent physical abuse. The authors conclude that:

Programs designed to alleviate and reduce neighbourhood disorder may be effective at also reducing child physical abuse. The psychological and social distress of living in such neighbourhoods may create conditions

¹⁰ Research has not yet shown whether neighbourhood where the child is placed in OOHC makes a difference, but the POCLS will address this issue.

where parents use physical abuse to maintain control over a child's behaviour (Freisthler & Maguire-Jack, 2015: 276).

In conclusion, neighbourhood effects may have an influence in creating conditions conducive to maltreatment and poly-victimisation. There were consistent associations between neighbourhood maltreatment rates and neighbourhood characteristics, particularly structural characteristics (Coulton et al., 1999: 1132). The most consistent findings involved associations between rates of child maltreatment and socio-economic status and resources of the neighbourhood of the birth family¹¹, including poverty rate, income level, unemployment rate and residential instability. Other neighbourhood characteristics (e.g. safety and neighbourhood belonging) are shown to be strongly connected to development outcomes for all children and as predictors for entry rates into OOHC. However, there is no research which directly links neighbourhood characteristics of either birth families or carers to children's outcomes in OOHC.

4.10 Emotional and behavioural problems and temperament

This section discusses a range of problems or issues associated with a child's temperament, emotions and behaviour. Most studies in this area focus on behaviour only whilst others combine two or more aspects. As noted above, emotional and behavioural problems are both causes and consequences of structural outcomes such as placement stability and rehabilitation to birth families.

4.10.1 Age and emotional and behavioural problems

Various studies have shown (Tarren-Sweeney, 2006; 2008) that early behaviour problems have been found to predict subsequent poor outcomes, such as delinquency, substance use and inappropriate sexual behaviour among children in OOHC.

Gabrielli, Jackson and Brown (2015) assessed the behavioural and emotional outcomes for youth in care in the US ($n=479$) (average age of 13 years) using the Behavioural Assessment System for Children-2 (BASC-2). Data was also collected from carers of youth in foster care (63%), care staff of youth in residential settings (37%) and young people also completed a survey. In this study, 59% of the young people had a diagnosed mental disorder and 65% had received treatment for an emotional or psychological problem. Forty-one per cent of the youth had externalising behaviour problems (e.g. Attention Deficit Hyperactivity Disorder (ADHD) and Conduct Disorder), over two-thirds (68%) had internalising behaviour disorders (e.g. Major Depressive Disorder) and 16% had co-morbid disorders (e.g. ADHD and Anxiety Disorder).

¹¹ Research has not yet shown whether the neighbourhood where the child is in OOHC makes a difference, but the POCLS will address this issue.

Reflecting differences in children's developmental stages, the study found differences in the presentation of symptoms across the different age groups:

As youth age and develop more sophisticated cognitive, emotional, social, and biological processes, the complex nature and magnitude of these changes may contribute to the expression of behavioural and emotional symptoms, thereby supporting our finding of age differences in the measurement model. Moreover, for behavioural problems such as hyperactivity (a key factor difference in the child and adolescent measurement models in the present study) symptom expression is likely to change over the course of child development (Gabrielli et al., 2015: 431).

Based on an analysis of other data in the study, they concluded that while the BASC-2 PRS is an adequate measure of behavioural functioning as reported by non-biological caregivers in the lives of foster youth, 'continued research is needed to investigate the many influences related to behavioural outcomes for these foster youth, as well as to further the knowledge base on appropriate measures for use in this population' (Gabrielli et al., 2015: 430).

In her six-year longitudinal study of 214 ethnically diverse youth in the US, Taussig (2002) examined a number of behaviour problems, cognitive functioning, social support and self-perception of fostered children at baseline and after six years. Taussig concluded that 'psychosocial predictor variables were significant predictors of Time 2 risk behaviours. Furthermore, the early psychosocial variables were predictive of adolescent risk behaviour, over and above the control variables' (p.1192). Behavioural problems are associated with placement breakdown and a US study showed that it is possible to predict which placements will break down because of the severity of behaviour problems of children (Chamberlain et al, 2006). An Irish longitudinal study (2000-2004) of young children in care found children with behavioural problems were more likely to be in foster care, and that these children were least likely to be adopted (McSherry, Weatherall, Larkin, Malet & Kelly, 2010).

Parenting a child with behavioural problems can be demanding and stressful. Foster carers may lack the skills and support networks to effectively manage these problems, leading to placement breakdown. Placement breakdown has also been shown to predict child behavioural problems (Newton et al., 2000; Rubin et al., 2007). Newton and colleagues (2000) argue for an analytical approach that views behaviour problems as both a cause and a consequence of placement disruption; however, they note that 'the studies we reviewed are primarily cross-sectional or qualitative, thus precluding any analysis of the child's behavioural trajectories as a result of multiple placements in out-of-home care. Thus, the role of internalising or externalising behaviours as a cause or a consequence of multiple placements is difficult, if not impossible, to assess' (Newton et al., 2000: 1364).

In relation to a child's temperament, one UK study indicates that children with 'pro-social' characteristics (Sinclair et al., 2004) are less likely to have placement breakdowns, perhaps because they bond more effectively with the caregiver. This finding was supported by Dozier's (2005) finding in a small exploratory study in the US in which foster

parents tended to respond 'in kind' to an infant's behaviour when the child behaved in avoidant ways, the carer tended to respond as if the children did not need them; when the children behaved in resistant ways, the carer tended to respond angrily.

The US National Survey of Child and Adolescent Well Being (NSCAW) of children and young people in care ($n=342$) (aged 4-17 years) provides data on children's wellbeing outcomes (Berger, Bruch, James, Johnson & Rubin, 2009). Scales, including the Kaufman Brief Intelligence Test (K-BIT), were used to measure cognitive skills, while behaviour was assessed using the internalising and externalising behaviour problems subscales of the Child Behaviour Checklist (CBCL) for children aged 4-18. The study compared children who had been removed into care compared with those who had stayed in the family home. Berger and colleagues noted the importance of adjusting for selection factors when comparing children placed in care with those not placed in care, as well as the baseline data on assessment. The results suggested that, 'on average, out-of-home placement appears to neither place additional burden on the already vulnerable children who enter state custody nor contribute to improved wellbeing for these children, at least in terms of short-term changes in cognitive skills and behaviour problems' (Berger et al, 2009: 1871). The researchers concluded that:

To the extent that out-of-home placement does little to positively influence children's development, CPS [Child Protection Service] agencies should ensure that decisions to remove children from home continue to be driven solely by concerns for child safety (Berger et al., 2009: 1873).

More positive findings on wellbeing were found in a review of 21 Australian studies conducted between 1994 and 2006 by Osborn and Bromfield (2007). The review reported that the majority of children in care are in good physical health and display improvements in psychological functioning over time.

However, Osborn and Bromfield (2007) also reported a number of risks to wellbeing, including:

- a significant minority of children in care experience complex psychological and behavioural problems;
- children with a history of placement disruption tend to have a family history characterised by significant trauma; and
- adolescents are more likely to exhibit behavioural problems than younger children, with problem behaviours in adolescence possibly linked to trauma experienced in earlier developmental stages.

Positive wellbeing outcomes emerged from a survey of children ($n=829$) and young people ($n=1,180$) in care carried out by the Queensland Commission for Children and Young People and Child Guardian (QCCYPCG) (2013). Higher levels of wellbeing were reportedly associated with placement at a younger age, placement (and school) stability and continuity of their CSO (Community Service Officer). The survey findings also indicate that:

Wellbeing appears to be further enhanced when children and young people have better quality relationships with others including teachers, peers, carers and CSOs and are able to get help with their concerns (QCCYPCG, 2013: 2).

In conclusion, research indicates that a significant proportion of children in care experience complex psychological and behavioural problems (Osborn & Bromfield, 2007) and that early behaviour problems have been found to predict subsequent poor outcomes, such as delinquency, substance use and inappropriate sexual behaviour among children in OOHC (Taussig, 2002). As placement breakdown has also been shown to predict child behavioural problems (Newton et al., 2000; Rubin et al., 2007), behaviour problems can be considered to be both a cause and a consequence of placement disruption (Newton et al., 2000).


4.11 Resilience and protective factors

Of interest to this area of developmental outcomes is the differential response from some children who have been maltreated and placed in care. Findings from a US study by Finkelhor and colleagues (2007) suggest that some children with higher levels of resilience and fewer vulnerability factors can avoid becoming anxious or depressed. Multiple protective factors such as 'intelligence, parental/carer attachment, external interests, coping skills, peer relations and temperament' have been found in other research studies to be beneficial for children who are maltreated and/or poly-victims (Finkelhor et al., 2007: 21).

Witt and colleagues (2016) also found nearly half (46%) of their sample had significantly lower levels of psychopathology and a better level of psychosocial functioning indicating a degree of adaption and resilience to the impact of multiple forms of maltreatment and noted that while other studies found that 20% to 50% of maltreated children showed evidence of resilience, the proportion in their sample was at the higher end of the range, possibly due to their 'conservative definition of resilience as absence of psychopathology' (Witt et al., 2016: 8).

An Australian study of children in OOHC also found some children in foster care displayed resilience in social relations and prosocial behaviours. Children also showed gains in academic, emotional and behavioural outcomes as they progressed in their care placements (Fernandez & Maplestone, 2006). Findings from a South Australian study of children in foster care found the majority of children in the study displayed good psychosocial progress over the two-year study period. The children also expressed high levels of satisfaction with their quality of life in care (Barber & Delfabbro, 2004).

Moore and Ramirez (2016) studied a group of adolescents in the US who had experienced a variety of adverse childhood experiences (ACEs), such as psychological, physical or sexual abuse; living in poverty; exposure to domestic violence; living with a substance abuser or mentally ill or suicidal person, or someone who is, or had been, imprisoned. They found several potential protective factors that moderated poor



outcomes including residing in a safe neighbourhood, attending a safe school, and parental monitoring of friends and activities (Moore & Ramirez, 2016).

In summary, pre-placement factors strongly affect outcomes. These include exposure to maltreatment (including emotional, physical and sexual abuse and neglect); parental exposure to maltreatment (more likely to perpetrate on own children); domestic violence in home, parental misuse of alcohol and other drugs and family poverty/low socio-economic status. Children who have experienced maltreatment are likely to exhibit negative developmental outcomes in later childhood (Johnson-Reid et al., 2012) and negative outcomes in adulthood across a range of domains (Fernandez et al., 2016). However, protective factors such as intelligence, parental/carer attachment, external interests, coping skills, peer relations and temperament may have a mitigating effect (Finkelhor et al., 2007).

5 Placement Characteristics

This section focuses on children's pathways through care. It is in this area where service providers, in consultation with children, carers and birth families, might be expected to have some degree of control, including making decisions on the most appropriate type of care (foster, kinship or residential) to meet a child's needs, the estimated length of time a child may need to spend in the placement, and the level and nature of support/services required to maintain the placement.

At 30 June 2017, 70% of children on care and protection orders in Australia were with relative/kinship carers (38%), or in foster care (32%). Other care types included third-party parental care arrangements (11%), with their parents (7%), in residential care (5%) and around 7% in 'other/unknown' situations (AIHW, 2017). Due to the higher proportions of children in foster and kinship care, the discussion below focuses on these two types of care.

Barth, Guo, Green and McRae (2007) suggest that children with different characteristics are likely to be placed in kinship or foster care (due to the selection process) and that this complicates the interpretation of outcomes of child protection services. In the Australian context, the availability of an appropriate foster or kinship carer for the child's placement can also be a defining factor in a placement decision (McHugh et al., 2004; McHugh, 2010).

5.1 Placement type and outcomes

Caution is required in linking placement types (i.e. kinship care and foster care) with outcomes. Existing research does not adequately differentiate the impacts of care type itself from the children's pre-existing difficulties and therefore is beset with selection bias (children entering different types of care are likely to have different characteristics). The literature is limited by small samples, methodological problems and a lack of baseline measures from which progress comparisons can be drawn (Cashmore & Ainsworth, 2004; Connolly, 2003; Farmer & Moyers, 2005; Scannapieco, 1999). Cuddeback (2004), in a review of US and other literature, found that kinship literature had methodological limitations and significant gaps that restrict knowledge and suggested that a more rigorous research agenda was needed. This research gap is being addressed in Australia, with large scale studies with OOHC populations either completed or underway (see for example Eastman, Katz & McHugh, forthcoming; Winokur, Holtan & valentine, 2009; Winokur, Holtan & Batchelder, 2014).

Whilst there is no conclusive evidence that kinship care is overall a better placement option than foster care, a recent comprehensive systematic review undertaken by Winokur and colleagues (2014: 40) concluded that 'children in kinship care experience better outcomes in regard to behaviour problems, adaptive behaviours, psychiatric disorders, wellbeing, placement stability, guardianship, and institutional abuse than do

children in foster care... children placed with kin are less likely to achieve adoption and to utilise mental health services'. A US study found less risk of placement disruption in kinship care placements (Chamberlain et al., 2006). Children in kinship care tended to stay longer; however, children in foster care had planned moves, and once these were accounted for, there was little difference in the number of placements (Farmer, 2009). Cuddeback's (2004) research synthesis shows that children placed in kinship care, in comparison with those placed in foster care, tend to remain in care longer, are reunified with their birth families at slower rates, and are adopted at lower rates. Canadian, US and Australian studies also found that kinship care delayed reunification (Brisebois & Lee, 2012; Connell, Katz, Saunders & Tebes, 2006; Courtney, 1995; Courtney & Wong, 1996; Winokur et al., 2009).

A UK study of placement stability and outcomes for children in foster ($n=128$) and kinship ($n=142$) care found little difference in outcomes for children based on type of placement (kinship or foster care) – both groups had similar outcomes across a range of indicators of progress in placement (such as wellbeing, performing below ability, attending school regularly and exhibiting social behaviour acceptable to adults and other children) (Farmer, 2009). This indicates that type of placement (foster or kinship) is not generally predictive of outcomes.

In ensuring the best possible developmental outcomes for children at risk of maltreatment, researchers in one study acknowledged the difficulty of making decisions on whether to place a child at risk of maltreatment in foster care at all, or whether to leave a child in the biological home with support services in place (Goemans, van Geel, van Beem & Vedder, 2016). The Netherlands-based researchers used a series of meta-analyses to compare the cognitive, adaptive and behavioural functioning of children placed in foster care ($n=2,305$) with children at risk who remained with their biological parents ($n=4,335$) and children from the general population ($n=4,971$). The researchers found that foster children had generally lower levels of functioning than children from the general population; however, no clear differences were found between foster children and children at risk who remained at home. Both groups experienced developmental problems. They explain that:

... children placed in foster care might have experienced additional trauma compared with children at risk who remained at home. In addition, subsequent broken attachment due to the separation from their biological parents confronts foster children with another risk (Goemans et al., 2016: 212).

A small US study of a group of children in foster care ($n=35$) examined the relationship of early childhood factors (e.g. maltreatment history, placement history, parenting practices, environmental stress, developmental status and attachment behaviour) to development outcomes. The children had entered foster care in preschool and were aged 9-11 years at the time of the study. The study used the NEPSY – A Developmental Neuropsychological Assessment – (Korkman, Kirk & Kemp, 1998) to measure neuropsychological functioning. The tool includes a standardised test for children aged 3-12 years and includes 11 subscales resulting in five domains: Attention/Executive Functioning, Visuospatial Processing, Memory and Learning, Sensorimotor Function, and Language. Healey and Fisher (2011) found a significant correlation between environmental stress and emotional lability and negativity, between attachment behaviour

and emotion regulation ($r=-.33$, $p=.10$). School adjustment was positively correlated with developmental status, attention and executive function. Further, they found a lack of environmental stress during their early childhood foster care experiences had a significant positive relationship with the development of emotion regulation and school adjustment in middle childhood (Healey & Fisher, 2011).

Another US study of 46 kin and unrelated foster caregiver-infant dyads observed attachment behaviours using the Ainsworth Strange Situations Procedure (ASSP) (Cole, 2006). Infants were placed in a novel environment (strange situation), and their reactions and how the infant used the caregiver as a secure base were videotaped. The observed behaviours between the infants and foster and kinship carers indicated that the majority had secure attachments and there were similar percentages (67% and 68%) of secure attachment in both types of care (Cole, 2006). However, Cole noted that there was a higher than expected rate of infants in both groups exhibiting the disorganised/disoriented/cannot classify (DDCC) attachment category. Lawler (2008) also found support for the finding of no difference in emotional availability between foster and kinship carers of children in care. Literature reviewed by US researchers Mennen and O'Keefe (2005) on attachment theory highlighted the importance of the relationship between a child and their carer on affecting outcomes:

The quality of a child's attachment has been found to predict adjustment in many domains including social, psychological, behavioural, and cognitive domains... increasing the likelihood of positive outcomes for children in the child welfare system (Mennen & O'Keefe, 2005: 578).

Research conducted in the US by Lloyd and Barth (2011) examined developmental outcomes in domains such as cognition, language and social competence, using the Social Skills Rating System, the Vineland Adaptive Behaviour Scales Screener – Daily Living, Pre-School Language Scales (3rd Edition), Kaufman Brief Intelligence Test (K-BIT), Woodcock-Johnson tests of achievement and the Child Behaviour Checklist (CBCL) with a sample of children ($n=353$) five years after being placed in care in infancy (Lloyd & Barth, 2011). The study compared outcomes for children who were reunified with family ($n=63$), stayed in foster care (or kinship care) ($n=99$) or were adopted ($n=191$). The analysis indicated that adoption or reunification usually resulted in the best developmental outcomes overall, and remaining in foster care was typically associated with the poorest developmental outcomes. Similar to Goermans and colleagues (2016), the researchers noted that it could be that 'those who are adopted or reunified tend to be those with limited or no service needs' (Lloyd & Barth, 2011: 1,389).

5.1.1 Placement stability

Researchers from Norway and the US have discussed the concept of stability of a care placement (Christiansen, Havik & Anderssen, 2010; Harden, 2004; Leathers, 2006; Pecora, 2010). Pecora (2010: 4) conceptualises placement stability 'as the maintenance of continuity in a child's living situation in terms of the adults he or she lives with'. Whilst there is no unambiguous definition of what constitutes placement stability, Harden (2004: 31) suggests that 'family stability is best viewed as a process of caregiving practices that, when present, can greatly facilitate healthy child development'.

Critical to the concept of stability is the relationship between child and carer family, with Harden (2004: 31) suggesting that: 'providing stable and nurturing families can bolster resilience of children in care and ameliorate negative impacts on their development'.

Studies from Australia and the US have emphasised the importance of stability in a child's life in care (Bromfield et al., 1997; Jones, 2010; Lamont, 2011; O'Neill et al., 2010; Pecora, 2010; Wulczyn, 2010). McHugh (2013: 3) summarised the positive effects of stability as follows:

- stability minimises child stress, emotional pain and trauma (Pecora, 2010);
- stability reduces attachment disruption issues and emotional and behavioural disorders;
- stability decreases school changes and increases high school graduation;
- stability minimises service disruption and costs to agencies, reducing carer stress and encouraging carer retention;
- stability increases likelihood of attachment and positive relationships with other adults;
- stability helps ensure that educational, physical, and mental health needs will be assessed and addressed in a timely and consistent manner.

For Indigenous children, stability in care 'is grounded in the permanence of their identity in connection with family, kin, culture, and country' (Secretariat of National Aboriginal and Islander Child Care (SNAICC), 2016: 5).

In a large-scale Australian study of adult care leavers by Fernandez and colleagues (2016), stability (staying in the same home with a foster or kinship carer) was generally found to be associated with greater wellbeing and better outcomes (such as educational attainment), while those who had experienced the highest number of placements had worse outcomes across a range of domains (Fernandez et al., 2016). It should be noted that placement breakdown is associated with older age and greater exposure to maltreatment and abuse (in turn, associated with trauma-influenced emotional and behavioural problems and mental health disorders) prior to entering OOHC.

Fernandez and Maplestone (2006), in an Australian review of permanency planning literature, found several key factors associated with placement movement:

- initial period of placement the first six to seven months of placement constituted the period of highest vulnerability to placement movement;
- the child's age (i.e. being older);
- membership of economically and socially marginalised racial minorities.

While many of the studies lacked any analyses of possible relationships between reasons for placement and the type of placement and stability outcomes, where this was analysed, results varied widely (Fernandez & Maplestone, 2006).

Delfabbro and colleagues (2010) compared data from a longitudinal study in South Australia with findings from international studies and concluded that placement instability is a feature of both the Australian and the US systems. The Australian data suggests that placement movements may occur even more often in Australia because of the more 'crisis driven nature of practice and fewer residential care options for children with severe behavioural or conduct problems' (Delfabbro et al., 2010: 29).

A review of 21 Australian studies by Osborn and Bromfield (2007) conducted between 1994 and 2006 reported that nine studies contributed to the evidence base on issues related to stability. The review found that the majority of children in care achieve a stable and successful placement within their first 12 months in care and that ongoing and severe placement disruption only affects a relatively small sub-group.

There is a strong coincidence of early trauma and abuse and subsequent placement instability. A study of 364 children with a history of placement disruption spent an average of 4.8 years in care. On average, they had experienced 11 placements during their time in care and five placement breakdowns over the previous two years (Osborn & Delfabbro 2006a; 2006b). Children with high levels of placement disruption are reliably identified as those children who in the previous two years have experienced two or more breakdowns due to behavioural issues.

Foster care appears to be unsuitable for a small sub-population of adolescents in care, suggesting an urgent need for a wider range of placement options for this sub-group.

Early placement disruption may not be inherently damaging, but placement disruption extending beyond 12 months should be closely monitored, and the need for additional support assessed.

Sinclair and colleagues (2004), in the UK, concluded that children who have had previous placement breakdowns are more likely to have subsequent ones. Multiple breakdowns had a negative impact upon later adult functioning across a range of domains (Sinclair et al., 2004) and thus predict poorer outcomes. Similar to the findings on placement disruption by Osborn and Bromfield (2007), a review and meta-analysis of 26 studies focusing on disruptions in foster care by Oosterman and colleagues (2007) found that the quality of foster caregiving and other foster care related aspects, rather than placement type, were protective factors against placement breakdown. This is consistent with other research which indicates that carer attributes (e.g. warm, responsive parenting style, good parenting skills and effective discipline practices) and meaningful relationships with caseworkers are important in overall improved child wellbeing (Commission for Children and Young People and Child Guardian (CCYPCG), 2013). These studies indicate that placement instability may be prevented by interventions including more in-depth assessment and screening for known risk factors and appropriate placement support.

Whilst there are no Australian studies on the relationship of tribunal and court orders (e.g. finalised guardianship or custody orders) and outcomes, one UK study (Selwyn, Wijedasa & Meakings, 2014) examined outcomes, in relation to disruption and re-entry to care, by three types of orders: residence orders, special guardianship orders, and adoption orders. The research found:

- Age at entry to care was a significant predictor of disruption for all order types.
- Children who had multiple moves in foster care and had placements with unrelated carers (rather than kin) were more likely than others to experience disruption of residence or special guardianship orders.
- Overall, the disruption rates for all three types of orders were low 'compared with the movement that is reported for children who remain in the care system' (Selwyn et al., 2014: 273).

In summary, unpacking the concept of stability in relation to placements is complex, with numerous factors affecting stability. The literature reviewed here supports this contention, revealing an extensive list of factors that may need to be considered in relation to placement stability, including children's characteristics – age, reasons for placement, complexity of needs, physical and/or mental conditions (including disability), ethnicity, contact arrangements, part of a sibling group; care quality; residential (therapeutic) care; and relationships (specifically between children and carers, also between caseworkers, carer families, children and birth parents).

5.1.2 Sense of safety, security and happiness

Contributing to placement stability is a child's sense of safety, security and happiness in their current placement. The Queensland Commission for Children and Young People and Child Guardian (CCYPCG) (2013) surveyed children ($n=829$) and young people ($n=1,180$) in care in Queensland in 2011 and found that most children and young people reported being happy, safe and supported in their placements. Further, in a review of the literature, they found many studies demonstrating beneficial effects of being in care, with many children and young people perceiving their placements as providing increased safety and stability:

Many become increasingly content with their placement over time, reporting being better off in care, and providing positive reports about their lives after removal from their family of origin (CCYPCG, 2013: 6).

Similarly, the CREATE Report (McDowall, 2013) found 90% of the children and young people in their survey reporting that they felt safe and secure in their current placement, with 95% nominating at least one significant adult who cared about them and whom they believed would be dependable throughout their childhood or young adulthood. The CREATE Report also noted the majority (84%) of respondents ($n=892$) reported feeling happy about where they lived (McDowall, 2013).

Similarly, the Australian Institute of Health and Welfare in analysing data (in 2015) in relation to Standard 1 of the National Standards for OOHC, found the vast majority (91%)

of all children and young people in OOHC in Australia reported feeling safe and secure in their current placement (AIHW, 2016b)¹².

Being consulted about decision-making is also important to a child's sense of safety, security and happiness. The importance of participation in decision-making for children in care was reported on in a CREATE survey (McDowall, 2013). The report found that two thirds of children (63%) indicated that they were able to have a say about issues affecting them and were able to comment most about contact with family and friends, choice of school and subjects, and day-to-day living.

The Australian Institute of Health and Welfare (2016b) National Standards for Out-of-Home Care Data indicated that over two thirds (67%) of all children and young people in OOHC in Australia reported having an opportunity to have a say in decision-making¹³.

5.1.3 Family reunification

The Akin (2011) study in the US both corroborated and expanded previous conclusions from other studies on exits from care. The study offered insights into the importance of continuity and connections for children in care. The results suggest that policies and practices which keep children connected to their family are critical factors in relation to exits from care. The study also noted that a history of multiple placements was associated with a lower rate of family reunification (Akin, 2011). Smith (2003) also found that the number of placements was associated with lower rates of reunification.

However, large-scale longitudinal studies in the US have not found that the number of placements had a significant relationship with any permanent exit (Park & Ryan, 2009; Potter & Klein-Rothschild, 2002). In another study, Pabustan-Claar (2007) used public US child welfare agency data from 2000 to 2003 on child, case, and placement variables to identify which set of factors best explained case outcomes. Pabustan-Claar found that a higher number of placements was associated with a higher probability of reunification. She found no particular effect of the type of care on likelihood of reunification; however, the length of time in care seemed to be a factor. She concluded that '[t]he next potential research inquiry related to this study's findings is to compare the disruption rate between kin and non-kinship placement prior to achieving reunification/permanency status' (Pabustan-Claar 2007: 85). Likewise, in a systematic review of kinship care effects on outcomes that included only controlled experimental and quasi-experimental studies in which children placed in kinship care were compared cross-sectionally or longitudinally with children placed in foster care, researchers found no detectable differences between the groups on family reunification (Winokur et al., 2014).

¹² Standard 1 of the National Standards for OOHC: Children and young people are provided with stability and security during their time in care.

¹³ Standard 2 of the National Standards for OOHC: Children and young people participate in decisions that have an impact on their lives.

Two Australian studies have examined facilitators and predictors of family reunification. The first study examined factors facilitating family reunification outcomes for children. It utilised the *North Carolina Family Assessment Scale for Reunification* (NCFAS-R) tool (measuring family need and functioning) to ascertain whether the ratings for characteristics of birth parents and children differed at intake and case closure (Fernandez & Lee, 2013). It also investigated whether reunification was predicted by the NCFAS-R ratings. The sample of children ($n=145$) were aged between 0 and 12 years. At intake, the study found low scores for parental capabilities. The majority of families were on social security benefits and lived in public housing, and most (60%) had substance abuse problems. Over a half (52%) of children in the sample were reunified. Scores increased at closure with significant improvements in family safety and child wellbeing measures. Higher scores were also present for younger mothers (25 years and under) who had a higher level of education. Overall, NCFAS-R scores at closure significantly predicted reunification with parents or kin (Fernandez & Lee, 2013).

The second study by Delfabbro and colleagues (2013) on family reunification was conducted with a sample of children ($n=468$) in Tasmania. The study examined the nature and predictors of family reunification patterns based on characteristics of children and birth families and placements over a two- to four-year period in care. The study found that 50% of children were reunified with their families, with most reunifications occurring in the first six months of placement. Reunification was slower for younger children, children in kinship care and for families where poverty and substance abuse were factors.

In the Tasmanian study Aboriginal children, comprising 18% of the sample, were significantly more likely than non-Aboriginal children to have been in families with an abusive environment (61% to 40%), substance abuse problems (86% to 67%), housing problems (43% to 25%), sexually abusive home environment (44% to 28%), domestic violence (79% to 64%) and severe neglect (92% to 80%). Despite these factors, the study found no relationship between Aboriginal status and the likelihood of family reunification (Delfabbro et al., 2013). Results from the study were consistent with other international findings on family reunification.

Barriers to reunification have also been investigated by researchers. Based on an overview of a number of studies in the UK, Wilkins and Farmer (2015: 26) found several risk factors that militate against successful reunification outcomes:

- Alcohol and/or drug problems were highly related to repeated maltreatment. In one study, 78% of alcohol or drug misusing parents abused or neglected their children after reunification, as compared with only 29% of parents without these problems. Similarly, in another study, 81% of children who were reunified with alcohol or drug misusing parents experienced a return breakdown.
- Children who experienced previous failed returns home were more likely to experience a subsequent return breakdown, and these children experienced the worst outcomes.

- Attempts to support parents sometimes continued for too long – in 38% of cases, professionals in one study gave parents ‘too many chances’ to show they could care for their children.
- If Children’s Services were involved during pregnancy and parents had not made substantial changes within six months of a baby’s birth, real change was unlikely to occur.
- Children who had experienced chronic neglect or emotional abuse did significantly worse than others if returned home.
- Return breakdown rates and the quality of returns varied greatly by local authority (especially for older children), showing that variations in practice made a major contribution to children’s outcomes (Brandon, Belderson, Warren, Howe, Gardner, Dodsworth & Black, 2008; Davies & Ward, 2012; Farmer, Sturgess, O’Neill & Wijedasa, 2011; Farmer & Lutman, 2012; Sinclair et al., 2007; Thoburn, 2009; Thoburn, Robinson & Anderson, 2012; Wade, Biehal, Farrelly & Sinclair, 2011; Ward, Brown & Westlake, 2012).

In relation to failed returns home, there is some evidence from an Australian study that children in kinship care are less likely to re-enter care after reunification, compared with children in foster care (Fernandez, 2006).

5.2 Adoption

Adoption is not an ‘outcome’ per se; however, it is correlated with more positive outcomes overall due to the child tending to be younger at entry into adoptive care, having less exposure to maltreatment/trauma than older children, fewer behavioural problems, a greater likelihood of the adoptive parent(s) forming attachment with the child, and a greater level of stability provided by adoptive care. Adopted children tend to outperform children in foster care and kinship care.

5.2.1 Age and adoption

Infants are much more likely to exit foster care to adoption than older children and adolescents. US studies and a review by an Australian researcher have found that for each yearly increase in age, the chance of adoption is reduced by 22% (Barth, 1997; Barth, Courtney & Berry, 1994; Huntsman, 2014). A Northern Ireland study by McSherry and colleagues (2010) on care pathways for children under five years ($n=374$) found that adoption rates were highest for children aged less than 1 year when taken into care, and that adoption rates decreased as the age of the child increased on first entering care. The researchers suggest that the high level of adoptions (38%) among the sample was evidence of the growth in the ‘permanence movement’ in Northern Ireland, whereas prior to the commencement of the study, adoption was a rarely utilised pathway (McSherry et al., 2010).

Adoptions of infants aged less than six months have led to more successful outcomes when compared with children who were fostered (Sinclair & Wilson, 2003; Terling, 1999). Very young children are also less likely to be reunified with their birth family and more likely to be adopted (Akin, 2011)¹⁴.

In a review of adoption literature, Huntsman (2014) found that earlier adopted children were less likely to feel insecure or have behavioural problems. In contrast, late removal reduced the chances of long-term achievement of a stable adoptive home (Rees & Selwyn, 2009). Smith and colleagues (2006) also found that the risk of adoption disruption increased with age at adoption, going up 6% for each year.

5.2.2 Open adoption

As noted by Huntsman (2014), in the Australian context, open adoption has become the preferred option in most Australian jurisdictions. In March 2014, the New South Wales (NSW) Government introduced the *Child Protection Legislation Amendment Act 2014*. In addition to restoration to the birth family and guardianship, the aim of the legislation was to include open adoption as one method of providing greater permanence for children and young people in OOHC.

Huntsman (2014) noted the small number of adoptions in Australia. In 2014-15, carers (e.g. foster parents) adopted 94 children, with the majority of these (87 of the 94) occurring in NSW (AIHW, 2015a). Given the recent implementation of open adoption in NSW, there are no available studies on outcomes in NSW. Although there is a report from a Ministerial forum on open adoptions (Family and Community Services, 2016), this contains only anecdotal accounts from participants.

There are few studies available on children's views or outcomes in open adoptions versus those in confidential adoptions. A study by Berry, Cavazos Dylla, Barth and Needell (1998) in the US of over 700 non-foster parent adoptions found that openness of the adoption had little bearing on parents' feelings of satisfaction (however, this study was of parents, not child perceptions). For an overview of the issues, see Grotevant and McRoy (1998), who examined the evidence on positive and negative aspects of open and confidential adoptions (however, again the book focuses on the effects on parents). In a small qualitative study of the views of children, birth parents and adoptive parents about open adoption in NSW, Newton, valentine and Katz (forthcoming) found that children were positive about open adoption and valued the contact between birth families and children. Adoptive parents had more varied responses but overall were positive about open adoption.

¹⁴ It should be noted that there is likely to be a significant selection effect with regard to adoption. The probability of adoption reduces with the age of the child, and also for children who present with behavioural problems.

5.2.3 Adoption versus foster or kinship care

A Swedish national cohort study based on national register data compared outcomes for 900 adoptees with 3,100 children who grew up in foster care and found that foster children fell clearly short of adoptees on all outcomes – school performance at 15, cognitive competence at 18, educational achievement and self-support capability in young adult years – after adjustments for birth parent related confounders and age at placement in substitute care were made (Vinnerljung & Hjern, 2011). In another rigorous study, Quinton and Selwyn (2009) tracked a sample of 130 children of whom around a third were placed in foster care while the remaining two thirds were adopted. They found that placement breakdowns were significantly more common in foster care placements (46% vs. 17%). For other outcomes such as learning difficulties, emotional and conduct problems, over-activity and sense of self-esteem, there were also differences between the groups, but these were mostly explained by the extent of emotional or behavioural problems at baseline (time of adoption decision). In short, they found ‘no differences between the two types of placement on the great majority of psychosocial outcomes’ but that disruption rates were much lower for the adopted children (Quinton & Selwyn, 2009: 1124).

In terms of stability, Triseliotis (2002) found a lower level of disruption in adoption situations versus foster care; however, this was also affected by age, as disruption rates tend to converge as the child’s age at time of placement increases.

In conclusion, research has found that placement type (foster or kinship) is not generally predictive of outcomes across key domains. A study comparing attachment behaviour between infants and foster and kinship carers reported similar percentages (67% and 68%) of secure attachment in both types of care (Cole, 2006). However, some research has found that kinship care provides greater stability because there is less risk of placement disruption in kinship care placements (Chamberlain et al., 2006).

Placement stability is both a cause and a consequence of social, behavioural, emotional and cognitive outcomes for children in OOHC. Stability is very important in a child’s life in care (Bromfield et al., 1997; Jones, 2010; Lamont, 2011; O’Neill et al., 2010; Pecora, 2010; Wulczyn, 2010) and is associated with perceived emotional security (Cashmore & Paxton, 2006). Many studies have demonstrated the beneficial effects of being in care, with many children and young people perceiving their placements as providing increased safety and stability (CCYPCG, 2013). Research indicates that, rather than the type of placement, carer attributes (e.g. warm, responsive parenting style, good parenting skills and effective discipline practices) and meaningful relationships with caseworkers are more important in overall improved child wellbeing (CCYPCG, 2013). Placement breakdown may be associated with the age of the child and factors related to the child’s prior exposure to maltreatment and concomitant social and behavioural issues.

In regard to contact with the birth family, Barber and Gilbertson found that the evidence on which the belief that contact is generally beneficial to the child is based appears ‘weak or mixed’ (Barber & Gilbertson, 2001). Reunification with the birth family was slower (or less likely) for younger children, children in kinship care and for families where poverty and substance abuse were factors (Delfabbro et al., 2013). This was consistent with other international findings on family reunification.

Studies indicate that children placed for adoption tend to do better than those in other forms of care, especially if they are adopted at a young age. However, this may be due to selection effects, with children who have fewer problems and children placed in care at a younger age being more likely to be adopted. There is no research which definitively links openness in adoption (compared to 'closed' adoptions) to child outcomes.

5.3 Carer characteristics

At 30 June 2017, Australia had 10,172 foster carer households and 15,550 relative/kinship households. Over half (52%) of all foster care households had multiple (two to foster children) placements compared with 37% of relative/kinship households (AIHW, 2017).

5.3.1 Foster carer attributes

A carer survey in NSW ($n=450$) indicated that the typical foster carer was female, aged 48 years, Australian-born and had completed Year 10 schooling (or equivalent). Most primary carers were female (92%), and the majority of secondary carers were male (90%). Just over a quarter of the carers (27%) were single carer households (97% female) and close to three quarters were carer couple households (92% with a primary female carer) (McHugh et al., 2004).

More than half of the primary carers (56%) had a post-school qualification and most were not in the labour force (one third of primary carers were in paid employment). Of those not in paid work, many relied on government pensions or allowances as their principle source of income. Almost half of all carers had been fostering for five years or less, but over one quarter had been fostering for 11 years or more (McHugh et al., 2004).

A similar Victorian carer survey found that most foster carers ($n=116$) were female (86%), aged 45-54 years (38%) and English speaking (99%). Over half had completed a post-school qualification (53%) such as a trade certificate or higher education degree and had been fostering for two years or less (29%). Just over half of carer households were couples (56%) tending to care for one foster child (59%) (Wilks & Wise, 2011).

The profile of foster carers is changing. An examination of recruitment and retention of foster carers in the UK, the US and Ireland noted an increase in foster carers who are single females, in their middle years, professional couples in paid work, and same sex couples. The author suggests that the changing profile of foster carers means that additional support may be required to sustain placements and carers, and to prevent burnout and placement breakdown (Pell, 2008).

The fostering role can be associated with significant stress, emotional and behavioural problems or institutionalised behaviour (Quinton et al., 1999). Ameliorating carer stress is critical in supporting carers. In a systematic review of the effectiveness of cognitive behavioural training interventions in improving foster carers' psychological wellbeing and functioning (among other outcomes), Turner, MacDonald and Dennis (2007) found that there was little evidence of effectiveness in these interventions.

In relation to carer characteristics, there is no clear consensus on what the key variables are in terms of successful foster care placements. A UK study variously identified age of the carer, presence of birth children in the family, and the relative age of children and the fostered child, parenting characteristics, and carer stress as relevant (Sinclair et al., 2004). A Victorian survey by the Centre for Excellence in Child and Family Welfare (CECFW, 2007) found that the most important characteristics for successful carers were 'commitment and resilience'. Also important were 'flexibility', 'an easy-going nature', 'an understanding of the deeper issues' and 'a caring and compassionate nature' (CECFW, 2007).

Barber and Delfabbro (2006) identified several characteristics of effective foster care for which there is at least a moderate degree of empirical support, noting the following beneficial carer characteristics associated with successful placements:

- non-authoritarian child-rearing styles;
- non-possessiveness towards the child;
- rejection of the belief that child development is dependent on heredity;
- tolerance of difficult behaviour;
- tolerance of poor academic achievement;
- few demands for religious observance;
- female carers who identify with deprived or damaged children from personal experience.

Carer attitude is important, for example, in welcoming the child as a part of the family. A US study investigating carer characteristics affecting placement stability ($n=151$) using the Parent-Child Relationship Inventory (PCRI) and the Parenting Alliance Measures (PAM) found that 'this model explained 15% of the total variance in placement stability. Two parenting characteristics, parenting support and limit setting, were the two independent variables that accounted for the most variance in placement stability. Communication, parenting satisfaction, and parenting alliance did not significantly predict the outcome.' (Crum, 2010: 188).

Most Australian jurisdictions struggle to meet the demand for foster carers (AIHW, 2016a; Bromfield & Osborn, 2007a). There is a need for research to evaluate models of recruitment, assessment, training and support of carers to determine which methods are the most effective in recruiting and retaining carers and ensuring that carers are adequately prepared and supported to perform their important role (Bromfield & Osborn, 2007a; Thomson, Watt & McArthur, 2016).

An evaluation of the *Victorian Foster Care Communication and Recruitment Strategy* noted that recruitment and retention are strongly interrelated (Faircloth & McNair, 2012). The shortage of carers in the system leads to 'burnout' of existing carers and to emergency placements being added to existing placements, with children being almost randomly placed together. This has potentially destabilising effects for both the

placement and the continuation of the carer. Among their recommendations, the evaluators suggested that, due to a lack of accurate carer data, a minimum data set should be developed on existing carers, and further, that Aboriginal Community Controlled Organisations should be included in the development of a data set on Aboriginal carers. The data should comprise:

- the number and characteristics (including features of their changing profile) of current foster carers and the type of care provided;
- the number and demographic profile of exited carers;
- the number of enquiries made by potential carers;
- average time of agency response to enquiries;
- average time to orientation/accreditation and then to active foster caring (Faircloth & McNair, 2012).

Other recommendations included further development of a marketing approach, offering additional support to existing carers for retention purposes, and the introduction of a rural supplement to meet additional travel costs of carers (Faircloth & McNair, 2012).

In supporting and retaining carers, the provision of initial and ongoing carer training is of critical importance in the provision of OOHHC. Due to the increasing complexity of children's needs (emotional and behavioural problems) on entry into care, it is crucial that foster carers develop skills and competence to manage these problems (McHugh et al., 2004). In an overview of studies on foster carer training in Australia, Osborn, Panozzo, Richardson and Bromfield (2007) noted that carers wanted training that was both practically oriented and nationally accredited. They also noted that 'there is a dearth of research evaluating the effectiveness of carer training programs in imparting knowledge and skills and adequately preparing carers for their role' (Osborn et al., 2007: 12).

Training for carers in behaviour management techniques was suggested in a NSW study (McHugh et al., 2004). Other international literature suggests that the standard training programs provided to foster carers vary widely and lack a direct evidence base (Dorsey, Farmer, Barth, Greene, Reid & Landsverk, 2008). In addition, it appears that standard programs do not incorporate behavioural management training at a level sufficient to modify parenting practices.

There are a number of evidence-based training programs that have been used with parents of children with behavioural problems in the general population, and these programs also show promise for use with foster carers. There has been some research on two evidence-based parent training programs in the US foster care context: Parent Child Interaction Therapy (PCIT) and Incredible Years (IY). Findings from a small quasi-experimental study of 30 families using the Eyberg Child Behaviour Inventory (ECBI), a parent-report measure of behaviours associated with Oppositional Defiance Disorder and Attention-Deficit Hyperactivity Disorder, have shown that training foster carers in PCIT resulted in a reduction in problem behaviour and allowed them to better manage disruptive behaviours using the techniques taught in the training session (McNeil, Herschell, Gurwitch & Clemens-Mowrer, 2005). Findings of a randomised controlled trial

demonstrated that training both biological parents and foster parents in IY resulted in improvements in positive parenting and collaborative co-parenting such as a trend for the ‘slowing down’ of child externalising problems for intervention children (Linares, Montalto, Li & Oza, 2006).

Two randomised controlled trials have examined the effectiveness of training provided to foster carers on child behaviour and development. In a small-scale study with infants (mean age 19 months), Bick and Dozier (2013) tested the effectiveness of the intervention Attachment and Biobehavioral Catch-up (ABC) in a randomised trial with 96 foster mother-infant dyads. ABC is designed to help foster parents reinterpret foster infants’ signals to provide nurturing care, respond synchronously to an infant’s cues when appropriate and reduce displays of frightening behaviours towards foster infants during parent-infant interactions (Bick & Dozier, 2013). Approximately half of the mothers were assigned to the ABC intervention while the rest were the control group. The results indicated that the ABC intervention produced greater improvements in maternal sensitivity (Bick & Dozier, 2013).

Another randomised clinical trial by Dozier, Peloso, Lewis, Laurenceau and Levine (2008) assessed the effectiveness of the relational intervention ABC with regard to hypothalamus-pituitary-adrenal functioning with a sample of 141 children who were assigned to the ABC intervention, the Developmental Education for Families, or no intervention group. It found that the ABC intervention group had lower cortisol levels (indicating lower levels of stress) and fewer behavioural problems than children in the control intervention and comparison group (children who had never been in foster care).

Similarly, in a US study of 86 families, Price, Chamberlain, Landsverk and Reid (2009) examined the impact of a foster parent training and support intervention, Keeping Foster Parents Trained and Supported (KEEP) on placement changes to determine whether the intervention mitigated placement disruption risks associated with children's placement history. It was found that the intervention increased chances of a positive exit (such as reunification) and mitigated the risk-enhancing effect of a history of multiple placements.

The quality of parenting that children experience has major implications for their outcomes in every developmental domain throughout childhood and adulthood (Jones Harden, Meisch, Vick & Pandohie-Johnson, 2008). Overall, there is a lack of research on the quality of foster (or kinship) home environment and little is known about which aspects of the foster/kinship family exacerbate children’s poor functioning, ameliorate existing difficulties, prevent adjustment problems from developing, or assist with positive outcomes (Berrick & Skivenes, 2012; Orme & Buehler, 2001).

A review of research on foster parents’ parenting attitudes by Jones Harden and colleagues (2008) reported six indicators of quality foster parenting that are linked to positive child developmental and placement outcomes, including:

- *Motivation and commitment to foster.* The review found that commitment and attachment of a foster parent to a foster child are vital to successful foster parenting and associated with positive child outcomes. Positive motivations include wanting to make a difference in the life of a child in need and identifying

with deprived children or wanting a larger family, while negative motivations include wanting to replace a deceased or adult child, or financial motivations.

- *Attitude towards biological parents.* If foster parents maintain a general animosity toward the biological parents of their foster children, facilitating contact between foster children and their biological parents is likely to be associated with tension and hostility.
- *Attitudes towards problems of the child.* Foster carers who are uncomfortable with helping children in their care with behavioural or other problems may stay emotionally distant from them and refrain from forming any lasting attachment. A related issue is whether or not foster carers have the skills and abilities to manage behavioural problems.
- *Kinship care.* Kinship caregivers are often motivated by familial obligations and expectations and may have more positive perceptions about the children placed in their homes than non-relative foster caregivers.
- *Experiences as foster parents.* The fostering role can be associated with significant stress. Continued stressful experiences are strongly associated with a foster parent's decision to discontinue fostering.
- *Ambiguity in role of agency and foster parent.* The review suggests that ambiguity in the relationship between agencies and foster parents can be problematic (Jones Harden et al., 2008).

However, this list does not specifically include parenting practices, such as harsh parenting and sensitive, stimulating parenting, which are likely to be critical to child outcomes. For example, Jaffee (2007) found that infants and toddlers in NSCAW who had improvements in the amount of sensitive, stimulating caregiving that they had received had positive cognitive and behavioural outcomes 18 months later, despite early levels of neurodevelopmental risk.

There is evidence from randomised controlled trials that changing parenting practices of foster carers can improve the outcomes for children in foster care, which lends further support to the importance of quality of parenting (Bick & Dozier, 2013).

Berrick and Skivenes' (2012) study with a sample of US ($n=87$) and Norwegian ($n=54$) foster carers examined the characteristics of quality foster care. Carers were selected on the basis that they were providing high quality care (HQC). The study found that HQC is characterised by effective parenting skills and caregiving responses well beyond typical parenting. The researchers noted three important dimensions to HQC:

- 1) attending to the experience of integrating the child into a new family;
- 2) considering the relationships between child, birth family, and foster family;
- 3) responding to the development and special needs of the child (Berrick & Skivenes, 2012: 1958).

The carers who were interviewed spoke of a range of parenting strategies they used in providing HQC, which Berrick and Skivenes summarised as ‘evidencing responsive, proactive, engaged, intentional, age-sensitive and pro-social behaviours designed to promote children’s growth and development’ (Berrick & Skivenes, 2012: 1,963-4). The researchers suggest that to achieve HQC, the provision of foster carer training may need to go beyond the basic initial training offered to all carers to include training in these dimensions.

5.3.2 Kinship carers’ attributes

Over the last 13 years in Australia, there has been a significant increase in the use of kinship care, rising from 40% of all home-based placements in 2003 to 47% in 2015 (AIHW, 2005, 2016a). Nationally and internationally, kinship care is seen as the ‘preferred’ and ‘less obtrusive’ option when children need to be placed in care. In their systematic overview of kinship care, researchers found kinship care to be the ‘least restrictive (Hegar & Scannapieco, 1999) and safest setting (Gleeson, 1999) on the continuum of out-of-home placements’ (Winokur et al., 2014: 1).

Kinship carers have different characteristics and circumstances than foster carers. An overview of studies from a number of countries, including Australia, indicates that kinship carers are perceived as a ‘vulnerable’ group as they are often:

- older, single females;
- financially disadvantaged;
- in poorer health;
- less knowledgeable about child development and modern parenting practices;
- less well-educated;
- more likely to experience financial hardship and overcrowding when caring (McHugh, 2013).

Despite their love and commitment for their extended family, kinship carers often reported feeling obligated to care for them and are often motivated by family ties and responsibilities (Mason, Falloon, Gibbons, Spence & Scott, 2002; Paxman, 2006) and may have more positive perceptions about the children placed in their homes than non-relative foster caregivers. Evidence from the US on children living in kinship care suggests that some of its greatest strengths are the reduced stigma compared with foster care, the reduced trauma associated with separation from parents and the broad sense of familial relationships (Cuddeback, 2004; Messing, 2006).

An overview of US and UK studies found that children in kinship care receive substantial benefits from this type of care including:

- feeling loved, cared for and valued;
- maintaining identity and feeling settled because they were with family;

- fewer placement moves;
- maintenance of contact with family and friends;
- higher placement stability than in foster care (Mackiewicz, 2009: 2).

Factors that may impact negatively on effective kinship care according to a US study include economic disadvantage, stress, health issues and parenting skills. Conflict with the birth family is a feature of many statutory kinship care placements (Sykes, Sinclair, Gibbs & Wilson, 2002), and this adds to the stress kinship carers face according to Australian research (Dunne & Kettler, 2006). Further research is needed to understand the impact of kinship care on the lives of carers and, specifically, outcomes for children in kinship care (Broad, 2004; Bromfield et al., 2005; Dunne & Kettler, 2006; Holtan, Ronning, Handegard & Sourander, 2005).

In Australia, compliance with the Aboriginal Child Placement Principle results in kinship care being more commonly utilised than foster care when placing children from Indigenous families. Kiraly (2011) notes that there is no data on the characteristics of Indigenous foster/kinship carers in Australia and that there has been minimal research on Indigenous grandparents caring for their grandchildren (Kiraly, 2011). Brennan, Cass, Flaxman, Hill, Jenkins, McHugh, Purcal and valentine (2013) included 20 Indigenous grandparents in a study of grandparents raising grandchildren. They found that of the 20 Indigenous grandparents interviewed, 19 were female; of the nine that disclosed their age, all were 45 or older; the majority spoke one or more Indigenous language in addition to Aboriginal English or Standard Australian English; and most were caring for more than one child (six of the grandparents who took part in interviews had one grandchild in their care, eight cared for two grandchildren, three for three grandchildren and two for four grandchildren) (Brennan et al., 2013). Many Indigenous grandparents said they 'were raising grandchildren because they had previously been abused, neglected or witness to family violence' (Brennan et al., 2013: 142). Most reported being on Centrelink payments and reported that raising grandchildren 'had caused them considerable financial stress and hardship' (Brennan et al., 2013: 148). The higher socio-economic disadvantage of Indigenous carer households compared with other Australian households has been noted by researchers. Smyth and Eardley (2008), citing Brandon (2004), found that in 2001, Indigenous carer households had the second lowest gross household income after lone mother households and 'had proportionately much higher rates of poor dwelling conditions than other household types' (Smyth & Eardley, 2008: 10).

While kinship and foster care have many similarities, kinship carers, unlike foster carers, are rarely assessed, approved or trained before having children placed with them. A consistent theme in an overview of international kinship care studies is that statutory kinship carers, compared with foster carers, are less likely to receive support (including allocated caseworkers, case plans, annual review, training and services) and monitoring, to ensure that children's and carers' needs are met (McHugh, 2013). Kinship carers may therefore provide less effective care (Paxman, 2006). Nationally, there is also concern that whilst most children placed in OOH are eventually reunited with their families, this is less likely to be the case for kinship care, where children in these placements tend to stay longer in care (particularly in NSW) (Gallard, 2010). However, they may continue to see their families while in care.

The inadequacy of current systems and procedures for preparing and supporting Indigenous carers has been noted in several studies (DHS, 1998; Higgins et al., 2005b; New South Wales Community Services Commission, 2001). Recruitment of Indigenous carers is both aided and hindered by several factors. For example, Indigenous peoples experience disproportionate levels of material disadvantage, which limits their ability to become carers, and places additional financial strain on existing carers (Higgins et al., 2005b). Community-based (especially word-of-mouth) strategies have been reported as being the most effective way of recruiting Indigenous carers. Such strategies were also more effective when undertaken by Indigenous people (Higgins et al., 2005b; McHugh et al., 2004).

Indigenous carers reported that when they were adequately prepared for the carer role, they felt supported. Carers talked about the need for adequate and timely financial support, respectful relationships with the department, and practical and emotional support. Ongoing support for carers was crucial to prevent 'burnout' and loss of carers (DHS, 1998; Higgins et al., 2005b; McHugh et al., 2004).

In relation to carer assessment, training and support, previous research shows that existing assessment techniques and requirements are not culturally appropriate for Aboriginal and Torres Strait Islander people and may prevent Indigenous people from becoming carers. In addition, some Indigenous carers are not comfortable in accessing mainstream carer training sessions (McHugh, 2009).

To address the issue of culturally inappropriate assessment tools, a culturally appropriate resource, *Aboriginal Kinship Care Tool*, has been implemented in several Australian jurisdictions (Winangay Resources, 2016). The innovative assessment process implemented by Winangay acknowledges the expertise of Aboriginal kinship families. The cultural sensitivity of the tool is important, as the continuing impact of previous child welfare policies, and the effects of intergenerational trauma in Aboriginal communities and families in Australia, have contributed to Aboriginal kinship carers' fears and concerns about assessment processes, and being involved with child protection agencies. The Winangay team has provided training for Aboriginal and non-Aboriginal staff in 25 agencies in urban, rural and remote areas throughout Australia. Winangay has partnered with the Queensland Department of Child Safety and NSW FACS to pilot its resources (Winangay Resources, 2016).

In conclusion, the attributes of a carer (such as low income, health status, stress, and age) may impact on outcomes of children in OOHC. Generally, kinship carers provide longer placements for children but receive less support and training than foster carers. Foster carers are more likely to be better educated and less socio-economically disadvantaged than kinship carers. Kinship carers, compared with foster carers, are less likely to receive support (including allocated caseworkers, case plans, annual review, training and services) and monitoring, to ensure that children's and carers' needs are met (McHugh, 2013). Continued stressful experiences are strongly associated with a foster parent's decision to discontinue fostering and placement breakdown (Quinton et al., 1999). Carers who gave high parental support and had the ability to maintain effective limit settings with children in their care offered more stable placements (Crum, 2010). Some Indigenous carers are not comfortable in accessing mainstream carer training

sessions (McHugh, 2009). Development of culturally appropriate training and tools can assist in supporting Indigenous carers.

5.4 Casework, Services and interventions

Regardless of placement type, children in OOHC require a range of services and interventions to address the legacy of poor parenting, abuse and neglect that occurred prior to their entry into care. The provision of services ensures that children's needs, in relation to physical and mental health and wellbeing, and socio-emotional and cognitive development are addressed, and placement stability is supported. As noted elsewhere (Eastman et al., forthcoming), children require a number of age-specific services including health services (particularly mental health services), optical, dental, educational, therapeutic services (e.g. counselling, speech and physiotherapy) and recreational activities. In addition, placement-specific services including casework, case planning and management are also required.

5.4.1 Services and placement type

The level of service provision has been found to be associated with placement type, with evidence that kinship carers receive fewer services and less support than foster carers (Cuddeback, 2004; McHugh, 2013; McHugh & valentine, 2010; Winokur et al., 2014). Barth and colleagues (2007) found that in the US, kinship carers are less likely to enrol children in additional services. Spence (2004) found that in Australia, kinship carers are less likely to be supervised by a statutory agency. There is some evidence that caseworkers do not feel that the same level of services is necessary for kinship placements as for foster placements (Cuddeback, 2004).

Providing grandparent kinship carers with adequate information in an accessible form about roles, responsibilities and entitlements is seen as essential, as 'grandparent carer families appear to fall through the gaps of information provision' (valentine, Jenkins, Brennan & Cass, 2013: 428). McHugh (2009) found that most kinship care placements benefit from access to support/services, including respite services (e.g. child care, social/recreational activities and camps).

5.4.2 Caseworker support to child/young person

The provision of casework to children is a very important component of OOHC. Access to casework support is key for both children in OOHC and their carers. Caseworkers can also influence outcomes, with positive child/carer/worker relationships critical for placement stability and carer retention (Gilbertson & Barber, 2003; McHugh et al., 2004; Triseliotis et al., 1999). However, McDowall (2013) found that that relationships between workers and children are not always as strong as could be expected. A national survey with children in care asked children who they would confide in if they were worried about an issue of concern. The results showed that:

Over half (52%) would confide in their carer, but only 9% would talk with caseworkers. This suggests that the role of the caseworker needs to be

reviewed to define more clearly the level of support they should provide (McDowall, 2013: xxiii).

The survey found that over two-thirds (67%) of the participants said they could access their caseworker, although children in older age groups appeared to have greater access than younger children. Younger children found caseworkers more helpful, and were more comfortable with them, than the older group.

A case file audit ($n=205$) of children in foster care in South Australia found that over half (56%) did not have a current case plan. In less than a third (32%) of cases did children appear to be involved in developing their plan (Gilbertson & Barber, 2003). Over time, this situation appears to have improved significantly. An analysis conducted by the Australian Institute of Health and Welfare (2016b) in relation to Standard 4 of the National Standards for OOHHC found that the majority (87%) of all children and young people in OOHHC in Australia have an individualised case plan that details their health, education and other needs (AIHW, 2016b).

A CREATE survey in NSW found that just over a third (37%) of children and young people had 'knowledge' of their case plan, with older children more aware of a case plan than the younger group. One third (33%) of participants, mostly older children, had been involved in the case planning process and another third (34%) had little/no involvement (McDowall, 2013).

Australian studies report that few formal kinship carers appear to have a case plan for the child/children in care, and after assessment it was also rare for caseworkers to be allocated to kinship placements (McHugh, 2013). One study found just over a third (37%) of grandparent carers received caseworker support. Another third (29%) who did not have a caseworker would have liked one, with a further third (34%) not receiving caseworker support and not needing it (Brennan et al., 2013: 25).

There is limited Australian or international research on the frequency of reviews of outcomes of children's case plans. The notion that a review of a child's placement and case plan may be related to outcomes has been 'minimally explored and not well defined' (Whitaker, 2011: 1,683).

One US study of children in OOHHC ($n= 1,759$) by Whitaker (2011) examining the relationship between administrative case reviews and two child welfare outcomes (i.e. permanency and placement length) found that variables including race/ethnicity, age at removal, initial placement setting, removal reason, parental visitation, review attendance (with birth parent and foster parents) and the interaction between timely case review and caseworker contact are significant predictors of a child's length of stay in a placement. These variables also influenced a child achieving permanency, with the study's author suggesting that 'the results of this study provide evidence that timely case review, as an intervention, has a major effect on the child welfare outcome permanency' (Whitaker, 2011: 1,702).

Whilst agency caseworkers play a key role in facilitating access by children to appropriate services, it is often carers who play a strategic role in advocating for, and ensuring that children attend, various services. A national online survey conducted with foster carers

(*n*=187) of children aged 4-12 years examined the types of support identified as helpful when caring for children with 'challenging behaviours' (Octoman & McLean, 2016). Irrespective of the type of care provided or the extent of their previous experience, the highest score (73%) for the type of support seen as 'extremely helpful' was for 'knowledge about children's behaviour prior to fostering' and the second was 'a good relationship with social workers' (53%). When carers were asked who were 'the most valuable or knowledgeable group of people to deliver supports to foster carers?' their response was: current foster carers (49%), foster carer support workers (19%), psychologists (17%), former foster carers (9%) and caseworkers (9%) (Octoman & McLean, 2016).

5.4.3 Casework and caseworker training

Considering the challenging nature of managing OOHC placements, it can be assumed that the higher the level of experience and qualification of caseworkers and the more manageable a case load, the higher the likelihood of maintaining a placement's stability. Whilst quality of casework may have an impact on children's outcomes in OOHC, there is limited information on caseworker qualifications, training/supervision, professional development, caseloads, quality of casework and caseworker/staff turnover in both government and non-government agencies in Australian jurisdictions. This section reports on the findings from a small number of studies in NSW.

A survey of respondents whose work was related to the NSW OOHC system, conducted as part of the evaluation of the transition of children in OOHC from government to non-government agencies, examined the qualifications and experience of the respondents (*n*=1,031) (Social Policy Research Centre, University of Melbourne & Bankwest Curtin Economics Centre, 2016). Over two thirds of government (67.3%) and non-government (68.2%) survey respondents worked directly with children and young people in OOHC. Most were FACS staff (*n*=823), and the remainder were from the non-government sector (*n*=208). An analysis of the survey data (see Table 1) found that 86.0% of all respondents whose work related to OOHC had a degree level qualification, with respondents from the non-government sector slightly lower (74.5%).

Table 5.1: Characteristics of government and non-government sector respondents

	GSR (n=823)		NGSRs (n=208)		All (n=1031)	
	n	%	n	%	n	%
Qualifications and experience						
Has a social work degree	214	26.0	60	28.8	274	26.6
Has a degree level qualification in another human service field	564	68.5	102	49.0	666	64.6
Respondents with less than two years' experience working in a child and family welfare context	52	6.4	25	12.0	77	7.5
Respondents with more than 10 years' experience working in a child and family welfare context	393	47.8	84	40.4	477	46.3

Notes: GSR=Government sector respondents. NGSR=Non-government sector respondents.

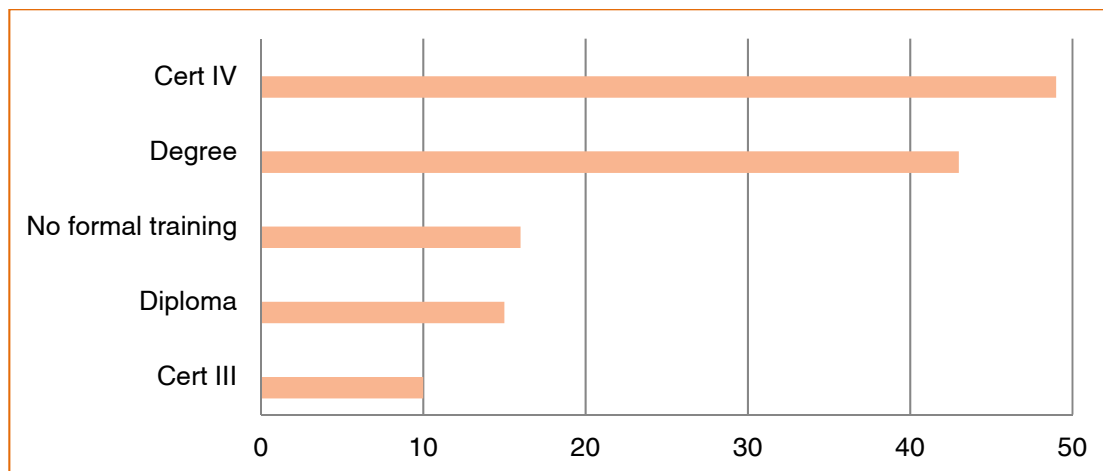
Source: Social Policy Research Centre, University of Melbourne and Bankwest Curtin Economics Centre, 2016.

The proportion of respondents with a social work degree was similar in the government sector (26%) and non-government sector (28.8%). More government sector respondents (68.5%) had a degree level qualification in a human service field (other than social work) compared with 49.0% in the non-government sector. In relation to experience, close to half (46.3%) of government sector respondents had more than 10 years' experience working in child and family welfare contexts compared with 40.4% of non-government sector respondents. A small proportion (6.4%) of government sector respondents had less than two years of experience compared with 12% of non-government respondents (Social Policy Research Centre, University of Melbourne & Bankwest Curtin Economics Centre, 2017).

Further evidence on care staff qualifications (educational/training) comes from a survey of NSW workers (i.e. direct care workers) (n=132) in non-government agencies (n=22) providing residential care. The survey was conducted for the study *'Developing a Framework for Therapeutic Out-of-Home Care in NSW'* (Family and Community Services (FACS) & Association of Child Welfare Agencies (ACWA), 2017).

The survey found that many workers had either a degree (n=43), Cert. III (n=10) or Cert. IV (n=48), or diploma equivalent qualification (n=15). Sixteen care workers had no formal training (see Table 2). The study found that most surveyed agencies were committed to ongoing worker training and skill development, although no data was provided on the type of ongoing training/skill development, or how often it was provided. Many residential agencies indicated that they were either providing, or moving towards, the adoption of therapeutic models of care. The survey revealed a sector in transition, with differences in training and skill levels of workers (FACS & ACWA, 2017).

Figure 5.1 Qualifications of residential care workers



Source: FACS and ACWA (2017).

5.4.4 Caseworker caseloads

In 2007, the Economics Unit in FACS (then DOCS) reviewed the available literature on caseworker caseloads (actual and recommended) in child and family services, including OOHC services. Caseload was defined as:

The number of cases/clients/families handled by a full-time equivalent direct worker (e.g. caseworker) at any point in time or over a stated period. Generally, caseworker activities include implementation of the case plan, conducting assessments, coordination of services and supports, and monitoring (Izmir, Yackoub & Moss, 2007: 3).

Data was provided for three Australian states: Queensland, Tasmania and NSW. Whilst information was provided on recommended caseloads for the three states only, data for Queensland indicated that the actual caseloads of caseworkers (23) far exceeded the recommended 15 cases per worker. In NSW, the caseload for children with 'high needs' was five, for 'medium-high' needs 6.5, for 'medium' needs 10, and for 'low needs' 20 (Izmir et al., 2007).

While it is difficult to compare caseload data on 'needs' (mentioned above) to 'care type' (see Table 3), it would appear that overall recommended caseloads have been reduced. An audit carried out after the transfer of OOHC placements from departmental agencies to the non-government sector noted that, according to data provided by FACS, the caseload for caseworkers varies by the type of care provided. The department developed a model that applied to all OOHC placements under contract to non-government organisations. The figures in Table 3 indicate that the caseload is highest for children in General Foster Care (12.8 cases) and lower for children requiring Intensive Residential Care (six cases) (NSW Auditor-General, 2015).

Table 5.2: Level of caseload by care type

Care category	Caseload
General Foster Care and Care +1	12.8
General Foster Care +2	12.8
Intensive Foster Care	7.5
Standard Residential Care	10.0
Intensive Residential Care	6.0

Notes: Care +1 refers to higher support needs. Care +2 refers to intensive support needs.
Source: NSW Auditor-General (2015).

5.4.5 Education

There is substantial Australian evidence that children in care do not fare as well as their peers in educational outcomes (AIHW 2015b; CREATE Foundation, 2006; McDowall, 2011; Osborn & Bromfield, 2007). Researchers note the important relationship between placement instability and participation in education, finding that placement disruption coincided with school changes. School changes were more likely to occur for older children, or for children placed some distance from their families (Osborn & Bromfield, 2007). One study found that Indigenous primary school-aged children in care were more likely to have changed schools four or more times compared with non-Indigenous children (McDowall, 2013).

Older children in care may be more disadvantaged than their younger peers. UK research on the educational progress of Australian and English young people in care suggests that it is not 'being in care' that contributes to poorer educational outcomes for adolescents. Other factors which may impinge on their progress include entry into care as teenagers, poorer behaviours (which may lead to exclusion from school), experiencing greater instability, changing schools in the previous two years, and the standard of the teaching and school (Sebba, Luke & Berridge, 2017). Other research by Sebba, Berridge, Luke, Fletcher, Bell, Strand, Thomas, Sinclair & O'Higgins (2015) suggests that adolescence brings its own sets of difficulties/stresses for young people, which may reduce their focus on doing 'well' at school (Sebba et al., 2015: 5)¹⁵.

Entry into OOHC may increase focus on educational attainment. Children in care in all Australian jurisdictions are required to have an individual education plan. The aim of the plan, developed by the school (e.g. the child's teacher) in collaboration with the caseworker, carer and child, is to identify the child's support or service needs in relation

¹⁵ A more extensive discussion on education is found in Eastman, Katz & McHugh, (forthcoming).

to educational progress and outline how desired goals are to be achieved¹⁶. In NSW, 10 OOHC Education Coordinators are available to assist schools in understanding the needs of children in care, and improving compliance in preparing an individual education plan (Beauchamp, 2015). Despite the advantages of implementing an education plan, it appears their use is limited (Hattie, 2012; McDowall, 2013; Queensland Child Protection Commission of Inquiry, 2013). In a CREATE study, only a quarter (25%) of the surveyed children ($n=267$) reported knowing of their plan (McDowall, 2013).

Research suggests that carers' knowledge and skills need to be increased to ensure more positive outcomes in children's education. Initial and ongoing training sessions should include:

- an understanding of the links between learning and behavioural difficulties in school and children's emotional behaviour (e.g. anxiety, depression and low self-esteem);
- how to provide positive encouragement and support with homework, reading and participation in extra-curricular activities;
- how to instil educational aspirations and encourage/support academic achievements in children/
- information on supporting career planning for young people in their care (Beauchamp, 2015; McCausland, 2014; McHugh & Pell, 2013).

An overview of foster care studies in the US found that where carers had high expectations for student success, this was a key factor influencing educational outcomes (Hattie, 2012). A Canadian study of young people ($n=687$) in OOHC indicated that the support from foster families and their involvement with the child in the educational context – providing tutoring, helping with homework, availability of books in the home and academic expectations of the caregiver – predicted positive academic outcomes for youth in care (Cheung et al., 2012). One Queensland study, however, presents a more negative view of the carer role in relation to a child's education. It suggests that foster carers are 'overloaded in their care duties' or feel 'ill-equipped in their understanding of education systems and processes', and this limits their participation in meetings related to children's education (Working Group on Education for Children and Young People in Out-of-Home Care in Queensland, 2011: 11).

¹⁶ In NSW, school principals are required to ensure that, within 30 days of entering OOHC, all preschool and school age children and young people in government schools have an individual education plan prepared for them. The education plan must be reviewed annually or when the student's circumstances change. There is no requirement for Catholic or independent schools to develop an individual education plan (Beauchamp, 2015: 17-18).

5.4.6 Health care

Children in care, compared with other children, have been found to experience more serious physical, mental and emotional health problems, many undiagnosed and untreated on entry into care. In Australia, except for a 'handful of academic research studies, relatively little has been recorded about the health of children in OOHC'. Unlike the UK and the US, there are no national or state level data sets on the health needs of children in OOHC (Webster, Temple-Smith & Smith, 2012: 10, 13). An Australian study of 50 children in Western Sydney found extensive waiting periods (12 months+) for specialist counselling services. In addition, the scarcity and cost of private providers as well as a lack of funding, treatment resources and options, caused delays when attempts were made to access services (Chalmers, Saunders, New, Williams & Stachurska, 2010).

An evaluation of one NSW program (*NSW OOHC Health Pathway Program*) found that 4,600 children had gained access to health assessments, clinical services and interventions in the three years since the program was introduced. Whilst most eligible children had been referred to the program, it was found that there were delays in referrals (Nous Group, 2014: 1). Indigenous children have been found to have a heightened risk of mental health difficulties (Sawyer et al., 2007), and Indigenous children and young people, compared with their non-Indigenous counterparts, have not fared as well in gaining access to health assessments, clinical services and interventions (Nous Group, 2014).

Being placed in OOHC may increase access to health care. All children in OOHC in NSW are required to have a health plan (NSW Children's Guardian, 2010). However, a case file audit conducted by the Children's Guardian in 2010 found that only one in every two files indicated that a health plan had been developed. Similarly, in only a third of applicable files was there evidence of a medical management plan for children with chronic conditions, e.g. asthma, epilepsy and diabetes. This is not to say that these children were not receiving 'appropriate treatment or services'; however, it was not clear whether there was a 'consistent and coordinated approach' for the most efficient and effective health services to meet the children's needs (NSW Children's Guardian, 2010: 22). The Children's Guardian Annual Report (2017) did not contain any information about health plans but notes that where children and young people had behavioural support needs, 69% had a current behaviour support plan in place, and where a child or young person was prescribed psychotropic medication, just over half (55%) had the necessary consent of the principal officer (NSW Children's Guardian, 2017).

Managing the behavioural difficulties of foster children can be challenging and highly stressful for carers. Researchers point out that a lack of support for carers, especially in relation to children's mental health issues, can have significant ramifications not only for the carer but for the child as well (Chalmers et al., 2010).

Some New Zealand, Australian and UK studies suggest that professionals (e.g. psychologists) should work with carers, empowering and enabling them to gain a better understanding of children's mental health issues and their needs (Murray, Tarren-Sweeney & France, 2011; Octoman & McLean, 2016; Sargent & O'Brien, 2004; Sawyer

et al., 2007; Young Minds, 2012). There is a need for training for Australian carers to enable them to detect child health problems (Kaltner & Rissel, 2011)¹⁷.

5.4.7 Therapeutic approaches

Children and young people with high needs in OOHC may require additional services and interventions to those described above. They generally present with complex problems including significant history of abuse (as victims, perpetrators or both), serious mental health issues, 'challenging' behaviours, intellectual and/or learning disabilities, history of school suspension/expulsion and difficult familial relationships. The NSW Department of Family and Community Services (FACS) and the Association of Children's Welfare Agencies (ACWA) have identified several key services or programs that are dedicated to children and young people with high needs, and these are outlined below.

In NSW, residential care is used for 2.6% of OOHC placements. The average age of young people in residential care is 14, and they had previously experienced multiple placements 28% had experienced more than three foster care placements and 8% more than 10 placements prior to entering residential care (FACS & ACWA, 2017: 16).

Based on a framework developed by FACS and ACWA in NSW (2017), NSW is on the cusp of introducing therapeutic services in all residential care settings. This is a new and evolving approach in Australia, informed by a sound understanding of trauma, attachment and developmental needs. The conceptual development of therapeutic residential care in Australia has been influenced by various international writers: Anglin (2002); Bloom (2005); McLean, Price-Robertson and Robinson (2011); and Perry (2006). Whilst it would be useful to review the literature on therapeutic residential care services, McLean and colleagues noted in an overview of the literature that comparing therapeutic residential care in Australia to other different types of residential care in other countries is difficult:

Complicated by the absence of clear definitions and conceptualisations of the different forms of care... the specific treatment or therapeutic components of different residential care programs are rarely elaborated, rendering much of the residential service provision a 'black box' of poorly understood elements that are difficult to generalise from or replicate (McLean et al., 2011: 3).

In addition, in some countries residential care services operate at the intersection of three major service systems statutory child welfare, child mental health and juvenile justice, which is a very different population of children from those in the child welfare systems operating in the Australian context (McLean et al., 2011).

Studies in Australia point to more positive outcomes that are possible with a therapeutic approach to residential care. A survey with non-government residential care providers

¹⁷ A more extensive discussion on health is found in Eastman, Katz and McHugh, (forthcoming).

(mix of standard and therapeutic care providers) ($n=25$) asked what factors were important in providing positive outcomes for children. The survey found that elements of therapeutic care identified by survey respondents included 'flexibility; individualised care; engagement and empowerment of young people; organisational congruence; skills; trained staff and consistent rostering' (FACS & ACWA, 2017: 27). Flexibility in service delivery was seen as an important factor for agencies providing residential care, as it allowed agencies to move children as their needs changed. Agencies need the ability to provide 'step up' (e.g. from foster/kinship to residential care) and 'step down' (e.g. from residential care to foster/kinship care) support according to the level of children's need for different levels of care.

Survey respondents reported positive outcomes for young people which stemmed from their practice that incorporated a therapeutic approach including:

- involving young people in decision-making;
- providing specialist services – e.g. psychologists, psychiatrists and legal services;
- developing meaningful relationships between young people and staff;
- having appropriately trained and skilled staff;
- promoting family contact.

Some of the barriers identified by survey respondents in relation to achieving positive outcomes in all residential care models included:

- funding limitations;
- difficult client behaviours;
- mental health/trauma issues;
- lack of skilled staff;
- drug and alcohol problems;
- inadequate matching processes;
- FACS caseworker involvement;
- lack of parental understanding and support (FACS & ACWA, 2017).

Other Australian research carried out by Verso Consulting on residential care indicated that therapeutic residential care provided better outcomes than standard residential care. In Victoria, an evaluation of Therapeutic OOH Residential Care Pilot Programs found that 'therapeutic residential care practice leads to better outcomes for children and young people than standard residential care practice' (Verso Consulting, 2011). These outcomes included:

- significantly improved placement stability;

- increased healthy lifestyles and reduced risk-taking behaviour;
- enhanced mental and emotional health;
- improved relationships and quality of contact between young people and their family;
- increased community connection;
- significant improvements in sense of self;
- increased staff satisfaction;
- increased engagement and participation of young people.

Therapeutic (or Multidimensional Treatment) Foster Care is an intensive family-based, therapeutic approach for children and young people with serious emotional and behavioural disorders. To date, Therapeutic Foster Care (TFC) has demonstrated efficacy in reducing violent crime by chronic juvenile offenders in a study in the US (Hahn, Bilukha, Lowy, Crosby, Fullilove, Liberman, Moscicki, Synder, Tuma, Corso & Schofield, 2005), and has been assessed as a ‘promising or probably efficacious’ intervention for children with high needs within the child welfare population (Farmer, Dorsey & Mustillo, 2004).

The best outcomes occur for children and young people who need less help – those with the least emotional and behavioural problems, fewer prior placements and less time spent in institutions, as well as good relationships with their foster family members. Based on current evidence, TFC appears to be most successful for children under the age of 14 and for boys rather than girls, with previous OOHC placement as the most significant predictor of impairment and change in mental health status over time. Turner and MacDonald (2015) recently completed a systematic review of initial program evaluations and experimental studies of TFC programs in Canada, the UK and the US involving five studies including 390 participants. They concluded that TFC is a potentially effective intervention for children and young people experiencing mental health problems, behavioural problems or problems of delinquency.

An evaluation of the *Circle Program*, a Victorian therapeutic foster care program (Frederico, Long, McNamara, McPherson, Rose & Gilbert, 2012), reported the following positive outcomes:

- real gains in children’s and young people’s placement stability;
- the attainment of developmental milestones (and in some instances exceeding) where there had been marked delay;
- the capacity to offer continuity of care to children and young people who were experiencing ongoing instability as a result of their legal status;
- successful reunification with the children and young people’s families (Frederico et al., 2012: 8).

An aspect influencing positive outcomes for children was that competent, confident, well trained and supported carers enhanced placement stability, allowing children to 'progress forward', especially with regard to developmental gains (Frederico et al., 2012: 80). Mennen and O'Keefe (2005: 581) argue that there is now sufficient evidence to suggest that 'a child's early experiences can be overcome if therapeutic intervention takes place and emotional stability and security is provided'.

An approach rated as beneficial for children exposed to or at risk of experiencing repeated and/or prolonged trauma through abuse and neglect is Trauma-Focused Cognitive Behavioural Therapy (TF-CBT). An overview from the US-based Child Welfare Information Gateway (CWIG) (2012) indicates that at least 11 empirical investigations have been conducted evaluating the impact of TF-CBT on children who have been victims of sexual abuse or other traumas, and that the findings 'consistently demonstrate TF-CBT to be useful in reducing symptoms of PTSD [Post-Traumatic Stress Disorder] as well as symptoms of depression and behavioural difficulties in children who have experienced sexual abuse and other trauma' (CWIG, 2012: 6).

Multi-Systemic Therapy (MST) is an intensive, goal-oriented, time-limited (typically three to six months), home- and family-focused treatment approach designed to equip children and young people and their families with the skills needed to function more successfully in their community environment. It is an evidence-based treatment which uses the family preservation model of service delivery.

Several reviews by US researchers have classified MST as a 'probably efficacious' treatment according to the criteria for empirically supported treatments (Brestan & Eyberg, 1998; Burns, Schoenwald, Burchard, Faw & Santos, 2000; Chorpita, Yim, Donkervoet, Arensdorf, Amundsen, McGee, Serrano, Yates, Burns & Morelli, 2002). More specifically, MST has been shown in randomised control trials to attenuate anti-social behaviour, such as aggression and criminal offences, and to improve social behaviour, such as family and peer relations (Borduin, Henggeler, Blaske & Stein, 1990; Henggeler, Melton & Smith, 1992).

Outcomes for young people rely on adhering to the MST strategy and its principles, training of the therapists, cooperation within and between relevant staff, involvement with peers and community or neighbourhood, and positive interaction between each, if not all, systems. In addition, there are some limitations to the translation of MST to other contexts in that most MST evaluations have involved juvenile justice populations, have been implemented in the US, and conducted by the developers. Therefore, the effectiveness of MST with younger children with milder forms of behavioural disorder has yet to be independently evaluated.

Case management of children with high needs has been shown to be an effective intervention. While the definition of case management may vary, its main elements include assessment, service planning, implementation and coordination, monitoring, evaluation and advocacy. For children and young people with high needs, a 'convincing evidence base' is developing for intensive case management as a 'promising' or 'potentially efficacious' service in reducing antisocial behaviour and the risk of use of restrictive settings (Evans & Armstrong, 2002; Farmer et al., 2004).

Similarly, 'wraparound services' are another intervention available to address the high needs of some children in care. While sharing similarities with case management, which operates at the client (i.e. child and family) level, wraparound services work at the system level, emphasising service planning, coordination and linking of services. The wraparound approach is designed to work with families and young people with serious emotional and behavioural disturbance and multiple, complex needs. It aims to address the lack of 'fit' between family needs and actual services/supports provided, the lack of full engagement of families in the process, and the lack of program and system environment to support flexible, individualised care for families (Bruns, Walker, Adams, Miles, Osher, Rast, VanDenBerg, & National Wraparound Initiative Advisory Group, 2004). While case management is a central component of wraparound, the focus of wraparound is the way in which service delivery is planned (Farmer et al., 2004).

A US study examining the outcomes of wraparound services for young people shows reductions in the number of days and level of restrictiveness of residential placements, and improvements in school performance and psychological and behavioural functioning (Burns et al., 2000). However, the wraparound approach's 'flexible' and 'individualised' nature and grassroots development makes rigorous evaluation difficult. Australian research found a lack of empirical evidence to show whether wraparound works any better than regular services such as individualised therapies (Schmied, Brownhill & Walsh, 2006).

5.4.8 Contact with birth family

One of the most problematic areas in any form of OOHC can be the maintenance of contact (where appropriate) between children in care and their birth family members. Studies have highlighted the difficulties faced by foster and kinship carers (Indigenous and non-Indigenous) in relation to contact/access visits with family members, and in managing the impact visits can have on children and themselves. This section of the report discusses contact and outcomes for children in foster care, followed by contact in kinship care and then contact between siblings.

In an overview of the international literature on contact, Taplin (2005) suggests there are several positive outcomes for children in relation to family contact as it:

- encourages reunification with the birth family;
- maintains/encourages attachment to the birth family;
- prevents idealisation of the birth family;
- maintains links and cultural identity;
- enhances the psychological wellbeing of the children in care (Taplin, 2005: 7).

Two reviews of the international literature (Akin, 2011; Taplin, 2005) found numerous studies reporting that contact visits from parents were associated with a higher likelihood of exit from foster care. Leathers' (2002) study of 230 children in OOHC also confirmed that visiting frequency is highly predictive of reunification, and that these associations could not be explained by maternal substance abuse, mental illness, or the child's

placement history. In contrast to these findings, work by Barber and Delfabbro (2004) found little apparent relationship between changes in the frequency of contact and the likelihood of reunification.

Several Australian studies that have reviewed the literature on contact suggest that whilst contact improved children's emotional and behavioural adjustment over time, they also showed signs of strain, presumably brought about by loyalty conflicts with foster families and the need to juggle two sets of parental relationships (Barber & Delfabbro, 2004; Taplin, 2005). Another Australian study found that the evidence on which the belief that contact is generally beneficial to the child appears 'weak or mixed' (Barber & Gilbertson, 2001).

In the Australian context, arranging contact is sometimes the role of a child's caseworker, and it takes experience, skill and time to arrange contact visits for children. Often it is the foster carer who takes responsibility for ensuring that contact visits occur as arranged. In a national survey of children in care ($n=484$), less than half (45%) of the children rated their caseworker as 'quite' or 'very supportive', compared with over two-thirds of children (69%) who gave the same rating to their carer. The research suggests that caseworkers, who have a central role in contact arrangements, may need to work more closely with carers and children to ensure that visits with all birth family members are rewarding (McDowall, 2013). One of the key messages from the children in the study was that they wanted more contact with family members, particularly with their siblings.

Similar findings come from a Swedish study (Lundstrom & Sallnas, 2012: 400) of children in OOHC ($n=240$) which found that 'the older the children and the longer the time they have spent in care, the more they crave contact with their siblings'. The authors also found a close to linear relation between frequency of contact and wish for more contact; 'i.e. the more seldom the children see their siblings the more they long to see them more often' (Lundstrom & Sallnas, 2012: 400).

There are limited research studies on contact arrangements for children in kinship placements. One study with young people ($n=67$) aged 18-28 years who had lived in kinship arrangements (predominantly with grandparents) found low frequency of contact with their birth family. Researchers noted that the finding coincided with those of other national studies such as the one conducted by del Valle, Lázaro-Visa, López and Bravo in Spain (2011), which found that insufficient attention was given to support and follow-up for those in kinship care (del Valle et al., 2011).

There is evidence that children placed with relatives are more likely to have contact with birth parents and siblings than children in foster care (Harden, Clyman, Kriebel & Lyons, 2004). While continued contact with the birth family is reportedly a benefit of kinship care, if it is not well managed and/or supervised, it may not be safe for children. In an overview of the literature on contact, Taplin (2005) noted:

Issues related to contact in kinship care, where the child remains with the extended family, are generally different from those in foster care. However, the safety of the child placed in kinship care may require more careful consideration, particularly when the child has been abused by a family member (Taplin, 2005: 1).

Offering specific training for kinship carers, particularly around managing contact visits with birth parents, could assist in ensuring that contact visits are safe for children (McHugh, 2013). This is an important issue, as few studies have directly assessed the safety of children in kinship care (Geen, 2003). In handling difficult family relationships around contact visits, one Australian study on parental contact with children in kinship care involving 18 mothers and two fathers, noted that ‘parents wanted workers to be understanding, non-judgmental and to provide continuity’ and that while family relationships could be fraught, especially where substance abuse was a factor, parents and children needed a greater say in ‘whether, when and under what circumstances’ they had contact (Kiraly & Humphreys, 2015).

5.4.9 Sibling groups and contact

A national study on sibling contact obtained the views of children in care ($n=1,160$) and caseworkers ($n=116$) (McDowall, 2015). McDowall compared the frequency of contact with family for children living in *Together*, *Splintered*, *Split*, and *Alone* placements. Family members who were accessible to the children included the mother, father, grandparents and other relatives. The analysis indicated that:

- the main effects (significant interaction) were found for ‘Sibling Placement’ and ‘Family Member’;
- those in *Together* placements had more frequent contact than children and young people in *Splintered* or *Split* placements;
- mothers were contacted more frequently than grandparents, who in turn were contacted more than other relatives;
- fathers were contacted least of all;
- children in *Together* placements contacted grandparents and other relatives far more frequently than those in other sibling relationships;
- comparisons of frequency of contact with other siblings showed no significant differences between *Splintered* and *Split* placements, but both groups saw their siblings more often than those *Alone* in care (McDowall, 2015: 36-37).

The study also examined how caseworkers achieved sibling contact for those children and young people who were not placed with all their siblings. Whilst nearly all (97%) agreed that contact between siblings was important, only 70% were involved in arranging contact visits. Twenty per cent of the caseworkers ‘reported high levels of difficulty in trying to organise sibling contact’ (McDowall, 2015: 60).

Significant proportions of the sample had no contact with fathers (33%) and no contact with mothers (19%). In relation to the provision of support in contact visits, carers were mainly responsible for helping children maintain contact with family members, with caseworkers less involved. Those children in the *Alone* group received significantly less assistance in maintaining contact with family than did children in *Split* placements, who received the highest level of support (than other groups received) (McDowall, 2015: 38-39).

In summary, children who enter care with a history of abuse and neglect require a number of age-specific services including health services (particularly mental health services), optical, dental, educational, therapeutic services (e.g. counselling, speech, physiotherapy) and recreational activities. In addition, placement-specific services including casework, case planning and management are also required. A NSW study of OOHC caseworkers found that 86% of all respondents whose work related to OOHC had a degree level qualification, with respondents from the non-government sector lower (74.5%). Caseload was highest for children in General Foster Care (12.8 cases) and lower for children requiring Intensive Residential Care (six cases) (NSW Auditor-General, 2015). The majority (87%) of all children and young people in OOHC have an individualised case plan that details their health, education and other needs (AIHW, 2016b). There is substantial evidence that educational outcomes for children and young people in care are not as good as those of their peers (AIHW 2015b: 1; CREATE Foundation, 2006; McDowall, 2011; Osborn & Bromfield, 2007). Support from foster families and their involvement with the child in the educational context predicted positive academic outcomes for youth in care (Cheung et al., 2012). Indigenous children have been found to have a heightened risk of mental health difficulties (Sawyer et al., 2007 cited in Dobia & O'Rourke, 2011), and research indicates that Indigenous children and young people, compared with their non-Indigenous counterparts, have not fared as well as in gaining access to health assessments, clinical services and interventions (Nous Group, 2014). Children and young people who present with complex problems and difficult familial relationships may benefit from therapeutic approaches (including psychologists/clinical support and involvement of carers, and in residential settings).

6 Conclusion

This review of the literature on factors that influence outcomes for children in OOHC has identified a range of influences that have been demonstrated empirically to affect outcomes, as well as factors that research indicates have no effect on outcomes. There are also factors where research findings are inconclusive or where insufficient research has been conducted to indicate whether the factor does have an effect. Much of the research on outcomes is affected by selection effects, where children with different characteristics are likely to receive different types of care. This is appropriate for the care of children, but it creates challenges for researchers who are concerned with attributing outcomes to specific variables.

What is known is that children in care, compared with children not in care, experience more serious physical, mental and emotional health problems. Many studies conducted in various countries have found that, in general, outcomes for children placed in OOHC are worse than for children never placed in OOHC, and that children in OOHC exhibit higher levels of behavioural and social problems (Clausen et al., 1998; Tarren-Sweeney & Hazell, 2006; Meltzer et al., 2003; Gypen et al., 2017). It is likely that these findings are due at least in part to selection effects – children with higher levels of emotional, social and behavioural difficulties being more likely to be placed in care.

Fairhurst and colleagues (2016: 2) state that explanations for ‘generally poor outcomes tend to coalesce around two interrelated factors, namely, the long-term impact of early childhood abuse, neglect, and maltreatment, and the lack of supports available to young people as they exit the OOHC system’.

Factors that are known to affect outcomes

In terms of child characteristics, research indicates that outcomes are affected by the child’s characteristics such as their pre-care experiences and their demographic and personal characteristics. In particular, poorer outcomes are associated with exposure to maltreatment and trauma, especially longer exposure. Another key predictor of poorer outcomes is being placed in care at an older age. These are associated with poorer outcomes overall, including behavioural and emotional problems, diagnosed mental disorders, and placement breakdowns. Conversely, placement in infancy, particularly before 12 months, is associated with secure attachment with carers and better outcomes. Likewise, adoption at a younger age is also associated with better outcomes.

Research indicates a strong correlation between the number of placements and poorer outcomes. Placement breakdown is in turn associated with behavioural problems, stemming from previous experiences. A higher number of placements in childhood is correlated with poorer outcomes in adulthood (Fernandez et al., 2016). Lack of secure attachment, and weak feelings of safety and security are associated with placement breakdown. However, as indicated below, these effects can be mitigated by the provision of quality OOHC and achievement of stability.

Demographic features also are known predictors of not only entry into OOHC but also outcomes. Aboriginal children are at higher risk of poor outcomes than non-Aboriginal children. Children from lower socio-economic areas are also at risk of poorer outcomes. Less is known about cultural factors and culturally matched placements as mitigating factors.

In regard to placement characteristics, research indicates that children's outcomes are affected by the quality of care as well as other factors which children experience while they are in care. The quality of caregiving and other care related aspects, rather than placement type, protect against placement breakdown (Oosterman et al., 2007). This is consistent with other research which indicates that carer attributes (e.g. warm, responsive parenting style, good parenting skills and effective discipline practices) and meaningful relationships with caseworkers are important in overall improved child wellbeing (Commission for Children and Young People and Child Guardian, 2013). The evidence indicates that placement instability may be prevented by interventions including more in-depth assessment and screening for known risk factors and appropriate placement support.

Research has indicated that services received, including training for carers, wraparound type support, and other interventions, do have effects on outcomes. Extended support (into young adulthood) reduces the level of poorer outcomes, as young people have more support moving into independence (Campo & Commerford, 2016; McDowall, 2016).

Factors that are known not to affect outcomes

Factors that seem to have little or only weak impact on outcomes are also indicated in research.

In regard to child characteristics, gender has little bearing on outcomes while in OOHC. However, after leaving care some studies show (Cashmore & Paxman, 2006) that young women tend to do better than young men in a range of domains.

With regard to placement characteristics, the type of care is largely irrelevant – it does not matter whether the carer is a foster or kinship carer. Children adopted, especially as infants, tend to have significantly better outcomes than those in foster or kinship care (Vinnerljung & Hjern, 2011).

Factors where the effect is unknown

For many of the factors which may affect outcomes in OOHC there is limited research in Australia or internationally, or the research is inconclusive.

For example, it is not clear that placement in OOHC, versus non-removal, improves outcomes. Some research has found that placement in OOHC (where it is determined that this is necessary) may improve outcomes (compared with no intervention) (Verso Consulting, 2011). However, other studies indicate that for children on the margin of placement (that is, in situations where not all investigators would agree they were in such danger that removal was necessary) tend to have better outcomes if left at home, especially older children (Doyle, 2007).

Studies on the effect of disability on outcomes are inconclusive. Some found that disability creates difficulties in placement; however, other studies found that once placement is achieved, outcomes are similar between children with disability and other children in OOHC who do not have a disability.

There are a small number of studies on CALD background and outcomes. This field is limited by the lack of collected data on the cultural background of children in care, particularly in Australia. With regard to culturally matched placements, studies were inconclusive as to whether this affected overall outcomes, although some reported improved self-esteem and feelings of connection.

It is not really known whether placement with siblings affects outcomes. Most research indicates that siblings desire contact, but it is not clear if other factors are stronger in predicting outcomes (for example quality of care from caregivers).

Contact with birth families is not strongly associated with outcomes, although frequency of visits is associated with reunification.

More research is required to examine the effects on children of the Aboriginal placement principle and cultural plans. It is unclear what, if any, effect placement with non-culturally matched carers can have on cognitive, emotional and behavioural outcomes. Importantly, however, children placed in kinship care with culturally similar carers report improved connections with their culture. Research also indicates that kinship carers may get less support than foster carers, have lower incomes and suffer more stress.

Overall, the research evidence indicates that the quality of care received by children is the strongest predictor of outcomes over time, given the level of difficulties they have on entry into OOHC. Research also shows that children's trajectories through the care system are determined by interactions between the different risk and protective factors over the course of their placement. It is these interactions, rather than the factors themselves, which are likely to have the greatest impact on children's wellbeing over time. For example, how carers and caseworkers respond to issues such as children's externalising or internalising behaviour difficulties, or the contact with birth families, will have an important influence on how these factors affect the child's outcomes in care. The research evidence is accumulating rapidly, and it is likely that new research, including the POCLS, and studies using data linkage will fill many of the gaps in the evidence base, particularly in the Australian context.

The purpose of this paper has been to provide a review of the literature on factors that were included for measurement in the POCLS. The POCLS will examine the outcomes for an entire cohort of children who entered OOHC for the first time within an 18-month period. Where children went on to receive a final order, their carers and the children if aged 7 or older, are invited to participate in a face-to-face interview. Where children did not go on to final orders, a number of administrative data sources will provide supplementary outcome indicators. This will therefore provide findings which will fill in many of the gaps identified in this review and will add to the evidence base for those factors for which there is already some research evidence. It is an internationally significant study which will contribute robust evidence to academics, policy makers and practitioners involved in designing and delivering OOHC.

7 References

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Appendix: Literature Review Methodology and Sources

The resources searched included Medline, Psychological and Behavioural Sciences Collection, PsycINFO, PsycARTICLES, PsycEXTRA, PsycBOOKS, SOCIndex with Fulltext, Australia and New Zealand Reference Centre.

A systematic search was undertaken using the following abstract fields:

(predictor* OR (factor* AND influence*) OR outcome*) AND (oohc OR “foster care” OR “foster home care” OR “kinship care”) AND (“age at admission” OR “admission age” OR “age of child*” OR “mental health” OR “placement breakdown” OR indigenous OR aboriginal OR race OR ethnic* OR disability OR disabled OR maltreatment OR sibling* OR “family background*” OR geographic OR neighbourhood).

Literature was also sourced from a number of websites, including the webpages of child welfare organisations and other specialist centres in Australia, the UK, the US and Australian government websites. These included:

- British Agencies for Adoption and Fostering (BAAF)
- Centre for Advanced Studies in Child Welfare
- Chapin Hall Center for Children
- Child Welfare Information Gateway
- Cochrane Database of Systematic Reviews
- Family Rights Group
- Hadley Centre for Adoption and Foster Care Studies
- National Society for Prevention of Cruelty to Children (NSPCC)
- Rees Centre
- School for Policy Studies, University of Bristol
- Social Care Institute for Excellence
- US Department of Health and Human Services.

In Australia, the following websites were examined:

- Anglicare Tasmania
- Anglicare Victoria
- Australian Centre for Community Services Research

- Australian Centre for Posttraumatic Mental Health and Parenting Research Centre
- Australian Institute of Health and Welfare
- Australian Institute of Family Studies
- Berry Street, Victoria
- Centre for Excellence in Child and Family Welfare
- Commission for Children and Young People and Child Guardian
- CREATE Foundation
- Department of Human Services (DHS) Victoria
- Institute of Child Protection Studies
- National Child Protection Clearinghouse
- NSW Auditor-General
- NSW Office of the Children's Guardian
- NSW Community Services Commission
- NSW Department of Family and Community Services
- NSW Law Reform Commission
- Queensland Child Protection Commission of Inquiry
- Social Justice Unit, Uniting Care
- Social Policy Research Centre, University of New South Wales
- Southern Cross University Centre for Children and Young People
- The Winston Churchill Memorial Trust of Australia

The literature reviewed was limited to English-language publications. In the Australian context, it is a difficult topic to research, as there appears to be very limited coverage by researchers or child welfare/child protection departments. In addition, not all work in this area is published. For example, in the transition process from government to non-government agencies in 2012, FACS conducted a survey of 58 non-government organisation service providers to identify the level of training required by caseworkers. This survey would have provided useful information on caseworker training, experience and level of qualifications, but was not available online or elsewhere. Similarly, foster and kinship carer characteristics are not directly linked to the outcomes literature; however, these characteristics as well as training and support provided may also be linked to outcomes. An effort has been made to include such literature in this review.

In regard to Australian literature, this review draws upon meta-reviews and research reports produced by Community Services' Centre for Parenting and Research. The *Audit of Australian Out-of-Home Care Research* carried out by Cashmore & Ainsworth (2004) identified the paucity of Australian research on OOHC and the significant gaps in the available research. Building on the work of Cashmore and Ainsworth in 2004, Bromfield and Osborn (2007b) provided a synopsis and critique of Australian OOHC research completed between 1995 and 2006. They found that, in general, the Australian research that related to outcomes for children and young people in care was of a very high quality relative to other areas of out-of-home care research; however, a survey of the literature found that 11 of the 21 studies were based on data from a single South Australian longitudinal study (Bromfield & Osborn, 2007b).

Audits of Australian child protection research have been completed: a *National Audit of Australian Child Protection Research 1995-2004* (Higgins, Rennel, Bromfield, Richardson & Aldana, 2005a); *The Protecting Australia's Children: Research and Evaluation Register (1995-2010)* (McDonald et al., 2011). Finally, the most recent, the *Protecting Australia's Children: Research and Evaluation Audit (2011-2015)* identified 295 research items categorised under the topic out-of-home care (including leaving care). The audit noted a significant 77% increase in the number of Australian research projects focused on child protection from 2011 to 2015.

The literature review also includes many US studies as well as UK and Canadian studies, and a small number of European studies. It is not always advisable to extrapolate from this international literature to the Australian (or NSW) context in a policy sense because of differences in population, legislation, and systems of OOHC, health and other services. For example, Australia, unlike the UK and the US, has more kinship than foster carers, and adoption is more common in the US than in Australia¹⁸. However, despite these system differences, international studies on factors and outcomes are relevant to the Australian context.

¹⁸ In 2015, in the US 12.5% of children in care (427,910) were placed in adoption (53,549) and over 60,000 foster carers are pre-adoptive carers. US Department of Health and Human Services (2015) Adoption and Foster Care Analysis Reporting System (AFCCARS), www.acf.hhs.gov/programs/cb

